Unannounced Care Inspection Report
23 June 2016

Harold McCauley House

Type of Service: Nursing Home
Address: 7 Camowen Terrace, Omagh, BT79 0AX
Tel No: 028 8225 2550
Inspector: Bridget Dougan

1.0 Summary

An unannounced inspection of Harold McCauley House took place on 23 June 2016 from 12.00 to 16.30 hours.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence of competent and safe delivery of care. Planned staffing levels were kept under review to ensure the assessed needs of the patients were met. Newly appointed staff completed a structured orientation and induction programme and a robust system was in place to ensure staff attended mandatory training.

Whilst there was evidence that all relevant pre-employment checks had been completed, some of the documentation had been retained by their Human Resources department at another location. The registered manager confirmed that copies of the relevant documentation would be stored in the home and made available for future inspections.

The environment was well decorated, clean and comfortable. Patients, relatives and staff felt that the care provided was safe and patients were protected from harm.

There were no requirements or recommendations made.

Is care effective?

Care records accurately reflected the assessed needs of patients; were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate.

Staff meetings were held quarterly and there was evidence of good teamwork. Patient / relatives meetings were held quarterly and they expressed their confidence in raising concerns with management/staff.

There were no requirements or recommendations made.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.
There were no requirements or recommendations made.

Is the service well led?

There was a clear organisational structure within the home and evidence that the home was operating within its registered categories of care. Systems were in place to monitor and report on the quality of nursing and other services provided. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Patients and relatives assessed this aspect of the service as excellent.

It was evident that there was effective leadership, management and governance and a culture focused on the needs and experiences of patients in order to deliver safe, effective and compassionate care.

There were no requirements or recommendations made.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs. Caroline Crawford, registered manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 7 April 2016. There were no further actions required to be taken following the last inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered provider: Presbyterian Board of Social Witness Mrs. Linda Wray	**Registered manager:** Mrs. Caroline Crawford
Person in charge of the home at the time of inspection: Mrs. Caroline Crawford	**Date manager registered:** 01/04/2005
Categories of care: NH-PH, NH-PH(E), NH-I, NH-DE, NH-LD A maximum of 7 patients in category NH-DE and a maximum of 2 patients in category NH-PH/PH(E). Category NH-LD for 1 identified patient only.	**Number of registered places:** 32

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection we met with 20 patients, three registered nurses, five care staff, one activities co-ordinator, one catering, one domestic staff and the hairdresser.

Nine patients, eight staff and four relatives completed questionnaires.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training planner for 2016/17
- two staff personnel records
- accident and incident records
- notifiable events records
- sample of audits
- complaints and compliments records
- NMC and NISCC registration records
- staff induction records
- nurse competency and capability assessments
- minutes of staff meetings.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 April 2016

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 7 April 2016. No requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last care inspection dated 29 June 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 5.3 **Stated:** Third time	The registered manager must ensure that patients care plans are reviewed and updated to specify the pressure relieving equipment on the patient's bed and also when sitting out of bed.	**Met**
	Action taken as confirmed during the inspection: A sample of three care records were reviewed and evidenced that this recommendation had been met.	

Recommendation 2 **Ref**: Standard 19.1 **Stated:** First time	It is recommended that the registered manager ensures that care staff receive training on breaking bad news communication skills	**Met**
	Action taken as confirmed during the inspection: The majority of care staff had attended training on 8 January and 6 June 2016. This training included information on breaking bad news communication skills.	
Recommendation 3 **Ref**: Standard 32.3 **Stated:** First time	It is recommended that the registered manager ensures that care staff receives training on palliative/end of life care, appropriate to their roles and responsibilities.	**Met**
	Action taken as confirmed during the inspection: The majority of care staff had attended training on 8 January and 6 June 2016. This training included end of life, death and dying and dealing with loss.	
Recommendation 4 **Ref**: Standard 41.1 **Stated:** First time	The registered manager should review staffing levels to ensure the number and ratio of staff on duty at all times meets the care needs of patients.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of a sample of duty rotas evidenced that staffing levels had been reviewed and an additional carer had been rostered to work at weekends. No further concerns were raised by patients, relatives or staff regarding staffing levels.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rotas for weeks commencing 13, 20 and 27 June 2016 evidenced that the planned staffing levels were adhered to. The registered manager advised that staffing levels had been increased in relation to the dependency levels of patients. An additional carer had been rostered to work at weekends from January 2016 (refer to section 4.2).

Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with the registered manager confirmed that there were systems in place for the safe recruitment and selection of staff, and staff consulted confirmed that they had only commenced employment once all the relevant checks had been completed.

Two personnel files were viewed and whilst there was evidence that all relevant pre-employment checks had been completed, some of the documentation was not retained in the personnel records. A copy of the references and the health assessments were not maintained on file. However a checklist, signed by the Head of Human Resources was in place indicating the dates on which all the relevant documentation, including two satisfactory references and a health questionnaire had been received for each member of staff.
The registered manager explained that the Human Resources function for the home was managed centrally at their headquarters in Belfast and the references and health assessments were retained at that location. The registered manager confirmed that she would contact their Human Resources department and request copies of these documents to be forwarded to the home and retained on file for future inspections.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Records for three staff members were reviewed and found to be completed in full and dated and signed appropriately.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Review of training records evidenced that mandatory training had been completed to date. Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training.

Staff clearly demonstrated the knowledge, skills and experience necessary to fulfil their role, function and responsibility.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Discussion with the registered manager confirmed that a range of audits was conducted on a regular basis (refer to section 4.6 for further detail). A sample of falls audits confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends. An action plan was in place to address any deficits identified.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident. Trust representatives, patients' representatives and RQIA were notified appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Comments received in the returned questionnaires from patients, relatives and staff indicated that patients were safe and protected from harm. Some comments received are detailed below:

"Mother said in her own words that she feels "safe and secure". Staff take a great pride in their care and our home"

Overall, everyone felt the care provided in the home was safe.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that registered nurses, assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. Risk assessments informed the care planning process. It was evident that care records accurately reflected that the assessed needs of patients.

There was evidence that care records were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate. There was evidence also of regular communication with patients' representatives regarding the patients' ongoing condition.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. The registered manager and staff also confirmed that regular quarterly staff meetings were held and records were maintained.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Discussion with the registered manager and review of records evidenced that patient and/or relatives meetings were held on a quarterly basis. Minutes were available.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives were aware of who their named nurse was and knew the registered manager. Some comments received as follows:

"Reviews take place at regular intervals with staff and the social worker"
"We are looked after very well, 24 hours a day. You couldn't ask for more. We have the freedom to do our own things and yet we have someone here to care for us when we need them"

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

We were informed that a weekly prayer meeting had been held in the home just before lunchtime and any patients who wished to attend were facilitated to do so.

Observation of the lunchtime meal confirmed that patients were given a choice in regards to food and fluid choices, and the level of help and support requested. The dining tables were nicely set with a tablecloth, condiments and fresh flowers on each table. Staff were observed to offer patients reassurance and assistance appropriately.

A musician provided live entertainment in the lounge in the afternoon and the majority of patients attended. Patients told us that they enjoyed listening to the music and reminiscing. Live entertainment was provided on a regular basis as part of the activities programme.

Discussion with the home's activities co-ordinator evidenced that she had taken up the post following her retirement as a registered mental health nurse. She had a detailed knowledge of dementia care and used her knowledge and experience to plan a programme of meaningful activities for the patients as well as providing training for staff in dementia awareness.

Patients spoken with commented positively in regards to the care they received and life in the home. Those patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Questionnaires were distributed to patients and their relatives in March 2016. Twelve questionnaires were completed and the comments provided were complimentary. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients/relatives meetings were held on a quarterly basis and records had been maintained.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Some comments received from patients:

"Staff are all excellent"
"I'm well settled here. There is nothing I can think of that needs improved"

Relatives' comments:

"It is very easy to talk to staff about any aspects of care and very easy to visit McCauley House as relatives are made very welcome at any time"

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities. Staff also confirmed that there were good working relationships and that the registered manager was responsive to any concerns raised.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager, a review of care records and observations confirmed that the home was operating within its registered categories of care.

Review of the home's complaints record and discussion with the registered manager evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. No complaints were received since the previous care inspection.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

There was evidence that a range of audits had been completed on a monthly basis, including care records, accidents/incidents, medication management and infection prevention and control. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Discussion with the registered manager and review of records for March, April and May 2016 evidenced that Regulation 29 monthly quality monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any

areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Feedback received in the returned questionnaires confirmed that patients, relatives and staff felt the service was well led. Some comments from relatives included the following:

"All staff from the manager to the care assistants are very approachable and caring"
"I come in here every day to visit my relative and everything is very good. Staff are all very nice and friendly".

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards.

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