# Unannounced Follow-up Care Inspection Report
# 2 December 2019

# Harold McCauley House

**Type of Service: Nursing Home (NH)**
**Address: 7 Camowen Terrace, Omagh BT79 0AX**
**Tel no: 02882252550**
**Inspector: Michael Lavelle**

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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 DHSSPS Care Standards for Nursing Homes 2015.

## 1.0 What we look for


## 2.0 Profile of service

This is a registered nursing home which provides care for up to 32 patients.

## 3.0 Service details

| | |
|---|---|
| **Organisation/Registered Provider:**<br>Presbyterian Council of Social Witness<br><br>**Responsible Individual:**<br>Lindsay Conway | **Registered Manager and date registered:**<br>Michelle Murray – acting, no application required |
| **Person in charge at the time of inspection:**<br>Michelle Murray | **Number of registered places:**<br>32<br><br>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. |
| **Categories of care:**<br>Nursing Home (NH)<br>I – Old age not falling within any other category.<br>DE – Dementia.<br>LD – Learning disability.<br>PH – Physical disability other than sensory impairment.<br>PH(E) - Physical disability other than sensory impairment – over 65 years. | **Number of patients accommodated in the nursing home on the day of this inspection:**<br>30 |

## 4.0 Inspection summary

An unannounced inspection took place on 2 December 2019 from 07.10 hours to 13.15 hours.

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 DHSSPS Care Standards for Nursing Homes 2015.

The inspection was undertaken following receipt of information from an anonymous source regarding staffing and discussion with the adult safeguarding team from the Western Health and Social Care Trust.

It is not the remit of RQIA to investigate adult safeguarding concerns made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, if RQIA is notified of a potential breach of regulations or minimum standards, it will review the matter and take appropriate action as required; this may include an inspection of the home.

The following areas were examined during the inspection:

- staffing and delivery of care
- management of falls, infections and wounds and care delivery
- environment
- consultation.

Patients described living in the home in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

## 4.1 Inspection outcome

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | *2 | 1 |

*The total number of areas for improvement includes one under regulation which has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Michelle Murray, acting manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

## 4.2 Action/enforcement taken following the most recent inspection dated 13 September 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 13 September 2019. Other than those actions detailed in the QIP no further actions were required to be taken.

## 5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received, for example, serious adverse incidents.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from weeks commencing 2 December 2019
- incident and accident records
- four patient care records
- a selection patient care charts including personal care records, food and fluid intake charts, reposition charts, topical medicine administration records and bowel charts
- RQIA registration certificate.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

## 6.0 The inspection

## 6.1 Review of areas for improvement from previous inspection dated 13 September 2019

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1<br><br>Ref: Regulation 16 (2) (b)<br><br>Stated: Second time</td><td>The registered person shall ensure patient care plans are kept under review.<br><br>This area for improvement is made in reference to management of infections.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:<br>Review of records confirmed this area for improvement has been met.</td></tr>
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| | | |
|---|---|---|
| **Area for improvement 2**<br><br>**Ref:** Regulation 13 (4) (c)<br><br>**Stated:** Second time | The registered person shall ensure a written record for the administration of thickening agents and medicines for topical administration is accurately maintained. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of records evidenced a new system had been introduced for the administration of thickening agents. Discussion with the acting manager confirmed they have completed a review of medicines for topical administration and the system is due for implementation. | |
| **Area for improvement 3**<br><br>**Ref:** Regulation 13 (1) (a) (b)<br><br>**Stated:** First time | The registered person shall ensure that care records are reviewed and evaluated regularly in accordance with regulations. All patients must have up to date and individualised care plans in place to direct staff in the delivery of care. Nursing entries should be meaningful and patient centred. | **Partially met** |
| | **Action taken as confirmed during the inspection**:<br>Review of records and discussion with the manager confirmed some improvement in care evaluation. However, some deficits identified. This is discussed further in section 6.3.<br><br>**This area for improvement has been partially met and has been stated for a second time.** | |
| **Action required to ensure compliance with The Care Standards for Nursing Homes (2015)** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref**: Standard 4.9<br><br>**Stated:** Second time | The registered person shall ensure contemporaneous nursing records are kept of all nursing interventions and procedures carried out in relation to each patient, in accordance with NMC guidelines. Registered nurses should evidence review of supplementary care records. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of a selection of supplementary care records confirmed this area for improvement has been met. | |

## 6.2 Inspection findings

The inspection sought to validate the areas for improvement identified at the last inspection on 13 September 2019 and seek assurances in relation to staffing levels, the delivery of care and management of falls, infections and wounds.

**Staffing and delivery of care**

On arrival at the home we were greeted by the nurse in charge who welcomed the inspector to the home. They 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 duty rota for week commencing 2 December 2019 evidenced that the planned staffing levels were generally adhered to. There were a number of shifts that were covered by relief or agency staff. This was discussed with the acting manager who confirmed the home has successfully recruited two registered nurses and created two new positions for senior care assistants. They advised that they had reviewed the overall staffing and were hoping to receive approval for a twilight care assistant.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. We noted that some patients were not assisted out of bed until late morning on the day of inspection. We observed one staff member not assisting a patient in a timely manner. This was discussed with the acting manager for action as required.

Staff spoken with were not satisfied that there was sufficient staff on duty to meet the needs of the patients. Staff said,

"We could do with a twilight shift care assistant. Sometimes the nurse does not complete the evening medications until after 11pm."
"Staff are rushing to attend people's needs. Patients would say 'you are so busy tonight, I won't keep you long'. Sometimes the nurse doesn't finish the drug round until midnight leaving only two care assistants. Sometimes you have to work on your own with patients who need the assistance of two. I feel the heart has went out of the home, there is a lot of relief staff."

Patients spoken with indicated that the care they received was good and that they felt safe and happy living in Harold McCauley House. Some patient's comments on staffing included,

"There is not enough staff. Sometimes you have to wait sometimes on going to the toilet."

One relative spoken with stated,

"Sometimes staff are not attending to patient's in a timely manner. Sometimes patients need two people but only one is available."

We discussed the comments received with the acting manager and highlighted concerns regarding staffing levels. We sought assurances that staffing levels would be reviewed before the end of the inspection. We received assurances in writing from the responsible individual post inspection that staffing levels had been reviewed with additional resources allocated. An area for improvement was made.

**Management of falls, infections and wounds and care delivery**

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

We examined the management of patients who had falls. Review of one patient's records evidenced that falls were managed in keeping with best practice guidance. We asked the acting manager to ensure registered nurses complete risk assessments post fall in a timely manner. This will be reviewed at a future care inspection.

Review of a patient with an infection confirmed involvement from the patient's general practitioner and an appropriate care plan was in place to direct care.

Wound care, which was being provided to two identified patients, was also considered. Body maps were in place and there was evidence that the wounds were being dressed regularly and healing. Wound care documentation evidenced that the patient's plan of care had not been updated to reflect the assessed needs of the patient. In addition, the evaluation of care was not in keeping with best practice guidance and contained meaningless statements. Deficits in evaluation were identified on review of further care records. This was discussed with the manager and was identified as an area for improvement during the inspection on 13 September 2019. This is stated for a second time.

During review of patient care plans we were unable to confirm that activity assessments had been completed consistently or that activities had been appropriately care planned for. Review of the daily progress notes for identified patients did not evidence evaluation of activities. We discussed the need for registered nurses to view activities as an integral part of the care process with the acting manager. An area for improvement was made.

We observed liquid medication to be unattended in a communal lounge. This was discussed with a registered nurse and the acting manager. Assurances were sought that patients take medication once administered. This will be reviewed at a future care inspection.

**The environment**

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated and fresh smelling throughout. Fire exits and corridors were observed to be clear of clutter and obstruction. Stairwells were also observed to be clear. Compliance with infection prevention and control had been well maintained. Patients, relatives and staff spoken with were complimentary in respect of the home's environment.

**Consultation**

During the inspection we consulted with six patients, two patient's relative and five staff. As previously stated, patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others. Patients said,

"Things are good. The care is good. The staff have enough time for you. They treat me with dignity and respect. The food is good. The best thing about the home is the staff. I am content enough."

"I'm getting on well."

"I am getting well looked after. The staff are very helpful."

"I am getting on well. I have no concerns."

The relatives consulted spoke positively in relation to the care provision in the home. They said:

"There are always activities in the afternoon such as game, music and ball games. This is a good home. The care is good. If I have any concerns I can address these with confidence that they would be addressed."

"I am very happy with the care provided here. No concerns."

Comments from five staff consulted during the inspection included:

"Management are very approachable. I am happy and content. I really like this job. The staff and residents are lovely."

"It was daunting at the start but now I have my routine. We have a good caring team and we know the residents. The teamwork is very good and our work is all about the patient wants and needs. The girls wouldn't have it any other way. We treat people with dignity and respect."

**Areas of good practice**

Areas of good practice were identified in relation to home's environment, the culture and ethos of the home and maintaining patient's dignity and privacy.

**Areas identified for improvement:**

Two new areas for improvement were identified in relation to staffing and activity assessment, planning and evaluation.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 2 | 0 |

## 7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Michelle Murray, acting manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

## 7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

## 7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

## Quality Improvement Plan

| Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 | |
|---|---|
| **Area for improvement 1**<br><br>**Ref:** Regulation 13 (1) (a) (b)<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>With immediate effect | The registered person shall ensure that care records are reviewed and evaluated regularly in accordance with regulations. All patients must have up to date and individualised care plans in place to direct staff in the delivery of care. Nursing entries should be meaningful and patient centred.<br><br>Ref: 6.3 |
| | **Response by registered person detailing the actions taken:**<br>Care records are reviewed monthly by the keyworker or sooner if there is a change in need. All nursing staff attended training on Care Planning and Person Centred Care Record Keeping on the 4th December 19. All nursing staff have received a copy of the NIPEC "Standards for Person Centred Nursing & Midwifery Record Keeping Practice. Audits are carried out on a regular basis by the Senior Staff Nurse or Home Manager and nursing entries are reviewed to ensure they are person-centred, accurate and meaningful. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 20 (1) (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect | The registered person shall ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients.<br><br>Ref: 6.2 |
| | **Response by registered person detailing the actions taken:**<br>Staffing levels within the home have been review and additional staff have been recruited to reflect the increasing needs of the residents in order to provide a safe environment to deliver a high standard of care. |

| Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015 | |
|---|---|
| **Area for improvement 1**<br><br>**Ref**: Standard 11<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 December 2019 | The registered person shall ensure activities are recognised as an integral part of the care process with care plans developed and reviewed by registered nurses as required. Daily progress notes should reflect on patient's activity provision.<br><br>Ref: 6.2 |
| | **Response by registered person detailing the actions taken:**<br>Activity questionnaires have been completed in conjunction with each resident to reflect their likes and dislikes. Activity plans have been developed for each resident as a result of these questionnaire and nursing staff will complete a care plan to incorporate the residents' desired wishes. Activity Co-ordinator has now completed training on Person-centred record keeping and continues to record daily evaluation notes on comtemporaneously. |

***Please ensure this document is completed in full and returned via Web Portal***

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

**Tel** 028 9536 1111
**Email** info@rqia.org.uk
**Web** www.rqia.org.uk
@RQIANews