Unannounced Follow Up Care Inspection Report 13 September 2019

Harold McCauley House

Type of Service: Nursing Home
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 provider from their responsibility for maintaining compliance with legislation, standards and best practice.

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: Presbyterian Council of Social Witness **Responsible Individual:** Lindsay Conway	**Registered Manager and date registered:** Jill Nicholl - registration pending
Person in charge at the time of inspection: Jill Nicholl	**Number of registered places:** 32 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: I – Old age not falling within any other category. DE – Dementia. LD – Learning disability. PH – Physical disability other than sensory impairment. 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:** 31

4.0 Inspection summary

An unannounced inspection took place on 13 September 2019 from 10.30 hours to 16.45 hours.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection on 29 April 2019 and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the home's environment, the culture and ethos of the home and maintaining patient's dignity and privacy.

One new area requiring improvement was identified in relation to accurately reflecting the care needs of patients.

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	*3	*1

*The total number of areas for improvement includes two under regulation and one under standards which each have been stated for a second time.

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

4.2 Action/enforcement taken following the most recent inspection dated 29 April 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 29 April 2019. 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 for week commencing 9 September 2019
- staff training records
- incident and accident records
- one staff recruitment and induction file
- four patient care records
- a selection patient care charts including topical medicine administration, thickener administration, personal care records, food and fluid intake charts and reposition charts

- a sample of governance audits/records
- staff supervision and appraisal planner
- minutes of staff meetings
- activity planner and associated records
- a sample of reports of visits by the registered provider.

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 the most recent inspection dated 29 April 2019

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 29 April 2019

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (7) **Stated:** Second time	The registered person shall ensure suitable arrangements are in place to minimise the risk/spread of infection between patients and staff. This area for improvement is made in reference to the issues highlighted in 6.3.	**Met**
	Action taken as confirmed during the inspection: Observation of practice and review of the environment evidenced this area for improvement has been met.	

Area for improvement 2 **Ref**: Regulation 20 (1) (c) (i) **Stated:** First time	The registered person shall ensure that the persons employed by the registered person to work in the nursing home receive mandatory training appropriate to the work they are to perform. Updates in mandatory training should be delivered in a timely manner.	**Met**
	Action taken as confirmed during the inspection: Review of records evidenced a robust training matrix is now in place. Mandatory training is ongoing with further training planned.	
Area for improvement 3 **Ref**: Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure as far as is reasonably practicable that all parts of the home to which the patients have access are free from hazards to their safety, and unnecessary risks to the health and safety of patients are identified and so far as possible eliminated.	**Met**
	Action taken as confirmed during the inspection: Review of the environment confirmed this area for improvement has been met.	
Area for improvement 4 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that nursing staff carry out clinical and neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record.	**Met**
	Action taken as confirmed during the inspection: Review of records for one identified patient who had an unwitnessed fall confirmed that the incident was managed in keeping with best practice guidance.	

Area for improvement 5 **Ref**: Regulation 16 (2) (b) **Stated:** First time	The registered person shall patient care plans are kept under review. This area for improvement is made in reference to management of infections	**Not met**
	Action taken as confirmed during the inspection: Examination of records evidenced this area for improvement has not been met. This is discussed further in 6.3 of this report. **This area for improvement has not been met and has been stated for a second time.**	
Area for improvement 6 **Ref**: Regulation 13 (4) (c) **Stated:** First time	The registered person shall ensure a written record for the administration of thickening agents and medicines for topical administration is accurately maintained.	**Partially met**
	Action taken as confirmed during the inspection: Examination of records evidenced this area for improvement has been partially met. This is discussed further in 6.3 of this report. **This area for improvement has been partially met and has been stated for a second time.**	
Area for improvement 7 **Ref**: Regulation 10 (1) **Stated:** First time	The registered person shall ensure that robust governance arrangements are established and maintained. Monthly audits should be completed in accordance with best practice guidance. Any shortfalls identified should generate an action plan to ensure learning is disseminated and the necessary improvements can be embedded into practice.	**Met**
	Action taken as confirmed during the inspection: Review of records and discussion with the manager evidenced significant improvements in governance arrangements. Audit systems have been enhanced for multiple areas of governance including accidents and incidents, wounds, medications, hand hygiene, environment, care records and restraint. We discussed ways of enhancing some of the audit systems in place. This will be reviewed at a future care inspection.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 40.2 **Stated:** First time	The registered person shall ensure all staff have a recorded annual appraisal and supervision no less than every six months. A supervision and appraisal schedule shall be in place, showing completion dates and the name of the appraiser/supervisor.	**Met**
	Action taken as confirmed during the inspection: Review of supervision and appraisal records evidenced this area for improvement has been met.	
Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First 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.	**Partially met**
	Action taken as confirmed during the inspection: Examination of records evidenced this area for improvement has been partially met. This is discussed further in 6.3 of this report. **This area for improvement has been partially met and has been stated for a second time.**	
Area for improvement 3 **Ref**: Standard 41 **Stated:** First time	The registered person shall ensure that staff meetings take place on a regular basis, at a minimum quarterly.	**Met**
	Action taken as confirmed during the inspection: Review of staff meeting records confirmed meetings take place on at a minimum quarterly basis.	

Area for improvement 4 **Ref**: Standard 11 **Stated:** First time	The registered person shall ensure the programme of activities reflects the preferences and choices of the patients and is evaluated at least twice yearly. Arrangements should be made to ensure activities are delivered in the absence of the activity co-ordinator.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and review of records confirmed that arrangements are in place to allocate care staff to deliver activities in the absence of the activity co-ordinator. There was evidence of engagement with patients in the development of the activity planner. This is ongoing and will be reviewed at a future care inspection.	

6.3 Inspection findings

The inspection sought to validate the areas for improvement identified at the last inspection on 29 April 2019. Through review of records, observations of staff practice and discussion with staff we evidenced and acknowledged the progress made in relation to areas for improvement identified previously.

On arrival at the home we were greeted by the manager who was friendly and welcoming. The 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 rota for week commencing 9 September 2019 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.

In order to determine if care was delivered safely we talked with a number of the patients. Patients told us that staff attended to them promptly and if they were in their bedrooms staff came as quickly as they could when they called them. The patients said that staff were pleasant and attentive to them. One issue raised by a patient was shared with the manager who confirmed the action taken following the inspection. One patient commented that they felt the home was short staffed and would benefit from an additional member of staff in the evening. This was discussed with the manager who confirmed that staffing was under review. This will be reviewed at a future care inspection.

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. Patients, relatives and staff spoken with were complimentary in respect of the home's environment. We commended the home for receiving runner up in the amenity council awards.

There was evidence within four patients' care records reviewed that appropriate risk assessments were completed on admission and reviewed on a regular basis. Care plans had been developed which were reflective of the risk assessments. The care plans which were in place had also been reviewed regularly or as the patients' needs changed. We reviewed the management of infection, falls and wound care. Care records contained details of the specific care regarding falls management. A daily record was maintained to evidence the delivery of care.

Deficits were identified in relation to management of infection for one identified patient. There was no care plan in place to manage an active infection. An area for improvement in this regard has now been stated for the second time.

There was evidence that the some patient care records reviewed, failed to accurately reflect the care needs of patients. Review of wound management for two patients evidenced deficits in care planning. Care plans were not adequately developed to reflect the changing needs of the patients, to direct care and to reflect the tissue viability nurses' recommendations. Body maps were completed identifying the location of the wound and there was evidence of good oversight of wound assessment and observation with charts completed to monitor the progress of the wound at the time of wound dressing. However, a review of records evidenced limited evaluation and photos had not been taken of one wound in keeping with best practice guidance. Daily evaluation records and care plan review entries were reviewed. Although there were examples of good practice regarding evaluation of care; some entries were repetitive. Registered nurses should ensure that all documentation has been recorded in a meaningful and patient centred manner. This was discussed with the manager and an area for improvement under the regulations was made.

Review of supplementary care charts such as food and fluid intake records and repositioning charts evidenced improvements in record keeping. In addition, improvements were also noted in the administration of thickening agents. However, deficits were identified in the completion of personal care records and in administration of topical medicine administration. The manager must ensure contemporaneous records are completed and should review the current system of recording personal care delivery. Management of medicines and contemporaneous record keeping had been identified as areas for improvement during the previous care inspection on 29 April 2019. Both areas for improvement have now been stated for a second time.

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. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Consultation with five patients individually, and with others in smaller groups, confirmed they were happy and content living in Harold McCauley House. Some of the patient's comments included:

"The food is too good and too often."
"Friendly staff. They always engage in conversation. Excellent care."

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.

Two relatives/visitors were spoken with during the inspection. Some of the comments received included the following:

"It is brilliant. It couldn't be better."
"My relative was recently in hospital. He used to say he wanted to go home to his own home but he now calls this his home."

Since the last inspection there has been a change in management arrangements and a new home manager has been appointed. An application for the registration of the manager with RQIA is being processed. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff, patients and patients representatives evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the home's environment, the culture and ethos of the home and maintaining patient's dignity and privacy.

Areas for improvement

One new area for improvement under the regulations was identified in relation to accurately reflecting the care needs of patients.

	Regulations	Standards
Total number of areas for improvement	1	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 Jill Nicholl, 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 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 DHSSPS 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 **Ref:** Regulation 16 (2) (b) **Stated:** Second time **To be completed by:** Immediate action required	The registered person shall ensure patient care plans are kept under review. This area for improvement is made in reference to management of infections. Ref: 6.2 and 6.3
	Response by registered person detailing the actions taken: Person centred care plans for the management of infection are now in place.
Area for improvement 2 **Ref:** Regulation 13 (4) (c) **Stated:** Second time **To be completed by:** Immediate action required	The registered person shall ensure a written record for the administration of thickening agents and medicines for topical administration is accurately maintained. Ref: 6.2 and 6.3
	Response by registered person detailing the actions taken: All staff have been reminded of the importance of accurate documentation especially relating to the administration of thickening agents and medicines for topical administration. This will be monitored and reviewed daily by nursing staff.
Area for improvement 3 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** Immediate action required	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. Ref: 6.3
	Response by registered person detailing the actions taken: Nursing staff have been reminded of the importance of individualised, person centred care plans and the need to review and update accordingly. Additional training arranged for staff on care planning, report writing and recording.

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 **Ref**: Standard 4.9 **Stated:** Second time **To be completed by:** Immediate action required	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. Ref: 6.2 and 6.3
	Response by registered person detailing the actions taken: Staff have been reminded of the impotance of contemporaneous recording of all nursing interventions and proceedures carried out. Nurses have been instructed to ensure there is clear evidence that supplementary care records are being reviewed.

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

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