The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
27 March 2018

Parkview House

Type of Service: Nursing Home (NH)
Address: Parkview Road, Castlederg, BT81 7XH
Tel no: 028 8167 9192
Inspector: Sharon Loane

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 27 persons.

3.0 Service details

Organisation/Registered Provider: Apex Housing Association Responsible Individual(s): Gerald Kelly	Registered Manager: Marion Davina McAllister
Person in charge at the time of inspection: Davina McAllister	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. LD (E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment.	**Number of registered places:** 27 comprising: 2 – NH-LD(E) 1 – NH-PH

4.0 Inspection summary

An unannounced inspection took place on 27 March 2018 from 11.00 to 15.15.

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 Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection 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 across all four domains. There was evidence that safe effective and compassionate care was being delivered. The home was well led with good management and governance arrangements in place.

An area for improvement made at the last care inspection under the regulations was not met and has therefore been stated for a second time.

Areas requiring improvement under the care standards were identified in regards to the completion of risk assessments and care plans following admission to the home and specific aspects of documentation pertaining to wound management.

Patients said they were happy living in the home and were looked after well. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. The comments and opinions of patients and relatives may be found in section 6.6.

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	*1	2

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

Details of the Quality Improvement Plan (QIP) were discussed with Davina McAllister, registered 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 25 October 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 25 October 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the lay assessor and inspector met with six patients and two patients' representatives. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. The inspector met with five staff. A poster inviting staff to provide feedback via an online survey was given to the registered manager to display in the staff room.

A lay assessor, Nan Simpson was present during the inspection and their comments are included within this report.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- duty rota for all staff from 26 March to 1 April 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC)
- incident and accident records
- three patient care records
- two patient care charts including food and fluid intake charts and reposition charts
- a selection of governance audits

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 25 October 2017

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

6.2 Review of areas for improvement from the last care inspection dated 25 October 2017

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 12 (1)(a) **Stated:** First time	The registered persons shall ensure that patients, who are identified as being at risk of pressure ulceration, are repositioned in accordance with their care plan.	**Not met**
	Action taken as confirmed during the inspection: A review of care records evidenced that this area for improvement had not been met. Please refer to section 6.5 for further detail.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 35 **Stated:** First time	The registered persons shall review the process of checking nurses' registrations with NMC, to ensure that it is robust. **Action taken as confirmed during the inspection**: A discussion with the registered manager and a review of information evidenced that this area for improvement was met. Please refer to section 6.4 for further detail.	**Met**
Area for improvement 2 **Ref**: Standard 22.6 **Stated:** First time	The registered persons shall ensure that the falls risk assessments are reviewed in response to patients' falls. **Action taken as confirmed during the inspection**: A review of information for one patient identified that following a fall; the care plan had been reviewed and evaluated to ensure that the interventions remained appropriate. Although the actual falls risk assessment tool had not been updated, this information was captured within the documentation included in the daily progress notes and the care plan evaluation. The falls risk assessments were being reviewed on a monthly basis. Discussions held with both the registered and deputy managers demonstrated the need for the actual falls risk assessment tool to be completed as part of the post- falls review. This area for improvement was partially met and on the basis of the information reviewed has not been stated for a second time.	**Partially met**
Area for improvement 3 **Ref**: Standard N38 **Stated:** First time	The registered persons shall ensure that the emergency equipment box includes a selection of patient airways. **Action taken as confirmed during the inspection**: A review of the emergency equipment box evidenced that this area for improvement had been met.	**Met**

Area for improvement 4 **Ref**: Standard 48 **Stated:** First time	The registered persons shall review the location of the patients' personal emergency egress plans (PEEPs), to ensure that they are readily accessible to staff in the event of an emergency. **Action taken as confirmed during the inspection**: A contingency folder held in the nurses' office includes a copy of each patient's personal emergency plan (PEEP). A copy of the plan is also maintained within the electronic care records. A discussion with the nurse in charge confirmed their knowledge in this regard.	**Met**
Area for improvement 5 **Ref**: Standard 23 **Stated:** First time	The registered persons shall review the system for recording patients' fluid intakes, to ensure that the records are accurate; evidence of any action taken in response to deficits must be recorded in the daily progress notes. **Action taken as confirmed during the inspection**: A review of care records for two patients' evidenced that this area for improvement was met. Please refer to section 6.5 for further detail.	**Met**
Area for improvement 6 **Ref**: Standard 4 **Stated:** First time	The registered persons shall ensure that separate care plans are developed for each wound; and that wound care records are supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines. **Action taken as confirmed during the inspection**: A review of wound care records for an identified patient evidenced that a care plan was available. Photographic evidence of the wound was not available; this was in keeping with the patient's individual wishes.	**Met**

Area for improvement 7 **Ref**: Standard 35.18 **Stated:** First time	The registered persons shall review the system for managing alerts for staff that have sanctions imposed upon them by their professional bodies, to ensure that it is robust.	**Met**
	Action taken as confirmed during the inspection: A discussion held with the registered manager and a review of information evidenced that this area for improvement was met. Please refer to section 6.7 for further detail.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 rota for week commencing 26 March 2018 evidenced that the planned staffing levels were generally adhered to. It was noted that the registered manager also worked on the floor as a registered nurse to cover any shortfalls. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. There were no specific concerns raised by staff in respect of the staffing arrangements. One staff member spoken with felt that staffing levels for some shifts needed to be increased however advised that they had already raised this matter with the registered manager for their consideration.

We also spoke with six patients and two relatives/ visitors during the inspection; all commented positively regarding the care delivered and the staff working in the home. One of the relatives/visitors spoken with indicated that "sometimes it took staff up to 30 minutes to come and take a resident to the toilet and felt that there didn't seem to be enough staff". During the inspection, staff were observed responding and attending to patients in a timely manner. This comment was shared with the registered manager for information and actions as deemed appropriate.

Discussion with staff evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

The arrangements in place to monitor and confirm the registration status of registered nurse with the Nursing and Midwifery Council (NMC) were discussed with the registered manager. A review of records of NMC registration evidenced that all of the registered nurses on the duty rota for the week of the inspection were included in these checks. There were robust systems in place to confirm registration at the time of renewal. An area for improvement identified at the last inspection had been met.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. The registered manager discussed the status of any open safeguarding concerns and there was evidence that these had been managed 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. However, it was noted that some of these were not completed within the five day timeframe as outlined in the care standards. This is discussed further in section 6.5.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. However, a review of accident and incidents records evidenced that one accident had not been reported. The registered manager advised that this was a genuine oversight. This omission was acknowledged and the registered manager agreed to submit the identified notification retrospectively. This area of reporting will continue to be monitored at subsequent care inspections.

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, 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.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the staffing arrangements, risk management and the homes environment.

Areas for improvement

No new areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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. However, it was noted within one care record that some risk assessments and care plans had not been completed within the five days of admission to the home. This has been identified as an area for improvement under the standards.

We reviewed the management and recording of wound care for one patient. The care records contained a care plan which included the frequency with which the wound required to be redressed. An assessment was recorded at each dressing change and a review of these assessments evidenced that care was being provided as prescribed. This had been identified as an area for improvement at the last inspection and now is met.

However, it was noted that a body map had not been completed and the measurements of the wound had not been recorded in line with best practice. This has been identified as a new area for improvement.
A care plan to manage another patient's risk of developing pressure ulcers was reviewed. The care plan did not include the frequency for which the patient required to be repositioned for effective pressure relief. Therefore it was difficult to determine if the care being delivered was appropriate to meet the identified need. However, it was noted that the patient's skin was intact. Pressure relieving equipment, for example mattresses and cushions were in place.

A review sample of repositioning charts identified that these were not maintained in accordance with best practice guidelines. For example, records reviewed for an identified patient, evidenced that they had been repositioned on the same side for three consecutive times and there was no evidence that the condition of the skin had been checked to identify redness or early detection of pressure damage. An area for improvement identified at the last inspection continued not to be met and has been stated for a second time.

We reviewed the management of catheter care for one patient. A care plan was in place and care records reviewed evidenced that catheter care was managed appropriately; the catheter was changed regularly and no less than 12 weekly. Records evidenced that the patient's intake and urinary output were recorded daily and totalled at the end of every 24 hour period.

A review of food and fluid intake charts for two patients was undertaken. A review sample of daily progress notes for both patients evidenced that registered nurses were recording the total fluid intake within these records. A comparison of information recorded within food and fluid charts and the daily progress notes confirmed the accuracy of the recordings across the two records. Entries recorded accurately reflected when food and fluid intake was satisfactory and/or inadequate; there was evidence that appropriate actions had been taken when intake was poor for example; communication with the general practitioner (GP).

Care records accurately reflected the assessed needs of patients, 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.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift.

Staff stated that there was effective teamwork and confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the assessment of patient need and care planning; we observed good communication between patients, staff and visitors.

Areas for improvement

Two new areas for improvement have been identified. These are in regards to the completion of risk assessments and care plans at the time of admission and completion of specific documentation pertaining to wound management. An area for improvement identified at the last inspection under regulation has also been stated for a second time.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

When we arrived in the home we were greeted by staff who were helpful and attentive. Patients were enjoying their mid-morning refreshments in the lounges or in their bedroom as was their personal preference; some patients remained in bedrest, again in keeping with their personal choice. The hairdresser was visiting the home and some patients had had their hair washed and set and others were waiting to be attended too.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with six patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect.

Patients stated that they were happy living in the home. Those 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. The following are examples of comments provided by patients:

“happy with the care, I like the home, no complaints”
“everything is very good, feels safe well looked after, can be independent but know I can ask for help if needed”
“care is good but it’s not home but the home is a good place to be”
“very happy to be here”.

Discussion with two patients' relatives/ visitors indicated that they were satisfied with the care provided. The following are examples of comments provided:

"Very happy with all aspects of care provided. Staff are always available and approachable would give the home 100%".
"Generally staff are very good …sometimes there doesn't seem to be enough staff".

In the afternoon, the activities co-ordinator was observed decorating the home for the Easter Celebrations. Patients seated in the lounge were observing this activity and advised that there were other activities organised to celebrate Easter, for example; egg decorating, Easter bonnets and an Easter party.

As previously discussed in section 5.0 a poster was given to the registered manager to display to enable staff to provide feedback via an online survey. No responses were received prior to the issue of this report. Staff spoken with confirmed that they were happy working in the home and advised that if they had any issues they could raise these with the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff, patients and their representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were in the majority managed appropriately. This has been discussed in detail in section 6.4.

Discussion with the registered and deputy manager confirmed that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. Whilst these were not reviewed in detail there was evidence that appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been embedded into practice.

A discussion with the registered manager confirmed that since the last inspection more robust systems and processes were now 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. A review of information confirmed this information.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	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 Davina McAllister, registered 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 **Ref:** Regulation 12 (1)(a) **Stated:** Second time **To be completed by:** 31 May 2018	The registered persons shall ensure that patients, who are identified as being at risk of pressure ulceration, are repositioned in accordance with their care plan. Ref: Section 6.2 & 6.5
	Response by registered person detailing the actions taken: an andAll risk assessments have been updated .Paper copies of repositioning charts have now been implented to facilitate the recording of skin condition on re-positioning
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 4 Criteria 1 **Stated:** First time **To be completed by:** 31 May 2018	The registered person shall ensure that risk assessments and care plans are commenced on the day of admission and completed with five days of admission to the home. Ref: Section 6.5
	Response by registered person detailing the actions taken: The checklist on epiccare will be reviewed to ensure that all care plans and risk assessments are completed within 5 days of admission to the home
Area for improvement 2 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 31 May 2018	The registered person shall ensure that records for pressure ulcers and wounds are maintained in accordance with best practice guidelines. This relates specifically to but not limited to; the completion of body mapping and wound measurement records. Ref: Section 6.5
	Response by registered person detailing the actions taken: The registered person will ensure that records for pressure ulcers and wounds are maintained in accordance with best practice guidelines.A new body map will be completed for each new wound and each wound's measurement will be recorded.

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

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