Unannounced Care Inspection Report
25 January 2017

Gortacharn

Type of Service: Nursing Home
Address: Brookborough Road, Lisnaskea, BT92 0LB
Tel no: 028 6772 1030
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Gortacharn took place on 25 January 2017 from 11.00 to 15.30 hours. The residential unit was not inspected as part of this inspection process.

The inspection sought to assess progress with any issues raised 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.

On the day of inspection patients, relatives and staff spoken with commented positively in regard to the care in the home. A review of records, discussion with the registered manager and staff and observations of care delivery evidenced that all of the requirements and recommendations made as a result of the previous inspection have been complied with.

One recommendation was made as a result of this inspection.

Throughout the report the term “patients” is used to describe those living in Gortacharn which also provides residential care.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Jill Trimble, 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.

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 30 August 2016.

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent 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. Please refer to section 4.3.1.

2.0 Service details

Registered organisation/registered person: Mrs Robena Heather Trimble Mr Richard James Trimble	**Registered manager:** Ms Jill Trimble
Person in charge of the home at the time of inspection: Jill Trimble	**Date manager registered:** 20 November 2015
Categories of care: RC-LD(E), RC-I, NH-LD, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 55

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events 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 plan (QIP) from the previous care inspection
- the previous care inspection report

The following methods and processes used in this inspection include the following:

- a discussion with the responsible individual and registered manager
- discussion with staff
- discussion with patients
- five patient care records
- staff duty roster
- records of registered nurses Nursing and Midwifery Council (NMC) registration
- records of care staff registration with Northern Ireland Social Care Council (NISCC)
- a review of quality audits
- complaints and compliments
- incident and accident records
- review sample of policies and procedures
- review sample of staff training records

During the inspection, care delivery and care practices were observed and a review of the general environment of the home was undertaken.

A number of staff were consulted during the inspection process including the deputy manager and one registered nurse, care staff and ancillary staff on duty. In addition, six patients and the representatives of two patients' were also consulted.

Ten questionnaires were also issued to relatives and staff and five to patients with a request that they were returned within one week from the date of this inspection.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 30 August 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector. This QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 6 June 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 14 (2) (c) **Stated:** First time	The registered person must ensure that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated.	**Met**
	Action taken as confirmed during the inspection: A review of care records and observations made at this inspection evidenced that appropriate actions had been taken in regards to the concerns raised at the last inspection.	
Requirement 2 **Ref:** Regulation 19 (3) (b) **Stated:** First time	The registered person must ensure that records confirming staffs registration status with appropriate professional regulatory bodies, namely the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), are available for inspection at all times.	**Met**
	Action taken as confirmed during the inspection: Records as outlined above were available at the time of inspection and were maintained to a satisfactory standard.	
Requirement 3 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time	The registered person must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This relates specifically to the arrangements for managing accidents and incidents that occur in the home.	**Met**

	Action taken as confirmed during the inspection: A review of accident and incident records and care records for two identified patients evidenced that appropriate actions had been taken by staff when accidents/incidents had occurred. Medical attention had been sought as deemed appropriate and patients were monitored for any adverse side effects. Risk assessments and care plans had been reviewed and updated accordingly.	
Requirement 4 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person must ensure to promote and make proper provision for the nursing, health and welfare and where appropriate, treatment and supervision of patients in their care. This relates specifically to the management and treatment of wounds and pressure care in accordance with the care prescribed and best practice guidelines.	**Met**
	Action taken as confirmed during the inspection: A review of a care record for a patient receiving treatment and care for wounds and/or pressure damage was undertaken. The review of wound assessment charts and associated documentation evidenced that the dressing regimes had been adhered to and were recorded in line with best practice guidelines. There was evidence that the treatment and care delivered was effective as per the progress and improvement of the wounds and/or pressure damage.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 46 **Stated:** Second time	The registered person must ensure that the infection prevention and control issues identified in the report are actioned as required.	**Met**
	Action taken as confirmed during the inspection: An observation of the environment evidenced that in the majority, infection prevention and control was managed to a satisfactory standard. Appropriate actions had been taken in relation to the issues identified at the previous care inspection.	

Recommendation 2 **Ref:** Standard 35 **Stated:** First time	The registered manager should develop a system to ensure that checks are being conducted on a regular basis in relation to staff's registration status with NMC and NISCC.	**Met**
	Action taken as confirmed during the inspection: A system was in place to review staff's registration status with the relevant professional body. A matrix was available and included all relevant information with evidence that checks were being completed and reviewed at monthly intervals by both the administrator and the registered manager.	
Recommendation 3 **Ref:** Standard 39 Criteria 9 **Stated:** First time	It is recommended that a system is developed to monitor staffs compliance with training to ensure mandatory training requirements are met.	**Met**
	Action taken as confirmed during the inspection: A matrix was available and included all staff employed and areas of training completed. A review of the information identified some gaps indicating that staff had not completed mandatory training requirements. A discussion with the registered manager provided a rationale for these shortfalls. For example; no longer employed; on maternity leave and /or bank staff. The registered manager was advised that the matrix should be updated to reflect the rationale for the gaps. The registered manager agreed to update the matrix to include this information and also to include the frequency for which training had to be completed as per policy, standards and legislative training requirements.	
Recommendation 4 **Ref:** Standard 18.10 **Stated:** First time	It is recommended that staff are trained to recognise what constitutes restrictive practice. Records of training should be retained.	**Met**
	Action taken as confirmed during the inspection: A review of staff training records evidenced that training had been completed 9 November 2016 in regards to 'restrictive practice'. A discussion with staff evidenced that they were knowledgeable in this area of practice.	

Recommendation 5 **Ref:** Standard 39.8 **Stated:** First time	It is recommended that registered nurses receive training in relation to the nursing process. Records of training should be retained.	**Met**
	Action taken as confirmed during the inspection: A review of staff training records evidenced that 14 registered nurses had completed training in relation to the 'nursing process'. The content of the training was also available for other staff to refer to for information.	
Recommendation 6 **Ref:** Standard 22.10 **Stated:** First time	The registered persons should ensure that falls are reviewed and analysed on a monthly basis to identify any patterns or trends and appropriate action taken.	**Met**
	Action taken as confirmed during the inspection: A review of quality audits evidenced that falls analysis was completed on a monthly basis. The analysis included any patterns and/or shortfalls identified in regards to falls management. An action plan was devised and there was evidence that the areas for improvement had been reviewed to ensure quality improvement.	
Recommendation 7 **Ref:** Standard 4 **Stated:** First time	It is recommended that care plans are developed for acute care interventions for example; chest infections.	**Met**
	Action taken as confirmed during the inspection: A review of two care records evidenced that care plans were in place for patients who were receiving treatment and care for acute care interventions. These were in relation to both chest and urinary tract infections.	
Recommendation 8 **Ref:** Standard 4 **Stated:** First time	It is recommended that input and output charts are maintained for all patients with indwelling catheters in line with best practice guidelines. The care records should provide rationale if this intervention is deemed not appropriate. The total input/output should be recorded within daily progress records.	**Met**

	Action taken as confirmed during the inspection: A review of care records for an identified patient with an indwelling catheter evidenced that documentation and practice was in accordance with best practice guidelines. Records reviewed evidenced that intake and output was being monitored and recorded within daily progress notes by registered nurses.	
Recommendation 9 **Ref:** Standard 16 Criteria 11 **Stated:** First time	It is recommended that the records of complaints are maintained in accordance with legislative, care standards and professional guidance.	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager and a review of the complaints record confirmed that no complaints had been received since the last inspection. The template for recording complaints had been reviewed and amended and was in accordance with legislative, care standards and professional guidance. A discussion was held with the registered manager as to what constituted a complaint to ensure that they understood that a complaint is an expression of dissatisfaction with any area of service provided in the home.	
Recommendation 10 **Ref:** Standard 35.4 **Stated:** First time	It is recommended that the systems for auditing care records are further developed to address the deficits identified during this inspection.	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager and a review of records evidenced that a suite of auditing systems had been developed and implemented. A number of audits had been undertaken since the last inspection, these included; wound care; accident and incidents; topical creams; and care plans. A review of the above audits evidenced that an action plan had been developed for areas of improvement. There was also evidence that the areas for improvement had been re-audited to check compliance to ensure quality improvement.	

4.3 Inspection findings

4.3.1 Care delivery and practice

The inspection commenced at 11.00 hours. There was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Patients were observed to be sitting in the lounge, or in their bedroom, as was their personal preference. The staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients, as was required from time to time. Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences.

The serving of lunch commenced at 12:30 hours. The majority of patients chose to come to the dining room where the tables were nicely presented with cutlery, crockery and a choice of condiments. Those patients who choose to remain in their bedroom were served their meals on trays set with condiments; the meals were covered prior to leaving the kitchen. A record was maintained for all patients to reflect their food and fluid intake at each mealtime. A discussion with catering staff demonstrated that they were knowledgeable regarding the patients dietary needs. This included; patients who required modified diets; diabetic diets and food fortification.

A review of care records for two patients receiving treatment for the management of diabetes was undertaken. There was evidence that care plans had been reviewed and updated in response to the changing needs of patients. The care plans reviewed clearly demonstrated the care interventions required in relation to the needs and risks identified. Any advice and recommendations from other health and social care professionals were referred to as deemed necessary and appropriate. Blood sugar monitoring records evidenced appropriate monitoring and demonstrated that registered nurses had taken appropriate actions or sought any advice from relevant medical and healthcare professionals. A protocol was also available to guide and direct registered nurses in relation to care and treatment interventions for patients presenting with symptoms of unstable blood sugar in line with best practice. Recommendations made by the Western Health and Social Care Trust, July 2016 in relation to the management of diabetes and medication management, had been actioned appropriately and the learning had been shared with staff and embedded into practice.

A review of one care record evidenced that a number of risk assessments and care plans had not been reviewed following a patient's admission to hospital. A further review evidenced that the patient had not been weighed for a number of months as a result of hospitalisation and was not re-weighed on their return to the home. We discussed this matter with the registered manager who agreed to update the risk assessments; care plans, and obtain the patients weight. Post inspection, information submitted to RQIA to acknowledge that these actions had been taken highlighted that the patient had identified "weight loss." Upon receipt of this information, RQIA contacted and discussed the information submitted with the registered manager who provided assurances that appropriate actions and monitoring arrangements were in place to ensure the health and welfare of the patient. The registered manager advised that whilst the patient had identified "weight loss," their Body Mass Index (BMI) was satisfactory and that the patient had actually gained weight since their return to the home. A review of weight monitoring records evidenced that all other patients accommodated were weighed at monthly intervals and/or in accordance with the level of risk identified. No concerns were identified in this area of care delivery.

A recommendation was made that risk assessments, care plans and other care interventions should be reviewed and updated following any patients admission to hospital as per the nursing process, care standards and legislative requirements..

4.3.2 Consultation

Patients spoken with commented positively with regard to the care they received and were happy in their surroundings. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect and in a timely manner. It was evident from staff and patient engagements that they knew each other well and the majority of the patients spoken with knew the registered manager.

During the inspection we met with a number of patients; staff and one relative. Some comments received from patients are detailed below:
"I've been treated wonderfully by everyone."
"They (the staff) never leave without checking that you are ok."
"Couldn't be better great care."
"Brilliant home and staff all very good".

One relative spoken with was complimentary regarding the care, staff and management.

We also issued questionnaires as outlined in section 1.1 to gain additional feedback from patients; staff and patients representatives. Three patients, five staff and four relatives had returned their questionnaires within the identified timeframe. All respondents indicated that they were either "very satisfied" and/or satisfied that the care was safe, effective and compassionate and the home was well led. No additional written comments were received.

4.3.3 Staffing

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 roster for weeks commencing 16 and 23 January 2017 evidenced that the planned staffing levels were adhered to. On the day of the inspection two registered nurses had reported sick however cover had subsequently been obtained. Discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing provision within the home.

4.3.4 Environment

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The home was found to be clean, reasonably tidy, warm and comfortable. A cupboard observed within one of the bathroom/shower areas had a number of items stored inappropriately. A wall tile and a toilet hand rail in the same area were damaged. A number of commodes observed had the 'rubber tip' missing of the legs of the commode causing instability. These matters were brought to the attention of the registered manager who agreed to address immediately. Post inspection an email correspondence has been received 27 January 2017 to confirm that appropriate actions have been taken in regards to the matters aforementioned.

Areas for improvement

A recommendation was made that risk assessments, care plans and other care interventions should be reviewed following any patients admission to hospital.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jill Trimble, registered manager as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 25 January 2017	The registered provider should ensure that risk assessments, care plans and other care interventions should be reviewed and updated following any patients admission to hospital as per the nursing process, care standards and legislative requirements.
	Response by registered provider detailing the actions taken: A new protocol is in place for residents who are admitted back to the home following a hospital admission. This will ensure that risk assessments, care plans and other care interventions are reviewed and updated as per the nursing process, care standards and legislative requirements.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews