Unannounced Care Inspection Report
26 April 2018

Knockmoyle Lodge

Type of Service: Nursing Home
Address: 29 Knockmoyle Road, Omagh, BT9 7TB
Tel No: 028 8224 7931
Inspector: Sharon Loane

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 and residential care for up to 35 persons.

3.0 Service details

Organisation/Registered Provider: Mrs Linda Beckett (registration pending)	**Registered Manager:** See below
Person in charge at the time of inspection: Mrs Alison Sweeney	**Date manager registered:** Mrs Alison Sweeney – registration pending
Categories of care: Nursing Home (NH) DE – Dementia. MP (E) - Mental disorder excluding learning disability or dementia – over 65 years. Residential Care (RC) DE – Dementia.	**Number of registered places:** 35 comprising: The home is also approved to provide care on a daily basis for 1 person. There shall be a maximum of 1 named patient in category NH-MP (E). There shall be a maximum of 1 named resident receiving residential care in category RC-DE.

4.0 Inspection summary

An unannounced inspection took place on 26 April 2018 from 11.00 to 15.45 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 term 'patient' is used to describe those living in Knockmoyle Lodge which provides both nursing and residential care.

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; safe; effective; compassionate care and well-led. There was evidence that the home was operating according to its statement of purpose.

No areas requiring improvement were identified at this inspection.

Patients described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. There was evidence that the management team listened to and valued patients and their representatives and taking account of the views 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	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Alison Sweeney, manager, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent inspection dated 12 December 2017

The most recent inspection of the home was an unannounced enforcement care inspection undertaken on 12 December 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
- pre-inspection audit

During the inspection we spoke individually with three patients and the majority of others were observed either sitting or resting in the day lounges, dining room and/or bedrooms as per their personal choice. Eight staff were spoken with, these included, registered nurses, care staff, ancillary staff, the activities co-ordinator and the administrator for the home. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was provided which directed staff to complete an online survey for those staff not on duty during the inspection.

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 23 to 29 April 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one recruitment and induction file
- five patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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 12 December 2017

The most recent inspection of the home was an unannounced enforcement care inspection undertaken on 12 December 2017.

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 12 December 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that repositioning records are maintained to reflect all positional changes including when up to sit.	**Met**
	Action taken as confirmed during the inspection: A review of repositioning charts evidenced that these were maintained appropriately and that this area for improvement had been addressed.	

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 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 from 23 to 29 April 2018 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. We also sought staff opinion on staffing via the online survey. At the time of writing this report none had been received.

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Knockmoyle Lodge. We also sought the opinion of patients on staffing via questionnaires. One questionnaire was returned and the respondent indicated that they were very satisfied that "there were enough staff to help".

We also sought relatives' opinion on staffing via questionnaires. Three questionnaires were returned and all three relatives similarly indicated that they were "very satisfied" that staff had 'enough time to care'. No additional written comments were included.

As stated previously, observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

Review of a recruitment file for one staff member recently recruited evidenced that this was maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work. Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC. There were systems and processes in place to ensure that alerts issued by Chief Nursing Officer (CNO) were managed appropriately and shared with key staff.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2017/2018. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Observation of the delivery of care evidenced that training had been embedded into practice.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. The manager advised that two safeguarding champions had been identified for the home and arrangements were in place for them to attend training in relation to fulfilling this role. The details of these staff members (including photographs) were displayed on the notice board. A discussion was held with the manager regarding the development of systems to collate the information required for the annual adult safeguarding position report.

Review of five patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

We reviewed accidents and incidents records for the period, December 2017 to April 2018 in comparison with notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. Following this review an action plan was devised to address any identified deficits. This information was also reviewed as part of the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. From a review of records there was evidence of proactive management of falls.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, and dining room and storage areas. The home was found to be warm, fresh smelling and clean throughout. A discussion held with senior management indicated that plans were in place to re-decorate and refurbish some areas of the home.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Observation of practices and discussion with staff and review of records evidenced that infection prevention and control measures were consistently adhered to. Staff were observed attending to hand hygiene and wearing PPE when assisting patients. However, at lunchtime, staff were observed not wearing appropriate protective aprons. This matter was discussed with the manager who agreed that this should be implemented. The manager agreed to address this issue and has since confirmed by email correspondence that this practice is now in place.

In addition the manager maintained records of the incidences of health care acquired infections (HCAIs). Care plans were in place for patients with infections which outlined the treatment and care required.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example; bed rails and alarm mats. There was also evidence of consultation with relevant persons. Care plans were in place for the management of these interventions as deemed appropriate.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No 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 five patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient.

We reviewed care records in regards to the following: the admission process; discharge from hospital; the management of falls, nutrition, wound and catheter care. Care records were completed and reviewed both at the time of admission and on return from a hospital admission. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), Speech and Language Therapist (SALT) and Dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals.

Supplementary care charts such as food and fluid intake records evidenced that in the majority these were well maintained. A review of food and fluid intake charts for an identified patient evidenced some recording gaps in regards to breakfast time. This matter was discussed with the manager who gave assurances that they would address and monitor same. A review of the same care record identified that the patient was at risk of dehydration however no minimal target fluid intake was recorded. A review of the fluid intake charts demonstrated that fluids were being offered and recorded appropriately. The importance of a minimal fluid target was discussed with the manager who agreed to follow up with the GP and/or dietician.

A review of repositioning records evidenced that these were maintained in accordance with best practice. A record was maintained to evidence that all patients' skin was checked for any signs of pressure damage both on rising and retiring to bed. This is good practice.
A review of bowel monitoring records evidenced that these were maintained in keeping with best practice guidelines and no significant gaps were noted.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the manager or the nurse in charge. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

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. During the inspection, patient's representatives were observed interacting with staff regarding the needs and care of their loved ones.

Patient spoken with expressed their confidence in raising concerns with the home's staff/management. One patient spoken with stated; "that the manager knew about any issues before they spoke with them and that she knew all that was happening in the home".

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, audits and reviews, communication between residents, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

We arrived in the home at 11.00 hours and were greeted by staff who were helpful and attentive. Patients were enjoying a late breakfast or a morning cup of tea in the dining room and /or in one of the lounges. Patients had access to fresh water and/or juice and staff were observed assisting patients to enjoy their chosen activity and to eat and drink as required.

Some patients were also participating in a game of "bingo" and stated that they had enjoyed the activity and told the inspector about their "winnings". An activity programme was displayed on the notice board in the home. A discussion held with the person nominated for activities indicated that they enjoyed their role and acknowledged the importance of same. Records for the activity held were observed being maintained by the activities person. Arrangements to meet patients' social, religious and spiritual needs within the home were discussed with the manager. A record was maintained to reflect any visits made by the clergy or when the patients attended their place of worship.

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.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with processions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example; photographs, prompts to orientate patients to the time, date and place were displayed.

We observed the serving of the lunchtime meal. Patients were assisted to the dining room or meals were taken to a group of patients seated in one of the lounges. The rationale for this practice was discussed with staff who indicated that it provided a positive mealtime experience for those patients rather than attending the dining room. There were two dining room sittings for lunch and again staff had considered the holistic needs of the patients in this arrangement. Staff were observed assisting patients with their meal appropriately and senior care staff and registered nurses were overseeing the mealtime. Patients able to communicate indicated that they enjoyed their meal. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

"all the care you gave to …100% what a great care team you are"
"Thank you so much for your dedicated care & attention to our dad through his ups and downs & difficulties you all made him feel at home during his stay. Very much appreciated & meant everything to us all as a family".

A review of minutes from staff meetings held evidenced that the manager had communicated any compliments and/or positive feedback received from Trust staff and other persons to the staff team. This is good practice.

There were systems in place to obtain the views of patients and their representatives on the running of the home. A notice was displayed regarding a suggestion box which was available for all persons to avail off.

Consultation with three patients individually confirmed that Knockmoyle Lodge was a good place to live.

Patient comments included:
“looked after very well”
“looked after well, so happy and content”
“very happy; I have just being playing bingo and the staff are all very good to me”.

During the inspection, it was noted that the manager had made arrangements for one patient to receive a telephone call from their family who lived overseas. The patient expressed their appreciation for same.

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. Patients were presented well and attention to detail was apparent. For example; a number of the ladies were observed wearing clothing and accessories to match.

Ten relative questionnaires were provided; four were returned within the timescale. All four respondents indicated that they were very satisfied with the care provided across the four domains. No additional comments were included.

Staff were asked to complete an on line survey, no responses were received within the timescale specified.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

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 and their representatives and taking account of the views of 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.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

The manager has been in post since November 2017. An application for registration with RQIA has been received. Staff commented positively in regards to the new manager's leadership and management of the home. A review of the duty rota evidenced the manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff 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 manager. This was clearly recorded on the duty record.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The service did not collect any specific equality data on service users apart from information collated and recorded in care records as part of the admission process. The manager was advised to contact the Equality Commission for Northern Ireland for guidance on best practice in relation to collecting the data. Prior to the conclusion of the inspection, the manager had contacted the above for further guidance to include training for staff.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, IPC practices, care records, and hygiene audits. In addition measures were also in place to provide the manager with an overview of the management of infections, wounds etc. occurring in the home.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005/ The Care Standards for Nursing Homes.

Discussion with the 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.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised. No concerns were raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement 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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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