Unannounced Follow up Care Inspection Report
9 January 2020

Knockmoyle Lodge

Type of Service: Nursing Home
Address: 29 Knockmoyle Road, Omagh, BT79 7TB
Tel No: 028 8224 7931
Inspector: Jane Laird

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.0 What we look for

2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 35 persons.

3.0 Service details

Organisation/Registered Provider: Knockmoyle Lodge **Responsible Individual:** Linda Florence Beckett	**Registered Manager and date registered:** Carol Anne Byrne – acting manager
Person in charge at the time of inspection: Carol Anne Byrne	**Number of registered places:** 35 The home is also approved to provide care on a day basis for 1 person.
Categories of care: Nursing Home (NH) DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 32

4.0 Inspection summary

An unannounced inspection took place on 9 January 2020 from 09.15 hours to 15.10 hours.

The inspection assessed progress with all areas for improvement identified in the home 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.

During this inspection we identified evidence of good practice in relation to the management of notifiable events, adult safeguarding, falls management, care delivery and team work. Further areas of good practice were identified in relation to the culture and ethos of the home, listening to and valuing patients and their representatives, taking account of the views of patients and governance arrangements.

Areas of improvement were identified in relation to supplementary records and the management of complaints.

Patients described living in the home in positive terms. Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Carol Anne Byrne, acting manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 17 October 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 17 October 2019. 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

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.

During our inspection we:

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

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

The following records were examined during the inspection:

- duty rota for all staff from 30 December 2019 to 12 January 2020
- staff training records
- incident and accident records
- three patient care records
- four patient care charts including food and fluid intake charts and repositioning charts
- a sample of governance audits/records
- complaints record
- compliments received
- a sample of monthly monitoring reports from November 2019

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

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

6.0 The inspection

6.1 Review of areas for improvement from previous inspection(s)

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 (4) **Stated:** First time	The registered person shall ensure that suitable arrangements are implemented to ensure that wound care dressings are in stock within the home at all times as per individual patients prescribed needs.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of care records/audits confirmed that this area for improvement had been met.	

6.2 Inspection findings

6.2.1 Staffing provision

On arrival to the home at 09.15 hours we were greeted by staff who were helpful and attentive and appeared confident in their delivery of care. The majority of patients were seated within the dining room having breakfast whilst others remained in bed and staff were attending to their needs. The staff were observed to use every interaction as an opportunity for engagement with patients and they demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. There was clear evidence of a relaxed, pleasant and friendly atmosphere between patients and staff.

We reviewed staffing rotas from 30 December 2019 to 12 January 2020 and identified that a number of shifts had been cancelled at short notice. Discussion with the manager confirmed that where possible shifts were 'covered' with available staff. In addition recruitment for suitably skilled and experienced care assistants was on-going. Staff spoken with confirmed what the manager had discussed with us and that they were satisfied that there was sufficient staff on duty to meet the needs of the patients. Staff also stated that they have seen a very positive change within the home over the past few months.

Comments included:

- "Much better now"
- "Manager very supportive."
- "Really love working here."
- "Staff morale is good"
- "Care is really good here."
- "Good teamwork."

Discussion with staff evidenced that care staff were required to attend a handover meeting at the beginning of each shift. Staff understood the importance of handover reports in ensuring effective communication and confirmed that this was part of their daily routine.

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 management or the nurse in charge.

Areas for improvement

There were no areas for improvement identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.2.2 Patient Health and Welfare

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. Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Knockmoyle Lodge.

Patients' bedrooms were personalised with possessions that were meaningful to them and reflected their life experiences. Patients and staff spoken with were complimentary in respect of the home's environment whilst recognising that there is ongoing refurbishment. This is discussed further in 6.2.4.

Consultation with nine patients individually, and with others in small groups, confirmed that living in Knockmoyle Lodge was a positive experience.

Patient comments included:

- "Staff are very good."
- "Looking after me well."
- "Food is lovely."
- "No concerns"
- "Happy here."

Patient representative's comments included:

- "Staff are very friendly."
- "No concerns."
- "Care is very good."

Cards of compliment and thanks were available within a folder in the home. Some of the comments recorded included:

- "Thank you for all your love, care and thoughtfulness"
- "Thank you for the great care and compassion given"

Discussion with patients and staff and review of the activity records evidenced that activities were in place to meet patients' social, religious and spiritual needs within the home. The patients appeared to enjoy the interaction between the staff and each other. We identified that a schedule of activities was not displayed within the home and was discussed with the activity person and the manager who agreed to implement a weekly schedule going forward. This will be reviewed at a future inspection.

We identified two bedroom doors that were unable to close fully rendering them ineffective in the event of a fire. Prior to the completion of the inspection the doors were repaired by maintenance personnel and a review of all bedroom doors was completed. The manager agreed to ensure that bedroom doors are included in audits of the environment and reviewed on a monthly basis. This will be reviewed at a future inspection.

Areas for improvement

There were no areas for improvement identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.2.3 Management of patient care records

Review of three patient care records evidenced that care plans were mostly in place to direct the care required and generally reflected the assessed needs of the patients. However, on review of a recently admitted patient it was identified that a number of care plans had not been generated in relation to the patient's condition. This was discussed with the manager who agreed to review the identified patient's care records and to implement audits on all newly admitted patients following admission, to ensure that all relevant documents are in place. We further identified that when patients rise early and care/treatment has been provided, this was not documented within the patient's daily progress notes. The manager agreed to communicate the above findings with all registered nurses and to monitor through regular quality governance audits.

On review of repositioning records for an identified patient it was evident that they were being repositioned frequently, however, the recommended frequency of repositioning was not included in the care plan and/or the daily recording chart to direct staff. It was further identified that the dietary type and recommended fluid consistency was not recorded on the charts reviewed. The manager acknowledged the shortfalls in the documentation and agreed to review all patients' supplementary charts and care plans regarding dietary/fluid requirements and pressure area care and to communicate with relevant staff to ensure they document accurately the recommended frequency

of repositioning and dietary/fluid requirements within patients' supplementary charts/care records. This was identified as an area for improvement.

Areas for improvement

An area for improvement was identified in relation to supplementary records.

	Regulations	Standards
Total number of areas for improvement	0	1

6.2.4 General environment

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, the dining rooms and storage areas. The home was found to be warm, fresh smelling and comfortable throughout. Since the last inspection positive improvements had been made where new floors had been fitted to various areas within the home, communal areas and multiple bedrooms had been redecorated with new furniture and paint work throughout. The manager confirmed that work was ongoing and scheduled to the remaining areas within the home.

Areas for improvement

There were no areas for improvement identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.2.5 Management and governance arrangements

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded.

A number of audits were completed on a monthly basis by the manager to ensure the safe and effective delivery of care. For example, falls in the home were monitored on a monthly basis for any patterns and trends which provided the location, time and nature of the fall. IPC, care records, hand hygiene and environment audits were also carried out monthly and an action plan with timeframes was implemented where deficits were identified.

On review of the complaints ledger it was identified that not all complaints received were dated and there was no evidence to suggest that the complainants were satisfied with the outcome of the investigation. This was discussed with the manager who acknowledged that there were deficits in the recording of the complaints and an area for improvement was identified

Areas for improvement

An area for improvement was identified in relation to the management of complaints.

	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 Carol Anne Byrne, acting manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

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

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 24 **Stated:** First time **To be completed by:** 9 February 2020	The registered person shall ensure that all complaints received: • provide the date/time received • the name of the person who received the complaint • provide whether or not the complainant is satisfied with the outcome Ref: 6.2.5
	Response by registered person detailing the actions taken: new complaints folder layout printed and all staff updated on 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 **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall ensure that all nursing interventions are appropriate to the individual patients needs and supported by current evidence and best practice guidelines. Specific reference to repositioning and dietary/fluid intake recording charts and care plans: • The frequency of repositioning should be recorded within the repositioning chart to reflect the patients care plan • Dietary type and fluid consistency should be recorded on daily intake charts to reflect the patients care plan and direct relevant care. Ref: 6.2.3
	Response by registered person detailing the actions taken: Staff meetings held and all staff made aware careplans updated to reflect frequency of repositioning Fliud balances now record specific consistancy and these are updated as and when required

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

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