Unannounced Care Inspection Report
27 April 2021

Knockmoyle Lodge

Type of Service: Nursing Home
Address: 29 Knockmoyle Road, Omagh
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:** Sharon Colhoun 30 January 2020
Person in charge at the time of inspection: Sharon Colhoun	**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:** 31

4.0 Inspection summary

An unannounced inspection took place on 27 April 2021 from 10.30 to 17.15.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DoH) directed RQIA to continue to respond to ongoing areas of risk identified in homes. In response to this, RQIA decided to undertake an inspection to this home.

The following areas were examined during the inspection:

- staffing
- care delivery
- communication
- care records
- infection prevention and control (IPC) measures
- the home's environment
- leadership and management arrangements.

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.

4.0 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	4	6

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Sharon Colhoun, 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.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection, registration information, and any other written or verbal information received.

This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report.

Questionnaires and 'Tell us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

The following records were examined during the inspection:

- staff duty rota for weeks commencing 26 April 2021 and the 3 May 2021
- three patients' daily reports and care records
- record of staff mandatory training
- three patient care charts including food and fluid intake charts and repositioning charts
- complaints ledger
- incident and accident records
- a sample of governance audits/records
- one staff recruitment and induction files
- monthly quality monitoring reports from February 2021
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- registered nurses competency and capability assessments for taking charge of the home in the absence of the manager
- fire risk assessment.

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

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 6 October 2020. No further actions were required to be taken following this inspection.

6.2 Inspection findings

6.2.1 Staffing

On arrival to the home at 10.30 hours we were greeted by the manager and staff who were helpful and attentive. There was a pleasant, relaxed atmosphere in the home throughout the inspection and staff were observed to have caring, cheerful and friendly interactions with patients.

The manager advised us of the daily staffing levels and how these levels were reviewed regularly to ensure the assessed needs of the patients were met. On review of the staff duty rotas the planned staffing levels had been adhered to. We discussed with the manager that the exact hours worked by her needed to be included on the duty rota and not abbreviated as 'ON'. The manager agreed to ensure that this is completed going forward. This will be reviewed at a future inspection.

Discussion with staff confirmed that they were satisfied with current staffing arrangements. Comments from staff included:

- "Feel supported by management".
- "Very positive changes since previous inspections".
- "Great team here".
- "Lots of training".
- "Happy working here".
- "Love my job".

The manager confirmed that staff had completed training specific to the Mental Capacity Act (MCA) (Northern Ireland) 2016 Deprivation of Liberty Safeguards (DoLS) relevant to their role. However, on review of the training records and further discussion with the manager it was evident that ancillary staff had not completed MCA/DoLS training and an area for improvement was identified.

Review of one staff recruitment and induction file evidenced that relevant pre-employment checks had been received prior to commencing employment in line with best practice and the record of induction was available within the employees file.

There was a system in place to monitor staff registration with the Nursing and Midwifery Council (NMC). However, there was no system evident to confirm that relevant checks were being completed on care assistants to ensure they are registered with the Northern Ireland Social Care Council (NISCC) and an area for improvement was identified. The manager advised that all relevant staff were registered but acknowledged that a monitoring checklist was required to confirm this. Following the inspection the manager provided written confirmation on the 30 April 2021 that a monitoring check list had been implemented.

6.2.2 Care delivery

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 demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and of how to provide comfort if required.

Patients told us that they were well looked after by the staff and felt safe and happy living in Knockmoyle Lodge. Comments from patients included:

- "Staff are very friendly".
- "Happy here".
- "Food is lovely".

Since the previous care inspection the dining arrangements within the home had been reviewed by the management team and a conservatory room was being used for a number of patients for the provision of meals. The main dining room at reception was also in use and portable tables were provided for patients who preferred to have their meals within their bedroom and/or lounge. The importance of rooms being used for the purpose that they are registered for was discussed with the manager and the need to submit a variation application was explained and an area for improvement was identified. This is discussed further in section 6.2.5 below.

A menu was displayed offering a choice of two main meals within the main dining room at reception; however, there was no menu on display within the conservatory room. We further observed one patient seated at a table that was not suitable for dining and discussed the importance of ensuring that adequate/suitable tables are provided within the conservatory room with the manager. Following the inspection the manager confirmed in writing that a menu board and suitable table had been added to the conservatory room.

We observed three thickening agent containers within unlocked drawers in an identified lounge and brought this to the attention of the senior care assistant who immediately acknowledged that these should have been within a locked cupboard and removed them to a safe area. We further observed prescribed supplements within a lounge which were easily accessible to patients. This was discussed with the manager who agreed to monitor the storage of thickening agents and supplements during daily walk arounds and an area for improvement was identified.

6.2.3 Communication

Discussion with staff and patients confirmed that systems were in place to ensure good communications between the home, the patient and their relatives during the COVID-19 visiting restrictions. Some examples of the efforts made included**;** video calls, telephone calls, visits to the window and indoor visits under COVID-19 guidelines.

6.2.4 Care Records

We observed information regarding patients assessed needs displayed within a lounge and a dining room and discussed the potential breach of confidentiality with the manager who agreed to remove such information and to place in a folder accessible to staff. Following the inspection the manager provided written confirmation on the 30 April 2021 that this had been actioned.

Review of three patient care records evidenced that care plans were in place to direct the care required and generally reflected the assessed needs of the patient. However, moving and handling risk assessments had not been updated within the required timeframe for two patients and the use of correction fluid with scoring out/scribbling over written entries was evident resulting in the original entry not being able to read. This was discussed in detail with the manager who agreed to monitor this through regular audits and to discuss the importance of accurate record keeping with relevant staff. This was identified as an area for improvement.

Review of two patient's care records evidenced that supplementary recording charts and care plans did not contain the recommended frequency of repositioning. This was discussed in detail with the manager and an area for improvement was identified.

Care records reviewed for one patient regarding wound care identified that the care plan did not contain information regarding the recommended wound dressing type/treatment to be applied and the frequency of dressing renewal. Pressure area care was discussed with the manager and an area for improvement was identified.

6.2.5 Infection prevention and control (IPC) measures

There was an adequate supply of PPE and hand sanitising gel within the home. Staff demonstrated an awareness of the various types of PPE and were observed applying and removing PPE correctly within designated areas.

A number of light and/or emergency pull cords throughout the home were uncovered and could therefore not be effectively cleaned. Not all pillows were covered with a suitable pillow protector and surface damage was evident to identified armchairs, bedroom furniture, over bed tables and a communal bath. There was staining evident under some dispensers and a number of toilet brushes were stained and not air dried following use. Hand paper towels were observed outside of the wall mounted dispenser in a communal toilet at reception and there was no dispenser for hand paper towels within an identified bedroom and or laundry room. The entrance mat to the laundry was unclean and the cover to the ironing board and iron roller were torn. We discussed the above findings in detail with the manager and an area for improvement was identified. Following the inspection on the 30 April 2021 the manager provided written confirmation that relevant action had been taken to address the deficits with ongoing review dates scheduled to ensure all actions are completed.

Two staff were observed using the patients main dining room to have their break. We discussed the importance of implementing zones within the home for staff to ensure that the regional COVID-19 guidance is adhered to. The manager confirmed that a designated staff room has been provided and that due to social distancing the staff room could only be occupied by a certain number of staff at any given time. We provided some advice and guidance on how to manage staff breaks more appropriately and in line with IPC guidance. Prior to the completion of the inspection the manager had reviewed the staff break times to ensure that the COVID-19 guidelines are adhered to.

6.2.6 The home's environment

We could see that refurbishment works had been completed since the last care inspection and that new floor coverings had been laid. Walls within identified bedrooms and communal areas had been painted/decorated and patients' bedrooms were personalised with possessions that were meaningful to them and reflected their life experiences.

Whilst the majority of the environment was fresh smelling and clutter free, a malodour was evident within two identified patient bedrooms. A number of bed sheets were worn and the floor tiles within the main dining room were damaged. The frame surrounding a mirror within an identified communal shower room was unsecure and wardrobes within bedrooms were not secured to the wall. We observed holes in the ceiling and wall of a communal toilet; a hole in the ceiling within a corridor area and an identified en-suite. We observed a pane of glass cracked within a corridor window and potential trip hazards from a door saddle which was unsecure and a mattress which was on the floor within a corridor.

The above deficits were discussed in detail with the manager and an area for improvement was identified. Following the inspection the manager provided written confirmation on the 30 April 2021 that most of these issues had been addressed with ongoing review dates to address all other actions.

We also observed a fire door that was not fitting correctly to the door frame and a fire exit door that was not fully closing. We identified a lock at the bottom of a fire exit door and a cracked pane of glass. A further fire door leading from an outdoor area beside the laundry and into a corridor beside the kitchen area was held open on a hook. We also observed hand paper towels on a table within the smoking room. We requested the manager to review these issues from a fire safety perspective and an area for improvement was identified. This information was shared with the estates inspector. Following the inspection the manager provided written confirmation that the lock had been removed from the bottom of the fire exit door and that the other issues had also been addressed.

We identified that a sluice room was being used as a store room for storing wheelchairs and requested that a variation application is submitted for this room. This information was shared with the estates inspector and an area for improvement as mentioned in section 6.2.2 above has been stated in respect of this.

We identified a communal toilet with a connecting internal door leading directly into a patient's bedroom. This meant that patients using this room could not confidently use it in private. We discussed this with the manager and following the inspection written confirmation was received that the internal door has been secured.

6.2.7 Leadership and management arrangements

Since the last inspection there has been no change in management arrangements. Staff spoken with commented positively about the manager and described her as supportive and approachable. A clear management structure was evident within the home.

We reviewed a number of audits in relation to IPC, hand hygiene, environment and care records. Where there were areas for improvement identified, actions plans were in place with associated timeframes for completion.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the registered provider's representative. Copies of the report were available for patients, their representatives, staff and trust representatives and provided detailed information in relation to the conduct of the home. Where areas for improvement were identified, there was an action plan in place with defined timeframes.

Areas of good practice

Evidence of good practice was found in relation to the friendly, supportive and caring interactions by staff towards patients and we were assured that there was compassionate care delivered in the home.

Areas for improvement

Ten new areas for improvement were identified during the inspection. Details can be found throughout the body of the report and in the Quality Improvement Plan (QIP).

	Regulations	Standards
Total number of areas for improvement	4	6

6.3 Conclusion

There was evidence of appropriate leadership and management structures within the home and patients appeared to be content and settled in their surroundings. Staff were knowledgeable regarding the needs of patients and how to access relevant services to ensure that the needs of patients are met. We were satisfied that the appropriate action had been taken to address any immediate issues identified during the inspection.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Sharon Colhoun, 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 13 (4) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure thickening agents and prescribed supplements are securely stored. Ref: 6.2.2
	Response by registered person detailing the actions taken: Thickening agents and prescribed supplements were removed immediately on day of inspection by SCA. When supplements are required, they are supervised by staff.
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 27 May 2021	The registered person shall ensure that the infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance. With specific reference to: • surface damage to identified armchairs, bedroom furniture, over bed tables and communal bath • light/emergency pull cords are covered • hand paper towel dispenser is installed in the laundry room and identified bedroom • pillows have a protective cover • hand paper towels are stored within dispensers • toilet brushes are air dried following use • the cover to the ironing board and iron roller are replaced.

	Ref: 6.2.5
	Response by registered person detailing the actions taken: The chest of drawers identifed on the day of inpsection has been repaired. As discussed with inspector new bedroom furniture has been order to replace the outdated furniture. As we are a Dementia unit plastic overbed tables have been purchased as a trail as current tables are needing to be replaced quaterly due residents behaviors. The surafce damage identifed on the arm chairs have been discussed with a refubishment company, the four chairs identifed will be fixed at their earliest convinence. Plastic covers for light pull cords have now been ordered, as we were unaware that these were required as it had not been previosuly stated. These will be added to our enviromental monthly audits to ensure that we can monitor compliance. The two hand paper towel dispensors identified have now been installed, staff have been advised to esnure that all paper towels are kept within the dispeners until needed for use. A stock of pillow protectors have now been order, as this has not been previously identifed we were unware that is was a requirement. In additon, all staff has been made aware of the need for pillow protectors for each resident. New toilet brushes and holders have been purchased to ensure the brush is held up from the holder as identified on day of inspection. Senior House Keeper will ensure full compliance. The cover to the ironing board and iron roller have been replaced. In relation to communal bath, the area of concern has been discussed with the occupational theory team due to conerns regarding moving and handling safety for our staff and the potential risk to clients. Following this we have had a survey and architect view this communal bathroom, please see enclosed plans.
Area for improvement 3 **Ref:** Regulation 27 (2) (b) (c) (d) (t) **Stated:** First time	The registered person shall ensure that the environmental issues identified during this inspection are addressed. With specific reference to: • potential trip hazard from floor covering within identified area is repaired/replaced

To be completed by: 27 May 2021	• bed sheets that are worn to be disposed of • wardrobes to be secured to the wall • mirror within an identified communal shower room • floor tiles within the main dining room to be repaired/replaced • malodour in identified bedrooms is investigated and resolved • pane of glass is replaced to identified window • damage to the wall and ceiling within identified areas are repaired. Ref: 6.2.6
	Response by registered person detailing the actions taken: Screw has been installed at the door strip identified. Bed sheets are less than one year old, the sheets had ladder from the elastic corners. As a result of this we have made the company where the sheets were purchased aware. Stock of sheets within the nursing home are kept to a high level. New furnitures sets have been order, on delievry maintaince will commence the request of securing to the wall. Mirror within the identified communal shower room has now been removed, following the inspection. The main dinning room, is on our improvement plan. Measurements have been taken and quote as been received, this will be carried at a later date as it not an urgent request. Malodour has been identified, investigated and resolved. No further action was needed. As per Knockmoyle improvement plan, new windows and doors are being fiited at end of June. External company had assessed the pane of glass to ensure no risk whilst awaiting replacement date. Three small gaps to the ceiling areas that were identifed have been repaired
Area for improvement 4 **Ref:** Regulation 27 (4) (b) **Stated:** First time	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that: • fire doors are able to close effectively

To be completed by: With immediate effect	• pane of glass is replaced to identified fire exit door • fire doors are not held open. Ref: 6.2.6
	Response by registered person detailing the actions taken: External company has assesed all doors, identifying no issues or cause for concern. As per improvement three, an external company assessed the pane of glass in fire door which will be replaced at the end of June. Fire door idetfied on the day of inspection, was held open to allow Laundry trolley access into the main home. Due to the fact that staff have to go through a secure key pad on entry to the home, they have now been made aware to close door on return.

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 39 **Stated:** First time **To be completed by:** 27 May 2021	The registered person shall ensure that MCA/DoLS training is completed by all staff and evidence of such training is maintained within the home. Ref: 6.2.1
	Response by registered person detailing the actions taken: All staff within the home have completed DoLs training, evidence of this has been received and placed within training folder.
Area for improvement 2 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 27 May 2021	The registered person shall ensure that a system is implemented to evidence that relevant registration checks have been completed on care assistants to ensure they are registered with NISCC. Ref: 6.2.1
	Response by registered person detailing the actions taken: Knockmoyle has a NISSC system in place, with all details on an excel sheet. However, following advice from inspection an additional NISCC Matrix will be implemented to ensure good practice and checked monthly.
Area for improvement 3 **Ref**: Standard 44 **Stated:** First time **To be completed by:** With immediate effect	The registered persons must ensure that the nursing home, including all spaces, is only used for the purpose for which it is registered. A retrospective variation is to be submitted if the rooms identified are to remain permanently. Ref: 6.2.2 and 6.2.6
	Response by registered person detailing the actions taken: Currently seeking advice regarding this area of improvement. The room identied at the inspection is currently a communal day room. This room is used for actvities, meals and a general lounge area. As we are a Dementia Unit, we feel that it is in the best intrest of our residents to provide them with the choice as to where they have their meals. This is reflected in their care plans. The sluice room identified on the day of inpesction, is currently used as a wheelchair store. However, plans are in place to revert back to a sluice room within the coming months.

Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that moving and handling risk assessments are updated regularly and any amendments to care records are made in such a way that the original entry can be read. Ref: 6.2.4
	Response by registered person detailing the actions taken: On the day of the insepction all moving and handling risk assessments where relevant to the indivduals, however in order to maintain good practice we will return to updating on a monthly basis. An audit has been implemented to ensure ammendents to care records are in line with NMC to ensure orginal entry can be read.
Area for improvement 5 **Ref**: Standard 23.2 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that where a patient has been assessed as requiring repositioning that this is recorded within their care plan and repositioning chart. Ref: 6.2.4
	Response by registered person detailing the actions taken: As exisiting care plans reflected repositing on day inspection, repositiong charts have now been updated accroding to the indivdual needs of each resident whom requires this.
Area for improvement 6 **Ref**: Standard 23.2 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that where a wound has been assessed as requiring treatment, a care plan is implemented to include the dressing type and frequency of dressing renewal and is updated when necessary to reflect any changes. Ref: 6.2.4
	Response by registered person detailing the actions taken: On the day of the inspection, it was identifed that a separate wound care folder was in place which included; invdivdualised care plans, contact with multi-disciplinary team, photograghs and wound charts. I can comfirm that the Care plan in relation to the indentifed patient, does included the dressing type/treatment to be applied and the frequency of dressing renewal. As per gudiance from the inspector, these documents are now located within the Nursing folder, rather than a separate folder to ensure all areas of care is idenfied within the one area, which had been advised in previous inspections.

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

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