Unannounced Care Inspection Report
1 December 2020

Millcroft

Type of Service: Nursing Home (NH)
Address: 66 Mill Street, Enniskillen BT74 6DW
Tel No: 028 6632 4000
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 registered nursing home which provides care for up to 69 patients.

3.0 Service details

Organisation/Registered Provider: Carewell Homes Ltd **Responsible Individual:** Carol Kelly	**Registered Manager and date registered:** Carmen Leonard - acting
Person in charge at the time of inspection: Carmen Leonard	**Number of registered places:** 69 The home is also approved to provide care on a day basis for 2 persons.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 36

4.0 Inspection summary

An unannounced inspection took place on 1 December 2020 from 11.30 to 18.30 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk. In response to this, RQIA decided to undertake an inspection to this home.

The following areas were examined during the inspection:

- staffing
- patient health and welfare
- 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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	4	4

Details of the Quality Improvement Plan (QIP) were discussed with Carmen Leonard, manager and Carol Kelly, responsible individual, 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 returned QIP from 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 also left for staff inviting them to provide feedback to RQIA online.

The following records were examined during the inspection:

- staff duty rota for weeks commencing 23 November 2020 and the 30 November 2020
- three patients' daily reports and care records
- record of staff mandatory training
- two patient care charts including food and fluid intake charts and repositioning charts
- complaints ledger
- compliments
- adult safeguarding folder
- a sample of governance audits/records
- two staff recruitment and induction files
- monthly quality monitoring reports from October 2020
- 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
- water sampling test results.

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)

The most recent inspection of the home was an unannounced care inspection undertaken on 21 November 2019 which resulted in no areas for improvement.

6.2 Inspection findings

6.2.1 Staffing

On arrival to the home at 11.30 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 within each unit and how these levels were reviewed regularly to ensure the assessed needs of the patients were met. Review of staff duty rotas evidenced a number of deficits with the maintenance of the rota. For example: the person in charge of the home in the absence of the manager was not recorded; the hours worked by staff were recorded as '7.45 – 8' and were therefore not specific to either day or night duty and the manager's hours were not recorded for the week commencing the 30 November 2020. This was discussed with the manager and identified as an area for improvement.

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

- "The manager has been fantastic support throughout the COVID-19 outbreak."
- "We all work well as a team."
- "Plenty of training."
- "I love my job and feel very supported by the manager."
- "The patients are like my family as I have looked after them for so long."
- "Great team here."

We discussed staff training specific to the Mental Capacity Act (Northern Ireland) 2016 deprivation of liberty safeguards (DoLS) and were advised by the manager that the majority of staff had completed level 2 training. However, staff such as registered nurses with

overseeing responsibilities had not completed level 3 training. The manager agreed to have this training implemented with ongoing monitoring to ensure full compliance. This will be reviewed at a future inspection.

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

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 onsite visits in accordance to COVID-19 visiting guidance.

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

- "Very friendly people working here."
- "I have everything I need."
- "Very happy here."
- "Food is good."
- "Well looked after here."

Ten questionnaires were returned from patients. The respondents were either satisfied or very satisfied with the service provision within the home. However, one patient was unsatisfied with "Do you feel your care is effective." The details of the patient were not included and we were therefore unable to establish why they were unsatisfied with this area of care. This information was shared with the manager.

Seating and dining arrangements had been reviewed by the management of the home to encourage social distancing of patients in line with COVID-19 guidance. The dining room on the ground floor was not being used by patients following a risk assessment by the manager and portable tables were provided within the lounge areas during meal times. The manager advised that this was a temporary measure during the COVID-19 pandemic and that the dining room would return to its normal function when assessed as appropriate.

We observed prescribed food thickening agents/supplements stored within unlocked cupboards in the dining room on the ground floor which was easily accessible to patients. We also observed oxygen located within a corridor area across from a nurses station. There was no signage to indicate that oxygen was being stored there and the oxygen cylinder was not secure. These matters were discussed with management and an area for improvement was stated.

We observed the delivery of meals and/or snacks throughout the day and saw that staff attended to the patients' needs in a prompt and timely manner. Staff wore the appropriate personal protective equipment (PPE) and sat beside patients when assisting them with their meal. However, a daily menu was not displayed within the home and an area for improvement was stated.

On review of the environment we identified three sluice room doors that were unlocked with chemicals easily accessible to patients. We were unable to establish one of the chemicals as it was not labelled and discussed the potential risk to patients with the manager as an area for improvement.

We also observed the door to a lift servicing room unlocked with signage: “Door to be kept locked.” We discussed this with the manager who advised that this would be monitored during daily walk arounds to ensure that it remains locked and the importance of ensuring all other doors as mentioned above are kept locked, would be communicated with staff at handovers.

Two unoccupied bedrooms within the home were being used as staff changing rooms. The manager advised us that this was a temporary measure due to current COVID-19 restrictions. We discussed the importance of the rooms being used for the purpose that they were registered and requested written information regarding the location of the rooms and that this was a temporary measure during the COVID-19 pandemic. Following the inspection, this information was received in writing from the manager.

6.2.3 Care Records

We reviewed three patient’s care records which evidenced that the majority of care plans were person centred and reviewed regularly. However, a number of deficits were identified as follows:

- Inconsistencies in one patient’s care records regarding the recommended diet/fluid consistencies as per the speech and language therapist (SALT) assessment
- International Dysphagia Diet Standardisation Initiative (IDDSI) terminology not consistently recorded within care records
- activities of daily living assessment for one patient had not been updated following a change in the patient’s assessed needs.

Specific examples were discussed in detail with the manager who acknowledged the shortfalls in the documentation and agreed to communicate with relevant staff the importance of accurately recording such information within patients’ care records. In order to drive and sustain the necessary improvements, an area for improvement was made.

We reviewed two patients care records specific to wound management. One care record contained detailed information within the care plan regarding the wound assessment, frequency of dressing renewal and recommendations made by the tissue viability nurse (TVN). However, on review of care records for another patient, there was no care plan to direct the relevant care. We further identified that the wound assessment chart did not specify the grade of the wound and/or maintain a record of the wound measurement. This was discussed in detail with the manger as an area for improvement.

6.2.4 Infection prevention and control (IPC) measures

Upon entering the home, the inspector’s temperature and contact tracing details were obtained by the nurse who advised that this is completed on all persons entering the home in line with the current COVID-19 guidelines for visiting care homes.

We were advised by staff that temperature checks were being completed on all patients and staff twice daily and that any concerns or changes were reported to the manager and/or nurse in charge.

Staff spoken with were knowledgeable regarding the symptoms of COVID-19 and how to escalate any changes in a patient's usual presentation to the person in charge. Staff also said that if they themselves felt unwell, they would inform the person in charge and isolate, at home, as per regional guidance.

There was an adequate supply of PPE and hand sanitising gel at the entrance to the home and within each of the units. We observed a selection of gloves being used by staff and were advised by the manager that vinyl gloves were used for non-personal care interventions. Staff demonstrated an awareness of the various types of PPE and were observed applying and removing PPE correctly within designated areas.

We discussed the provision of mandatory training specific to IPC measures with staff. Staff confirmed that they had access to online training and that the training provided them with the necessary skills and knowledge to care for the patients. Training records confirmed that staff had completed IPC training and that management were monitoring progress with overall mandatory training to ensure full compliance.

A number of deficits were identified during the inspection in relation to the environment and IPC. We observed a number of en-suites and storage rooms to be cluttered with patient equipment and/or furniture; no cover on identified light pull cords; a number of water taps/shower heads with a build-up of lime scale and dust to a number of fans within en-suites and surface damage to identified bedroom furniture and two armchairs. We further observed clean linen on trolleys outside identified lounges uncovered; hoist slings stored beside an unclean sink within the laundry and access to hand washing facilities within the laundry were obstructed with equipment. This was discussed in detail with the manager and an area for improvement was stated.

6.2.5 The home's environment

On entering each unit the environment was fresh smelling, neat and tidy with the majority of communal areas such as lounges, reception areas and corridors were kept clear and free from obstruction. Patients' bedrooms were found to be personalised with items of memorabilia and special interests.

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 refurbishment of a number of en-suites had been completed, including the covering of exposed pipes. The manager further advised that any remaining exposed pipes within en-suites were currently assessed as safe with ongoing risk assessment until all pipes are covered.

Whilst the majority of the environment and equipment within the home was well maintained it was observed that glass to a fire resistant door was cracked and window blinds were damaged within two identified lounges. We identified a fire door that was unable to close and a number of bedroom doors with a hole where locks had not been fitted. This was discussed with the manager and the fire door was repaired prior to the completion of the inspection. Following the inspection written confirmation was received from the manager that the bedroom doors had

been fitted with an appropriate cover whilst awaiting the arrival of doors locks. The manager further advised that all other deficits were being addressed by the maintenance man. We reviewed the fire risk assessment which had been completed on 28 January 2020 and the manager confirmed the remedial works to address the action plan had been addressed.

We further observed a glove covering a smoke detector within two identified bedrooms and an office door propped open. We brought this to the immediate attention of both the maintenance man and the administrator who advised that this was not normal practice and acknowledged the importance of fire safety. The maintenance man removed the gloves and advised that work was being carried out in these rooms that would have sounded the fire alarm but acknowledged that he should have removed the gloves when the rooms were unsupervised. On review of online fire awareness training it was identified that the majority of staff had last completed training in March 2020. The manager advised that due to the reduced footfall within the home, face to face fire awareness training was unable to go ahead in September 2020 but confirmed that staff would be completing this training again online to ensure that twice yearly training is completed. We discussed fire safety with the manager and an area for improvement was stated.

On discussion with the manager and responsible individual and on review of the environment, it was established that whilst the home had several baths within en-suite rooms, there was no communal bath. This information was shared with the estates inspector and following the inspection the responsible individual provided written confirmation that a communal bath would be installed. This will be reviewed at a future inspection.

6.2.6 Leadership and management arrangements

Since the last inspection there has been no change in management arrangements.

Review of two staff recruitment files evidenced that appropriate employment checks had been carried out in line with best practice. Induction records were also reviewed and maintained within employee files.

We reviewed the annual adult safeguarding position report which was made available within the home. Prior to the inspection we reviewed notifiable events that had been submitted by the manager, including adult safeguarding referrals. On review of the information provided within the position report we identified that further information was required regarding the status of referrals and the outcome of any investigations. This was discussed in detail with the manager who agreed to review these records and update accordingly. This will be reviewed at a future inspection.

A number of audits including IPC, care records and hand hygiene audits were completed on a monthly basis by the management team to ensure the safe and effective delivery of care. Environmental audits were being carried out every three months by the manager and whilst the audits were identifying deficits and provided an action plan with timeframes to address the deficit, they did not identify all of the issues during this inspection. The manager acknowledged this and agreed to review the audit process. This will be reviewed at a future inspection.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the regional manager and/or monitoring manager. Copies of the report were available for patients, their representatives, staff and trust representatives. 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

Eight new areas were identified for improvement. These were in relation to the maintenance of the duty rota, appropriate display of the daily menu, control of substances hazardous to heath (COSHH), storage of prescribed food thickening agents/supplements and oxygen, care records, wound management records, environment and infection prevention and control (IPC) and fire safety.

	Regulations	Standards
Total number of areas for improvement	4	4

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 Carmen Leonard, manager and Carol Kelly, responsible individual, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider 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 14 (2) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all chemicals are appropriately labelled and securely stored in keeping with COSHH legislation to ensure that patients are protected at all times from hazards to their health. Ref: 6.2.2
	Response by registered person detailing the actions taken: All staff reminded of requirement to label all chemicals and secure in locked sluice rooms / cleaner's store. This is checked on managers walk about.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that prescribed medicines are securely stored at all times within the home. With specific reference to: • food thickening agents and supplements • oxygen must be stored securely with appropriate signage. Ref: 6.2.2
	Response by registered person detailing the actions taken: Staff reminded to lock cupboards storing supplements and thickening agents once accessed. Identified oxygen cylinder secured to wall with appropriate signage displayed.
Area for improvement 3 **Ref**: Regulation 27 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed. With specific reference to: • the storage of patient equipment and/or furniture within en-suites and storage rooms • clean linen is covered if stored in communal areas • light pull cords are covered • a cleaning schedule is implemented for shower heads, water taps and fans • furniture with surface damage is repaired/replaced • hoist slings are stored appropriately • hand washing facilities within the laundry are maintained and accessible to staff.

	Ref: 6.2.4
	Response by registered person detailing the actions taken: Clean linen removed from trolleys in communal area. Excess equipment and furniture removed from en-suites and storage rooms. All light pull cords replaced with washable covering. Cleaning schedule implemented for shower heads, taps and fans. Several taps have been replaced. Individual resident hoist slings returned to bedrooms after laundering. In process of installing new handwashing sink in linen room.
Area for improvement 4 **Ref:** Regulation 27 (4) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that: • fire doors are not propped open • smoke detectors are not covered unless supervised • fire awareness training is completed at least twice yearly by all staff. Ref: 6.2.5
	Response by registered person detailing the actions taken: All staff reminded not to prop fire doors open. Maintenance instructed not to leave smoke detectors covered. Staff informed that online training on fire awareness must be completed twice yearly in absence of face to face training. Allocation of courses o training site has been changed to reflect this. 95% of staff have completed this since inspection.
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 41 **Stated:** First time **To be completed by:** 1 January 2021	The registered person shall ensure the staff duty rota clearly identifies the hours worked by the manager; the person in charge of the home in the absence of the manager and the hours worked by staff in a format that differentiates between day and night duty. Ref: 6.2.1
	Response by registered person detailing the actions taken: Managers hours are entered into duty book, nurse in charge identified and hours worked entered in 24hr format.
Area for improvement 2 **Ref**: Standard 12	The registered person shall ensure that a daily menu is displayed in a suitable format and in appropriate locations within the home to reflect the meals on offer.

Stated: First time **To be completed by:** With immediate effect	Ref: 6.2.2 **Response by registered person detailing the actions taken:** Menu displayed in different areas around home.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that care records are reflective of the recommendations of other health care professionals and updated when the assessed needs of the patient change. With specific reference to care plans, risk assessments and activities of daily living assessments: • care records accurately reflect the recommended diet/fluid consistencies as per the speech and language therapist (SALT) assessment • International Dysphagia Diet Standardisation Initiative (IDDSI) terminology is consistently recorded within care records • activities of daily living assessment are updated following a change in the assessed needs of a patient. • Ref: 6.2.3 **Response by registered person detailing the actions taken:** Issues identified discussed with registered nurses, care records reviewed to ensure all up to date and accurately reflect needs. Management to monitor during audit process.
Area for improvement 4 **Ref**: Standard 23 **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 and risk assessment is implemented to include the grade of the wound, dressing type, frequency of dressing renewal and maintain a record of the wound measurement. Ref: 6.2.3 **Response by registered person detailing the actions taken:** Discussion with RNs re wound care documentation and advised of need to ensure accurate documentation. Wound audits continue on a monthly basis.

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

The Regulation and Quality Improvement Authority

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