Unannounced Care Inspection Report
4 March 2020

Slieve Na Mon

Type of Service: Nursing Home
Address: Tircur Road, Omagh, BT79 7TY
Tel No: 028 8225 1132
Inspector: Michael Lavelle

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 is registered to provide nursing care for up to 60 persons with residential care for two named patients.

3.0 Service details

Organisation/Registered Provider: East Eden Ltd **Responsible Individual:** Una McDonald	**Registered Manager and date registered:** Joan McLaughlin – registration pending
Person in charge at the time of inspection: Joan McLaughlin	**Number of registered places:** 60 A maximum of 38 patients in category NH-DE and 19 patients in category NH-MP/MP(E), 1 identified patient in category NH-LD. The home is also approved to provide care on a day basis for a maximum of 8 persons. There shall be a maximum of 2 named residents receiving residential care in category RC-DE and 1 named resident receiving residential care in category RC-MP(E)
Categories of care: Nursing Home (NH) DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. LD – Learning disability.	**Number of patients accommodated in the nursing home on the day of this inspection:** 56

4.0 Inspection summary

An unannounced care inspection took place on 4 March 2020 from 10.05 hours to 14.45 hours.

The inspection assessed progress with all areas for improvement identified in the home since the last premises 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 in relation to the culture and ethos of the home, maintaining patients' dignity and privacy, and maintaining good working relationships.

One new area for improvement was identified in relation to activities.

Patients described living in the home in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from patients, people who visit them, visiting professionals and staff during 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	*4

*The total number of areas for improvement includes four which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Joan McLaughlin, 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 26 September 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 26 September 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 for week commencing 2 March 2020
- incident and accident records
- one staff recruitment and induction file
- three patients' care records
- a sample of governance audits/records
- a selection of patient care charts including food and fluid intake charts and repositioning charts
- evidence of fire drills
- a sample of reports of visits by the registered provider

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met or carried forward to the next care inspection.

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 dated 26 September 2019

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 30 (1) (d) **Stated:** First time	The registered person shall give notice to RQIA without delay of the occurrence of any notifiable incident. All relevant notifications should be submitted retrospectively with all due haste.	**Met**
	Action taken as confirmed during the inspection: Review of a selection of accidents and incidents in the home evidenced this area of improvement has been met.	
Area for improvement 2 **Ref**: Regulation 13 (4) (a) **Stated:** First time	The registered person shall ensure thickening agents are stored in a secure place	**Met**
	Action taken as confirmed during the inspection: Observation of the environment confirmed that thickening agents were securely stored.	

Area for improvement 3 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that nursing staff carry out clinical and neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record.	**Partially met**
	Action taken as confirmed during the inspection: Review of care records for one identified patients evidenced this area for improvement has been partially met. This is discussed further in 6.2. **This area for improvement has been partially met and has been stated for a second time.**	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 43 **Stated:** Second time	The registered person shall ensure that all patients have effective access to the nurse call system as required.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment and discussion with the manager confirmed remedial works had been completed to ensure all patients have access to the nurse call system.	
Area for improvement 2 **Ref**: Standard 38.3 **Stated:** First time	The registered person shall ensure any gaps in an employment record are explored and explanations recorded. Before making an offer of employment applicants should have a pre-employment health assessment.	**Not met**
	Action taken as confirmed during the inspection: Review of one staff recruitment file confirmed gaps in employment records had not been explored and explanations were not recorded. Although a pre-employment health check was in the file, it did not contain a date to confirm it had been received prior to an offer of employment. **This area for improvement has not been met and has been stated for a second time.**	

Area for improvement 3 **Ref**: Standard 48.7 **Stated:** First time	The registered person shall ensure the personal emergency evacuation plans (PEEP's) are maintained in an up to date manner.	**Met**
	Action taken as confirmed during the inspection: Review of the PEEP's confirmed these were reflective of all the patients in the home on the day of the inspection.	
Area for improvement 4 **Ref**: Standard 21 **Stated:** First time	The registered person shall ensure that patients at risk of developing pressure damage have a care plan in place to prescribe the care required. The care plan must include the frequency of repositioning and skin checks and be reviewed as required in keeping with the patient's needs. Repositioning records should be accurately maintained to evidence care delivery.	**Partially met**
	Action taken as confirmed during the inspection: Review of care records evidenced this area for improvement has been partially met. This is discussed further in 6.2. **This area for improvement has been partially met and has been stated for a second time.**	
Area for improvement 5 **Ref**: Standard 4.9 **Stated:** First time	The registered person shall ensure monthly care plan review and daily evaluation records are meaningful and patient centred.	**Partially met**
	Action taken as confirmed during the inspection: Review of care records evidenced this area for improvement has been partially met. This is discussed further in 6.2. **This area for improvement has been partially met and has been stated for a second time.**	

6.2 Inspection findings

Staffing levels

Discussion with 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. The manager confirmed that a number of care assistants and one registered nurse had been successfully recruited since the last care inspection.

A review of the duty rota for week commencing 2 March 2020 evidenced that the planned staffing levels were in keeping with patients' assessed needs at the time. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Patients and care staff we spoke with expressed no concerns regarding staffing levels in the home.

Care records

We examined the management of patients who had a fall. Review of one patient's records evidenced that their falls were not consistently managed in keeping with best practice guidance. It was positive to note that clinical and neurological observations were taken in keeping with best practice guidance and there was evidence that the clinical observations taken post fall were considered by nursing staff when evaluating daily care. Although a risk assessment had been completed post fall, the patients care plan had not been updated. In addition, there was no documented evidence that the patient's next of kin or care manager had been notified of the fall. Management of falls was identified as an area for improvement during the inspection on 26 September 2019. This area for improvement is stated for a second time.

We examined the management of patients at risk of developing pressure damage. It was pleasing to see that an appropriate risk assessment and care plan were in place which included the frequency of repositioning checks. However, we saw frequent gaps in recording of skin condition. Management of patients at risk of developing pressure damage was identified as an area for improvement during the inspection on 26 September 2019. This was discussed with the manager and an area for improvement is stated for a second time.

While we saw some good examples of meaningful and personalised care evaluation, the need to ensure that this is done consistently by nursing staff was stressed. We saw some care records contained repetitive nursing entries and/or had not been completed contemporaneously. These findings were discussed with the manager who agreed to address the highlighted shortfalls with nursing staff. This was identified as an area for improvement during the care inspection on 26 September 2019. This is stated for a second time.

Care delivery

There was a pleasant, relaxed atmosphere in the home throughout the inspection; staff and patients had cheerful and friendly interactions. Patients were well presented, receiving support with personal care in a timely and discrete manner. Patients were comfortable around staff and in approaching them with specific requests or just to chat.

Staff were knowledgeable and adept at communicating with patients in both verbal and non-verbal styles. Patients who were unable to clearly verbally communicate were content engaging in their preferred activities. Any signs of discomfort or distress were promptly and effectively addressed by staff.

The staff we spoke with could describe the specific needs, interests and personalities of those who live in Slieve Na Mon; there was a clear person centred focus in the home.

The environment

A review of the home's environment was undertaken and included observation of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm and fresh smelling throughout. Bedrooms were personalised depending on the needs and wishes of the patients.

Consultation

During the inspection we spoke with nine patients, three relatives and seven staff. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others. Patients said:

"I am happy here."
"It's great here. All around the home is lovely."
"The staff are like a family to me."
"I'm doing ok."
"It's alright. No matter what home you go it's the same. Happy enough here."
"They are looking after me well. The staff are sound."
"They are taking very good care of me."
"It's a good spot here."

The visitors spoke positively in relation to the care provision in the home. They said:

"I am happy with the care my relative receives. The staff are responsive to any concerns I have."
"Since day one the staff make the effort to attend to my relatives every needs. I feel a peace with the care they receive. They are so much more settled here. The staff all know your name and they are on the ball."

Comments from staff spoken with during the inspection included:

“I am very happy. I like the team. Even when we are short staffed everyone works well together to meet the needs of the patients. The manager is very approachable.”
“I’m happy. No problems.”
“All is going well.”
“I am very happy here. I like the management and my work colleagues. Everyone works together.”
“I like it here. Everyone is so friendly and the patients are well looked after.”

Activity

The staff we spoke with had a good knowledge and understanding of the need for social and leisure opportunities to support patients’ health and wellbeing. An activity planner was on display and patient’s spoken with said the enjoyed the activities in the home. We were pleased to hear of the range of activities delivered in the home which includes in house cinema, scenic drives, visits to the local pub and live music. However, improvements in documentation could be made to evidence support of patients to engage in activities. We highlighted that patients’ activity records should evidence how patients are supported by staff to engage in activities and also include an evaluation of activities undertaken on a regular and consistent basis. This should be undertaken by a registered nurse. An area for improvement was made.

Management arrangements

There was evidence that the manager had effective oversight of the day to day running of the home. For example, a number of audits were completed to assure the quality of care and services. Areas audited included accidents and incidents, care records and the environment. Audits generated action plans that highlighted areas for improvement and there was evidence that the deficits identified were addressed, as required. We discussed the deficits identified in the care records and the regional manager confirmed they would focus on increasing audit activity. This will be reviewed at a future care inspection.

Review of records evidenced that quality monitoring visits were completed on a monthly basis on behalf of the registered provider.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

Areas of good practice were identified in relation to the culture and ethos of the home, maintaining patients’ dignity and privacy, and maintaining good working relationships.

Areas identified for improvement

One new area for improvement was identified in relation to activities.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Joan McLaughlin, 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 (1) (a) (b) **Stated:** Second time **To be completed by:** Immediate action required	The registered person shall ensure that nursing staff carry out clinical and neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record. Ref: 6.1
	Response by registered person detailing the actions taken: All accidents/incidents are fully recorded on Goldcrest system and are audited each time following fall. All trained staff have been alerted to the necessity and importance of completing either clinical/neurological observations following a fall.
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 38.3 **Stated:** Second time **To be completed by:** Immediate action required	The registered person shall ensure any gaps in an employment record are explored and explanations recorded. Before making an offer of employment applicants should have a pre-employment health assessment. Ref: 6.1
	Response by registered person detailing the actions taken: Pre employment health check form is part of the standard recruitment pack which is now fully audited post interview and selection.
Area for improvement 2 **Ref**: Standard 21 **Stated:** Second time **To be completed by:** 4 April 2020	The registered person shall ensure that patients at risk of developing pressure damage have a care plan in place to prescribe the care required. The care plan must include the frequency of repositioning and skin checks and be reviewed as required in keeping with the patient's needs. Repositioning records should be accurately maintained to evidence care delivery. Ref: 6.1

	Response by registered person detailing the actions taken: Trained staff have been alerted to the importance of ensuring that any resident who has a careplan in place for pressure area care and has a repositioning regime in place that this much match the repositioning regime that is in actual practice. When a residents health deteriorates trained staff are aware to ensure that the careplan has been reviewed and updated with the correct repositioning regime for that specific time. Carers are also prompted by Goldcrest system of the frequency of repositioning for each resident so as to ensure repositioning is achieved as prescribed and also documented as completed on the Goldcrest system.
Area for improvement 3 **Ref**: Standard 4.9 **Stated:** Second time **To be completed by:** 4 April 2020	The registered person shall ensure monthly care plan review and daily evaluation records are meaningful and patient centred. Ref: 6.1
	Response by registered person detailing the actions taken: Trained staff have been made fully aware to ensure full and complete recording of a residents day/night daily evaluation so as to include all Activities 0f Daily Living. All Activities of Daily Living are recorded on Goldcrest but nurse now will make reference to all recordings on the Goldcrest system. Staff have also been made fully aware to ensure that when careplans are been evaluated that they are comprehensive and fully relate to the area of need identified.
Area for improvement 4 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 4 April 2020	The registered person shall ensure individual activity assessments are completed for all patients. These should inform a person centred plan of care which is reviewed as required. Daily progress notes should reflect patient's activity provision. Activities provided in the home should be reviewed at least twice a year. Ref: 6.2
	Response by registered person detailing the actions taken: Activity staff have been updating all activity assessments for the residents obtaining information from the residents and their families. All grades of staff have been told to ensure all activities for each resident is fully recorded daily on Goldcrest and level of interest/interaction from the residents recorded. Trained staff are working very hard to ensure they refer in their daily/nightl evaluations about the activities completed by each resident as is recorded on the activity section in the residents goldcrest notes.

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

The Regulation and Quality Improvement Authority

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