Unannounced Care Inspection Report
13 February 2019

Slieve Na Mon

Type of Service: Nursing Home (NH)
Address: Tircur Road, Omagh, BT79 7TY
Tel No: 0288225 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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 60 persons.

3.0 Service details

Organisation/Registered Provider: East Eden Ltd **Responsible Individual:** Liam McDonald	**Registered Manager:** Ronagh McCaul
Person in charge at the time of inspection: Ronagh McCaul	**Date manager registered:** 17 January 2019
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 registered places:** 60 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)

4.0 Inspection summary

An unannounced inspection took place on 13 February 2019 from 09.50 hours to 16.30 hours

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

The term ‘patient’ is used to describe those living in Slieve Na Mon which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staffing, staff recruitment, induction, adult safeguarding, communication between patients, staff and other key stakeholders, the culture and ethos of the home, dignity and privacy and maintaining good working relationships.

Areas requiring improvement were identified in relation to access to the nurse call system.

Patients described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Ronagh McCaul, registered 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 25 September 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 25 September 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report
- pre-inspection audit.

During the inspection the inspector met with seven patients, two patients' relatives and nine staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten patients' questionnaires and ten patients' relatives/representatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the registered manager with 'Have we missed you' cards to be placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

A poster informing visitors to the home that an inspection was being conducted was displayed at the front door of the home.

The following records were examined during the inspection:

- duty rota for all staff for weeks beginning 4 February 2019 and 11 February 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- incident and accident records
- one staff recruitment and induction file
- agency and student nurse induction records
- three patient care records
- a selection of patient care charts including food and fluid intake, toileting, topical medicine administration, dietary supplements and behaviour charts
- a sample of governance audits
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 25 September 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 25 September 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 38.3 **Stated:** First time	The registered person shall ensure that all relevant recruitment checks have been completed prior to the staff member commencing in post. This is in reference to: • any gaps in employment record are explored and explanations recorded. • a pre-employment health assessment is obtained in line with guidance and best practice.	**Met**
	Action taken as confirmed during the inspection: Review of one staff recruitment file evidenced any gaps in employment record were explored and explanations recorded and a pre-employment health assessment is obtained.	
Area for improvement 2 **Ref**: Standard 39.1 **Stated:** First time	The registered person shall ensure that all staff who are newly appointed, including agency staff and students, complete a structured orientation and induction and records are retained.	**Met**
	Action taken as confirmed during the inspection: Review of a selection of agency and student nurse induction records confirmed that they completed a structured orientation and induction and records were retained.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for weeks beginning 4 February 2019 and 11 February 2019 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff.

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

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Slieve Na Mon.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

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

We reviewed accidents/incidents records since the last care inspection in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were generally well maintained appropriately and notifications were submitted in accordance with regulation. One incident where an identified patient sustained a head injury had not been notified. This was discussed with the registered manager who agreed to submit a notification retrospectively.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and generally clean throughout. One storage cupboard was found to have a dirty floor and was cluttered with some patient laundry and slippers. This was discussed with the registered manager who agreed to action this as required. Patients, representatives and staff spoken with were complimentary in respect of the home's environment. The registered manager confirmed that some refurbishment work was planned and ongoing. We observed guttering and fascia board being replaced during the inspection.

Inspection of the premises confirmed the absence of disposable hand towels in patient bedrooms, while some bedrooms were noted to have no waste bin. Personal protective equipment (PPE) dispensing units and alcohol gel dispensing units were also observed in bathrooms where they are at risk of becoming contaminated. Discussion with staff confirmed they were knowledgeable in relation to best practice in relation to hand hygiene and use of PPE. Observation of staff practice identified that staff generally adhered to IPC procedures. Staining was observed on patient equipment including a stand up hoist and shower chairs and communal toiletries were also observed in an identified sluice along with items of patient clothing. There was also no system in place to launder hoist slings. This was discussed with the registered manager who gave assurances that the above deficits would be addressed immediately. This will be reviewed at a future care inspection.

Domestic cleaning trollies which contained substances hazardous to health were observed unsupervised on two occasions. This was discussed with staff who confirmed they had control of substances hazardous to health (COSHH) training and were reminded of the potential risks to patients. A selection of topical medications were also observed to be stored in an unlocked sluice. This was discussed with the registered manager who addressed this during the inspection. This matter was also referred to the pharmacist inspector for information purposes.

During review of the environment deficits were observed in relation to patients having effective access to the nurse call system within the home. Patient bedrooms were found to lack the provision of nurse call leads for patients. This was discussed with the registered manager and an area for improvement under the care standards was made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction and adult safeguarding.

Areas for improvement

One area for improvement under the care standards was identified in relation to access to the nurse call system.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient.

We reviewed the management of falls, infections and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Minor deficits were observed in relation the management of one identified patient following an unwitnessed fall. All post fall actions were completed however no clinical or neurological observations were recorded and no consideration had been given to the potential for a head injury. This was discussed with the registered manager who confirmed that this was already known to her and supervision had been arranged for the staff member involved. A further care record had not been updated to reflect a recent infection of an identified patient. This was updated retrospectively prior to the end of the inspection.

Care records generally reflected that, where appropriate, referrals were made to healthcare professionals such as optician, podiatrist General Practitioners (GPs), dentist the speech and language therapist (SALT) and dieticians. Review of one care record where an identified patient had lost weight evidenced that a referral to the dietician had not been recorded. This was discussed with the staff member who made the referral and the record was updated.

Supplementary care charts such as food and fluid intake records, toileting, topical medicine administration, dietary supplements and behaviour charts evidenced that contemporaneous records were maintained. Minor deficits were noted in recording of 15 minute checks in two units. This was discussed with the registered manager for action as required. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), SALT or the dietician.

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

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge. Staff commented positively on the role of the registered manager. Comments included:

“The manager has her eye on the ball.”
“The manager is fair minded and sees things in a different perspective than we might. She is approachable.”

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and representatives spoken with expressed their confidence in raising concerns with the home’s staff/management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between patients, staff and other key stakeholders.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 09.50 hours and were greeted by staff who were helpful and attentive. Patients were enjoying a morning cup of tea/coffee in the dining room, in one of the lounges or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice and staff were observed assisting patients to enjoy their chosen activity and to eat and drink as required.

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

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. We observed patients enjoying live music in one of the lounges during the afternoon of the inspection. During review of patient care records we observed gaps of up to one month in recording of activities. This was discussed with the registered manager who confirmed that paper records are also retained however these were not reviewed during this inspection. The registered manager agreed to review the current arrangements to ensure activities are contemporaneously recorded in the central care record.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example appropriate signage, photographs, the provision of clocks and prompts for the date. We observed that menus were not appropriately displayed throughout the home. Patient's spoken with stated that they were asked what they would like for lunch and dinner in advance but did not have access to a menu at mealtimes. This was discussed with the registered manager who agreed to review the provision of menus. This will be reviewed at a future care inspection.

Consultation with seven patients individually, and with others in smaller groups, confirmed that living in Slieve Na Mon was a positive experience. Patient comments included the following,

"They take very good care of me. There are some great girls and some indifferent."
"I like the nurses. They are fine."
"It's very good."
"The food is quite good. The staff are obliging and they treat me with dignity and respect."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Ten relative questionnaires were provided; none were returned within the timescale. Two relatives were spoken with during the inspection. Their comments included the following;

"It's just lovely. They are very good to my relative."
"The staff are always pleasant, polite and courteous and I feel my relative is well cared for."

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home and dignity and privacy.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Two certificates of registration issued by RQIA were displayed in the foyer of the home. This was discussed with the registered manager who removed the certificate that was no longer valid. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been no change in management arrangements. An application for registration with RQIA has been received and approved. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff, patients and their representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

Discussion with the registered manager evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents and care records. The registered manager confirmed the care record audit involved a quantitative and qualitative review of care records.

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

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to maintaining good working relationships.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	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 Ronagh McCaul, registered 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 43 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all patients have effective access to the nurse call system as required. Ref: 6.4
	Response by registered person detailing the actions taken: A risk assessment has been completed for each resident prior to implementation of the nurse call bell system to ensure safety. Residents assessed as safe for use will have effective access to the nurse call bell system.

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

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