

Unannounced Follow – Up Care Inspection Report 17 October 2016



Slieve Na Mon

Type of Service: Nursing Home
Address: Tircur Road, Omagh, BT79 7TY
Tel no: 028 8225 1132
Inspector: Sharon Loane

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced care inspection took place on 17 October 2016 from 11.15 to 16.30 hours. The focus of this inspection was to follow up on the progress made regarding the findings of an unannounced care inspection conducted on 19 July 2016. This inspection identified serious concerns with regard to:

- governance and management arrangements
- quality of nursing care including care records
- registration issues.

The inspection also sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led. A serious concerns meeting was held on 27 July 2016 to discuss the issues raised during the previous inspection, an action plan was provided by Dr Brendan McDonald, registered person, and a further inspection to assess the level of compliance with the requirements and recommendations was planned.

For the purposes of this report, the term 'patients' will be used to describe those living in Slieve Na Mon which provides both nursing and residential care.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	*2	1

The total number of requirements made includes one requirement which was not met and has been stated for a second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Bernie McDaniel, home 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection on 19 July 2016. As a consequence of the inspection findings, a serious concerns meeting was held on 27 July 2016 to discuss the issues raised during the inspection and how the home planned to ensure that compliance was achieved. An action plan was provided to RQIA by Dr Brendan Mc Donald, registered person. The action plan addressed the issues raised. A further inspection to assess the level of compliance with the requirements and recommendations was planned.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: East Eden Ltd Dr Brendan McDonald	Registered manager: Bernie McDaniel (not yet registered)
Person in charge of the home at the time of inspection: Alice Cristea (Registered Nurse in Charge 11.15 – 14.00) Bernie McDaniel (Home Manager 14.00 – 16.30)	Date manager registered: Registration pending
Categories of care: NH-I, RC-MP(E), NH-LD, NH-LD(E), RC-DE, NH-MP, NH-MP(E), NH-DE A maximum of 36 patients in category NH-DE and 19 patients in category NH-MP/MP(E) with 2 additional identified patients in this category. A maximum of 3 residents in category RC-DE, 1 resident in category RC-MP(E). 1 identified patient in category NH-I and 1 identified patient in category NH-LD/LD(E). The home is also approved to provide care on a day basis for a maximum of 8 persons.	Number of registered places: 60

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events submitted since the previous care inspection
- action plan provided by the home following the last care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report
- pre-inspection assessment audit.

During the inspection the inspector met with five patients individually and the majority of others were greeted in small groups, five care staff, three registered nurses, four ancillary staff and two administrative staff.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- patient care records
- staff training records
- two recruitment files (including induction records)
- competency and capability assessments
- complaints records
- incidents/accidents records since the last care inspection
- a selection of quality audits
- monthly monitoring report in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- duty rota for week commencing 18 October 2016.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 July 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and has been validated at this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 19 July 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 Ref: Regulation 21(1) (b) Stated: First time	The registered provider must ensure the recruitment process is reviewed to make sure that all relevant information has been obtained and/or reviewed prior to a staff member commencing in post. Recruitment records must be retained in the home and available for inspection.	Met
	Action taken as confirmed during the inspection: A review of personnel files for two recently recruited staff members evidenced that all relevant information as outlined in Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005 had been sought and retained. Files were very well organised and information was easily accessed. This requirement has been met.	

<p>Requirement 2</p> <p>Ref: Regulation 30(1)</p> <p>Stated: First time</p>	<p>The registered persons must ensure that RQIA are notified appropriately, in regards to any serious injury that occurs in the home, this relates specifically to head injuries. This notification must include;</p> <ul style="list-style-type: none"> • the immediate actions taken • who has been notified of the event • how reoccurrence can be prevented. <p>Action taken as confirmed during the inspection: A discussion with the home manager evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA and/or other relevant bodies. A review sample of notifications of incidents/accidents since the last care inspection confirmed that these were managed appropriately.</p> <p>This requirement has been met.</p>	<p>Met</p>
<p>Requirement 3</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p>	<p>The registered person must ensure that all prescribed medicines are administered safely in accordance with best practice and only by staff who have been trained and deemed competent in this area of practice.</p> <p>Action taken as confirmed during the inspection. A discussion with the home manager and staff evidenced that care staff have received training and competency assessments have been undertaken in regards to the safe administration of bowel management medication. Staff spoken with demonstrated their knowledge and understanding of their role and responsibilities in this regard.</p> <p>A review of training information and competency assessments completed evidenced that the arrangements in place were appropriate to ensure safe and effective practice in this area of care delivery.</p> <p>This requirement has been met.</p>	<p>Met</p>

<p>Requirement 4</p> <p>Ref: Regulation 14 (4)</p> <p>Stated: First time</p>	<p>The registered person must ensure that any potential risks to patients are managed appropriately and that staff are provided with training. This relates specifically to patients who have been assessed by Speech and Language Therapist as high risk of choking. Training should be provided for staff in relation to Dysphagia and the management of Food Thickening Agents. Records of training should be retained for inspection.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>A review of records evidenced that the majority of staff had received training in regards to Dysphagia and Food Thickening Agents. Additional training was scheduled for staff that had still to complete.</p> <p>In addition competency assessments have been completed with care staff in regards to the use of Thickening Agents.</p> <p>Discussion with staff and observations made demonstrated staffs knowledge and understanding in this area of practice.</p> <p>Patients at risk had also been reviewed by Speech and Language Therapist (SALT) and care records had been reviewed accordingly. Catering staff advised that they had been provided with this updated information.</p> <p>This requirement has been met.</p>		

<p>Requirement 5</p> <p>Ref: Regulation 13 (7)</p> <p>Stated: First time</p>	<p>The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.</p> <p>Robust systems must be in place to ensure compliance with best practice in infection prevention and control within the home.</p> <hr/> <p>Action taken as confirmed during the inspection:</p> <p>A discussion with the home manager and review of information evidenced that audits had been undertaken to assure compliance with best practice in infection prevention and control within the home. An action plan had been generated and was still being actioned.</p> <p>There were noted improvements in regards to some of the issues identified at the previous care inspection; for example there was significant improvements noted in the standard of cleanliness of the environment and the storage of continence items in bathrooms. A number of areas within the home had been redecorated and refurbished. As discussed some actions were still being addressed.</p> <p>Staff acknowledged the improvements made and understood the rationale for same.</p> <p>This requirement has been met.</p>	<p style="text-align: center;">Met</p>
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<p>Requirement 6</p> <p>Ref: Regulation 15 (2)</p> <p>Stated: First time</p>	<p>The registered person must ensure that patient care records are maintained with accuracy and contain a detailed and comprehensive assessment of need, appropriate risk assessments, and appropriate regular reviews. Records should be completed in keeping with NMC guidance.</p>	<p style="text-align: center;">Not Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>A review of three care records evidenced that whilst some improvements were noted, shortfalls continued to be identified.</p> <p>A review of one care record identified that some assessments had not been completed at time of admission and thereafter; for example; falls risk assessments.</p> <p>A second care plan reviewed identified that the care plans in place were not reflective of the patients current care needs. Care plans had been reviewed and evaluated, however registered nurses had not identified that the majority of care plans were no longer relevant to the patient’s current health and wellbeing. It was not clear from the care plans available that the patient was in receipt of ‘palliative care’.</p> <p>The third care plan reviewed identified that the patient had ‘weight loss’ however there was no evidence that this had been identified by registered nurses and no care plan was in place. A care plan was developed for high risk of falls even though a falls risk assessment had not been completed.</p> <p>This requirement has not been met and has been stated for a second time.</p>		

<p>Requirement 7</p> <p>Ref: Regulation 19 (1)(a), schedule 3, (3)(k)</p> <p>Stated: First time</p>	<p>It is required that the registered person must ensure contemporaneous records of all nursing provided to the patient are recorded accurately to evidence actual care given and accounts for any concerns or deficits identified.</p> <p>Particular attention should focus on the accurate completion of dietary / fluid intake charts and personal care records.</p> <hr/> <p>Action taken as confirmed during the inspection: A sample review of dietary /fluid intake charts, personal care records and repositioning records evidenced that contemporaneous records were being kept of all nursing interventions, activities and procedures carried out in relation to each patient. There was noted improvement in the detail recorded in the records reviewed. Again, discussion with staff demonstrated their understanding and importance of keeping these records up to date to reflect the delivery of care.</p> <p>There was also evidence that registered nurses were reviewing the records at timely intervals to ensure the delivery of safe effective care.</p> <p>This requirement has been met.</p>	<p>Met</p>
<p>Requirement 8</p> <p>Ref: Regulation 12 (1) (a)(b)</p> <p>Stated: First time</p>	<p>The registered person shall ensure that food and fluids are provided to meet patient's individual needs and reflect current best practice. Patients requiring a modified diet must be offered suitable snacks throughout the day.</p> <hr/> <p>Action taken as confirmed during the inspection: Discussion with staff and a review of information and observations made evidenced that this requirement has been met.</p> <p>Since the previous care inspection, an independent consultant has been working collaboratively with the home in carrying out a review of the meals and mealtimes. A menu has been developed for the provision of snacks for patients requiring a modified diet. Audits have been carried out in regards to meals and mealtimes and are ongoing to ensure that patients' nutritional needs are met and that meals and mealtimes are in line with current best practice.</p>	<p>Met</p>

<p>Requirement 9</p> <p>Ref: Regulation 13 (8)(a)</p> <p>Stated: First time</p>	<p>The registered person shall make suitable arrangement to ensure that the dignity of patients is respected in regards to the care delivered.</p> <p>Particular focus should be given to the areas identified at this inspection.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>Discussion with staff and a review of documentation evidenced that 'personal hygiene' competency assessments have been undertaken with care staff since the previous inspection. Registered nurses spoken with advised that they observe the level of personal care afforded to each patient and if it is not satisfactory then this is addressed with the staff member responsible for delivering care.</p> <p>The majority of patients observed were presented well. The standard of personal care observed was to a satisfactory standard. Patients appeared clean and were suitably dressed in accordance with their own personal preference.</p> <p>A review of personal care records evidenced the care delivered/not delivered including the rationale.</p> <p>This requirement has been met.</p>		
<p>Requirement 10</p> <p>Ref: Regulation 15 (1)(c)</p> <p>Stated: First time</p>	<p>The registered person must ensure that the home adheres to the categories of care as outlined on the registration certificate issued by RQIA. A variation should be submitted to RQIA in respect of the findings of this inspection.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>A variation received by RQIA on 2 August 2016 was reviewed and approved and a registration certificate was issued by RQIA. At this inspection, the home was operating within its registered categories of care.</p> <p>This requirement has been met.</p>		

<p>Requirement 11</p> <p>Ref: Regulation 10</p> <p>Stated: First time</p>	<p>The registered person must ensure that robust governance / management arrangements are put in place to ensure the safe and effective delivery of care to patients.</p> <hr/> <p>Action taken as confirmed during the inspection: Discussion with the home manager and a review of information evidenced that robust governance / management arrangements had been developed and implemented since the previous care inspection.</p> <p>These systems included the implementation of an audit planner which included a suite of audits which monitored and reported on the delivery of nursing and other services provided. A review sample of audits evidenced that an action plan was generated and there was evidence of subsequent actions.</p> <p>A management consultant has also been appointed to provide support, direction and supervision for the senior management team. The monthly monitoring visits are also undertaken by this individual.</p> <p>This requirement has been met.</p>	<p>Met</p>
<p>Last care inspection recommendations</p>		<p>Validation of compliance</p>
<p>Recommendation 1</p> <p>Ref: Standard 39 Criteria (1)</p> <p>Stated: First time</p>	<p>The registered provider should ensure staff inductions (to include the registered manager's) are completed in a timely manner and retained in the staff's personnel file for inspection.</p> <hr/> <p>Action taken as confirmed during the inspection: A review of induction records for two staff members evidenced that these had been completed appropriately. The records were signed by the inductee and the mentor. A discussion with the home manager, established that these records would also be signed by the registered manager at the completion of the induction period.</p> <p>This recommendation has been met.</p>	<p>Met</p>

<p>Recommendation 2</p> <p>Ref: Standard 39</p> <p>Stated: First time</p>	<p>The registered person should ensure that the system to review mandatory training is further developed to ensure that staff have completed mandatory training within the required time parameters.</p> <hr/> <p>Action taken as confirmed during the inspection: A review of information evidenced that a system was in place to monitor training compliance. The information was reviewed by the homes administrator and the home manager on a monthly basis. Staff are alerted by a written correspondence if they have not completed their mandatory training. A copy of this letter was evidenced in one personnel file reviewed. Staff compliance with mandatory training requirements was 95 percent or more across all subject areas.</p> <p>This recommendation has been met.</p>	<p>Met</p>
<p>Recommendation 3</p> <p>Ref: Standard 35</p> <p>Stated: First time</p>	<p>The registered person should ensure that the care plan audits are reflective of the necessary actions to be taken in order to ensure care plans are up to date. This should include the archiving of information.</p> <hr/> <p>Action taken as confirmed during the inspection: A discussion with the home manager and a review of information evidenced that care audits had been completed. The audits reviewed identified actions and an action plan was developed accordingly. There was evidence that actions had been actioned.</p> <p>Whilst improvements were noted, shortfalls were still identified during a review of care records. For example; care interventions were not always appropriate and/or reflective of the assessed need and information continued not to be archived. This matter was discussed with the home manager who advised that it was their intention to peer review the completed audits and that hopefully this would ensure the robustness of the auditing systems.</p> <p>This recommendation has been partially met and has not been stated for a second time.</p>	<p>Partially Met</p>

<p>Recommendation 4</p> <p>Ref: Standard 16 Criteria 11</p> <p>Stated: First time</p>	<p>The registered manager should ensure that records are kept of all complaints and these include details of all communications; the result of any investigation; the action taken; whether or not the complainant was satisfied with the outcome; and how this level of satisfaction was determined.</p> <hr/> <p>Action taken as confirmed during the inspection: A review of records of complaints evidenced that any complaints received since the previous inspection had been managed in accordance with legislation and the DHSSPS Care Standards for Nursing Homes 2015.</p> <p>This recommendation has been met.</p>	<p>Met</p>
<p>Recommendation 5</p> <p>Ref: Standard 35</p> <p>Stated: First time</p>	<p>The registered person must ensure that the monthly monitoring report is informative and there is a robust action plan to address any areas for improvement.</p> <hr/> <p>Action taken as confirmed during the inspection: The home manager advised that an independent consultant had been appointed to complete the monthly monitoring visits. The monthly monitoring report completed for September 2016 evidenced that the report had been completed comprehensively and an action plan had been generated.</p> <p>The report was available to staff, patients and their representatives and relevant others.</p> <p>This recommendation has been met.</p>	<p>Met</p>

4.3 Inspection findings

4.3.1 Staffing arrangements

Discussion with staff, a sample review of duty rotas and observations made evidenced that there were shortfalls in the number of registered nurses on duty to meet the care needs of patients at this inspection. The number and ratio of registered nurses on duty was not in line with the DHSSPS Care Standards for Nursing Homes, 2015. While the number of care staff rostered exceeded the minimum skill mix the shortfall for registered nurses hours was significant. A discussion with the home manager indicated that the number of registered nurses on duty had been reviewed since the previous care inspection. The rationale provided for this review was due to the availability of registered nurses.

At this inspection, it was evidenced that one registered nurse working in an identified area of the home was under pressure to ensure the delivery of safe, effective care and ensure adequate supervision of patients in this unit. The registered nurse was observed trying to the best of their ability to attend to patients care, answer phone calls and assist members of the multi-disciplinary team, who were carrying out assessments and reviewing patient care needs. Whilst it was acknowledged that the registered nurse was able to seek assistance from nurse colleagues in the other unit, this was not ideal and had the potential to impact on the operations and care delivered within both units. The layout of the environment and the categories of care of patients within the unit, also posed potential risks. There was also evidence at this inspection, that the shortfall in the number of registered nurses hours had impacted on the accuracy of care records and records being kept up to date and a requirement made at a previous inspection continued not to be met and has been stated for a second time.

Discussion with all registered nurses on duty including the home manager agreed with the observations made and whilst staff stated 'they tried their best' they were concerned about the potential risks to patients and their 'duty of care and accountability'.

A discussion with the registered person indicated that actions had already been taken to recruit registered nurses. However, due to recruitment and employment procedures, the staff would not be available for a period of time. Whilst it is acknowledged that corrective actions have been taken to manage the shortfall in registered nurses, immediate measures must be implemented to ensure that the number of registered nurses rostered working over a 24 hour period was reviewed to ensure that the number and ratio of staff on duty at all times meets the care needs of patients. A requirement has been made.

4.3.2 Quality of Care

A review of care records identified shortfalls pertaining to the management of falls. An assessment for the risk of falls was not being carried out consistently within 24 hours of admission to the home. A review of information for one identified patient who had sustained a fall evidenced that a falls risk assessment had not been completed at time of admission and /or following an actual fall, despite a care plan being in place for 'high risk of falls'. This shortfall had been identified at a previous care inspection and whilst some progress has been made, further shortfalls have been identified. A recommendation has been made.

Areas for Improvement

A requirement has been made in regards to staffing arrangements specifically in regards to the number of registered nurses working over a 24 hour period.

A recommendation has been made in regards to falls management.

Number of requirements	1	Number of recommendations	1
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Bernie McDaniel, home manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements

Requirement 1

Ref: Regulation 15 (2)

Stated: Second time

To be completed by:
31 December 2016

The registered person must ensure that patient care records are maintained with accuracy and contain a detailed and comprehensive assessment of need, appropriate risk assessments, and appropriate regular reviews. Records should be completed in keeping with NMC guidance.

Ref: Section 4.2, 4.3.2

Response by registered provider detailing the actions taken:
Staff have been reminded of their responsibilities within their NMC and NISCC codes in relation to record keeping.
Senior Nurses have had intensive supervision to provide guidance and encourage confidence in challenging practice that does not meet the standards.
Primary Nurses have been tasked to update and keep risk assessments and care plans up to date and reflective of current needs.
Peer Audit has commenced and managerial audit with progress review. Specific focus is ongoing with regards to falls, weight loss management and palliative care.

Requirement 2

Ref: Regulation 20 (1)(a)

Stated: First time

To be completed by:
18 October 2016

The registered provider must ensure that the number of registered nurses working in the home over a 24 hour period is reviewed to ensure the delivery of safe effective care. This review should include the categories of care for which the home are registered and also the geographical layout of the home.

Ref: Section 4.3.1

Response by registered provider detailing the actions taken:
A staffing analysis has been conducted. The review considered -
The numbers of staff to numbers of patients.
The dependency levels assessed under Rhys Hearn to consider number of direct care hours needed for each dependency level.
The layout of the units.
The needs at peak times.
Specific patients with enhanced care needs and package of care commissioned by the Trust.
Feedback from the staff.
35% skill mix Registered Nurses.

The home is currently in the process of recruiting additional Registered Nurses.

The Responsible Person and the Manager will keep the staffing under constant review and when required implement a contingency plan if staffing requirements cannot be met. This will be recorded and evidenced.

Recommendations	
<p>Recommendation 1</p> <p>Ref: Standard 22</p> <p>Stated: First time</p> <p>To be completed by: 31 December 2016</p>	<p>The registered provider should ensure that patients are appropriately assessed for the risk of falls and that the falls assessment and preventative measures are carried out in line with best practice guidance.</p> <p>Ref: Section 4.3.2</p>
	<p>Response by registered provider detailing the actions taken:</p> <p>All patients have an updated risk assessment in relation to falls. Falls prevention measures are detailed within care plans. Consent is obtained for any restrictive practice with consideration to deprivation of liberty safeguards.</p>

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address



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