Unannounced Care Inspection Report
20 June 2017

Slieve Na Mon

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

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:** Dr Brendan McDonald	**Registered Manager:** Mrs Mary Bernadette McDaniel
Person in charge at the time of inspection: Bernadette McDaniel	**Date manager registered:** 8 December 2016
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. 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. LD (E) – Learning disability – over 65 years. Residential Care (RC) MP(E) - Mental disorder excluding learning	**Number of registered places:** 60 comprising: 36 NH-DE 19 NH-MP/MP(E) 3 RC-MP(E) 1 NH-I 1 NH-LD/LD (E)

4.0 Inspection summary

An unannounced inspection took place on 20 June 2017 from 10.00 to 15.30 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 Care Standards for Nursing Homes 2015.

The term ‘patients’ is used to describe those living in the home 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 staff recruitment and induction, training and development, adult safeguarding, risk management processes, the completion of risk assessments and care plans; wound and falls management and communication between patients, staff and other key stakeholders. There was also good evidence of robust systems in place to assure the quality of care and other services provided in the home.

Areas requiring improvement were identified in relation to the use of equipment for pressure management and the recording of repositioning charts.
Patients said that they were satisfied with the care and services provided and described living in the home, in positive terms.

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	2

Details of the Quality Improvement Plan (QIP) were discussed with Bernadette Mc Daniel, 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 17 January 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 17 January 2017.

There were no further actions required to be taken following the most recent 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
- 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
- pre inspection assessment audit

During the inspection the inspector met with nine patients, six care staff, three registered nurses, the activities co-ordinator, ancillary and administration staff and two patients' visitors/representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- duty rota for registered nurses and care staff from 12 June to 2 July 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction file
- four patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 17 January 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 17 October 2016

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 15 (2) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: A review of three patients care records evidenced that this area for improvement was met.	
Area for improvement 2 **Ref:** Regulation 20 (1) (a) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A discussion with management, staff and a review of duty rotas evidenced that the staffing arrangements were adequate to ensure safe effective care. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.	

Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref:** Standard 22 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of two care records evidenced that risk assessments were completed in regards to falls at the time of admission.	

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 commencing 12 June, 19 June and 26 June 2017 evidenced that the planned staffing levels were adhered to on most occasions. Where shortfalls were identified the registered manager was able to provide a rationale for same and advised what actions that had been taken /or planned to provide cover. Recruitment for registered nurses from overseas was in the final stages and recruitment for care staff was ongoing. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Staff spoken with at the time of inspection confirmed that planned staffing levels met the assessed needs of the patients and acknowledged that appropriate actions are taken to cover staff shortages. Staff advised that the registered manager is very supportive and works on the floor to ensure the delivery of safe, effective care. Opinions regarding staffing arrangements were also sought via questionnaires issued to patients, their representatives and staff. Responses received from patients (seven) indicated that they were either 'satisfied' or 'very satisfied' that staffing levels were sufficient to meet their needs. One questionnaire returned by staff indicated that they were 'very satisfied' with the staffing arrangements.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals. Individual supervisions were also conducted with staff in response to learning that was identified from the governance audits. For example, where deficits were identified there was evidence that focused individual supervision had been undertaken with staff members, to ensure that they adhered to best practice.

Review of the training matrix/schedule for 2017/18 indicated that training was planned to ensure that mandatory training requirements were met. A review of staff training records confirmed that staff completed training via e-learning (electronic learning) and face to face training. A training plan was available which detailed training planned from January to December 2017. Additional areas of training had also been completed for example; Syringe Driver; Supervision/Appraisal; Dementia and Palliative Care.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. Reviews were completed on a monthly basis and there was evidence that appropriate actions had been taken to ensure training requirements were met by staff. The most recent update was 19 June 2017 and there was evidence that actions had been taken for staff who had not met their training requirements.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. The staff understood what abuse was and how they should report any concerns that they had. The relevant contact details were available in a folder for all staff to access; including updated policies and procedures.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last care inspection confirmed that these were appropriately managed.

A number of patients had pressure relieving mattresses on their beds, to prevent skin breakdown. The correct mattress settings were indicated on the majority of mattress pumps, to ensure their effective use. However, some mattresses observed were not set at the correct setting as per review of patient's weights. A discussion with staff demonstrated that they were knowledgeable regarding the use of the equipment however advised that there was no system in place to monitor same. This has been identified as an area for improvement.

Infection prevention and control measures were adhered to and equipment was appropriately stored. There was evidenced of the availability of and adequately stocked personal protection equipment (PPE).

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 areas reviewed were found to be clean, tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items and life story noticeboards were in bedrooms.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment and induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

An area for improvement has been identified in regards to the monitoring of pressure relieving equipment to ensure they are effective for use.

	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 a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

A review of wound care records evidenced that wound care was managed in line with best practice. A review of the daily progress notes of one patient evidenced that the dressing had been changed according to the instructions within the care plan. Wound care records were supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.

Patients who had been identified at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner. Patients who were identified as requiring a modified diet, had the relevant risk assessments completed. Care plans in place were reflective of the recommendations of SALT and care plans were kept under review. A sampling of food and fluid intake charts confirmed that patients' fluid intake was monitored.

Patients' bowel movements were monitored by registered nurses on a daily basis, using the Bristol Stool guidance as a reference, to ensure that any changes from the patients' usual bowel patterns were identified and timely action taken.

Supplementary care charts such as repositioning/food and fluid intake records evidenced these records in the majority were maintained in accordance with best practice guidance, care standards and legislation. However, some repositioning records reviewed within specific units of the home were not maintained to a satisfactory standard. For example; some gaps were noted particularly during the hours of night duty. A discussion with staff and a review of other information within care records evidenced that this was a record keeping issue and there was no direct impact evidenced on patients' health and welfare. This has been identified as an area for improvement.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained. The most recent staff meeting was held March 2017. There was evidence that management meetings were also held. Group supervisions were held across staff teams at regular intervals. Records were maintained accordingly.

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 their line manager and /or the registered manager.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management. Patients and representatives knew the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care planning and care delivery, audits and reviews, communication between residents, staff and other key stakeholders. The standard of recording was maintained to a satisfactory level for the majority of care records reviewed. However as detailed below an area for improvement has been identified.

Areas for improvement

The following area was identified for improvement: the recording of repositioning charts.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Consultation with nine patients individually, and with others in smaller groups, confirmed that living in the home was a positive experience.

Patient comments included:
"Staff are all very good and I am happy living in the home."
"The staff couldn't do enough for me."
"They are looking after me very well and taking good care of me."

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.

Patients and /or their representatives were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients and /or patient representatives consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. There were two staff employed to provide activities in the home. There was evidence of a variety of activities in the home and discussion with staff confirmed that patients were given a choice with regards to what they wanted to participate in. There were various photographs displayed around the home of patients' participation in recent activities. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

The serving of the midday meal was observed. Tables were attractively set with cutlery, condiments and napkins. Those patients who had their lunch in the lounge or their own bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch. The day's menu was displayed in the dining room. Registered nurses were observed supervising and assisting patients with their meals and monitoring patients' nutritional intake.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. One staff, seven patients and one relative returned their questionnaires, within the timeframe for inclusion in this report. Outcomes were as follows:

The responses received from patients and the one relative were all positive indicating that they were either 'satisfied' or 'very satisfied' with the care and services provided within the home. No additional written comments were included. The one staff member who responded indicated that they were 'very satisfied' across all four domains.

Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the 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, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Mealtimes and activities were well managed.

Areas for improvement

No areas for improvement were identified during the inspection.

	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.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager and review of records and observations evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern. Some patients were observed referring to management and staff on a first name basis.

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 and patient representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. The registered manager has a very 'hands on' approach and was involved directly in the delivery of care. This is good practice.

Discussions with the staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff described how they felt confident that the registered manager would respond positively to any concerns/suggestions raised.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management.

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 the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been embedded into practice.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	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 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 DHSSPS 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 to Nursing.Team@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 30 August 2017	The registered person shall ensure that the settings of pressure mattresses are monitored and recorded, to ensure their effective use. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: System is now in place, label is placed on box at end of bed with what setting bed should be on this is reviewed daily by Carers. Nurses shall monitor weight and if adjustment is needed a new sticker shall be put in place. Discussed with staff at Handovers and Staff Meetings.
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 30 August 2017	The registered person shall ensure that repositioning charts are maintained to accurately reflect the delivery of care as outlined in the care plan. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: This has been discussed at Handovers, and at Staff Meetings, staff are aware that repositioning charts need to reflect what is in the individual's care plan. Care plans shall be audited to ensure how fteh turns are to take place.

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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