Unannounced Care Inspection Report
7 July 2016

Springlawn

Type of Service: Nursing Home
Address: 44 Old Dromore Road, Omagh, BT78 1RB
Tel No: 028 8224 4550
Inspector: Bridget Dougan

1.0 Summary

An unannounced inspection of Springlawn took place on 07 July 2016 from 11.30 to 16.30 hours.

The inspection 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.

Is care safe?

There was evidence of competent and safe delivery of care on the day of inspection. Staff were required to attend mandatory training and the observation of care delivery evidenced that knowledge and skill gained, through training, was embedded into practice. Staff also confirmed that there were good communication and support systems in the home, including; staff appraisal and staff supervision systems, staff meetings and staff were required to attend a 'handover meeting' when commencing duty.

The environment was well decorated, clean and comfortable.

There were no requirements or recommendations made.

Is care effective?

Care records generally reflected the assessed needs of patients; were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals. Two patients care records did not include the recent recommendations made by the dietician and SALT. A recommendation has been made in this regard. Patients' religious/spiritual needs and preferences had not been recorded in end of life care records. A recommendation has been stated for the second time.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate.

Staff meetings were held quarterly and there was evidence of good teamwork. Patient meetings were held monthly and they expressed their confidence in raising concerns with management/staff.

Two recommendations were made (one stated for the second time).

Is care compassionate?

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

Patients spoken with were complimentary regarding the care they received and life in the home. Those 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.

No requirements or recommendations were made.

Is the service well led?

There was a clear organisational structure within the home and evidence that the home was operating within its registered categories of care. Systems were in place to monitor and report on the quality of nursing and other services provided. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

There were no requirements or recommendations made.

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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2*

*Includes one recommendation that has been stated for a second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Sylvia Ewart, nurse in charge and with Mrs Sharon Colhoun, registered manager by telephone following the inspection, 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 3 September 2015. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

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: Bernadette Kiernan O'Donnell	**Registered manager:** Sharon Margaret Colhoun
Person in charge of the home at the time of inspection: Sylvia Ewart, Registered Nurse	**Date manager registered:** 1 April 2015
Categories of care: NH-LD(E), NH-PH, RC-PH, RC-I, NH-I, NH-PH(E)	**Number of registered places:** 40

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection we met with 20 patients, two registered nurses, four care staff and one catering staff.

Ten patients, ten staff, and six relatives' questionnaires were left for distribution. Seven staff, seven patients and three relatives completed and returned questionnaires.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records including the planner for 2016/17
- three staff personnel records
- accident and incident records
- notifiable events records
- sample of audits
- complaints records
- NMC and NISCC registration records
- staff induction records
- nurse competency and capability assessments
- minutes of staff meetings.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 3 September 2015

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

4.2 Review of requirements and recommendations from the last care inspection dated 3 September 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 20.2 **Stated:** First time	The registered manager should ensure that patient's religious preferences/ spiritual needs are documented in end of life care plans.	**Not Met**
	Action taken as confirmed during the inspection: Three patients care records were reviewed and we were unable to evidence that patient's religious preferences/ spiritual needs had been documented in end of life care plans. This recommendation will therefore be stated for the second time.	
Recommendation 2 **Ref**: Standard 32 **Stated:** First time	The registered manager should review the palliative care and end of life policy and procedures to ensure they reference current best practice guidance such as the Gain Palliative Care Guidelines, November 2013.	**Met**
	Action taken as confirmed during the inspection: Palliative care and end of life policy and procedures had been reviewed and referenced current best practice guidance such as the Gain Palliative Care Guidelines, November 2013.	
Recommendation 3 **Ref**: Standard **Stated:** First time	The registered manager should ensure that a written protocol has been developed for timely access to any specialist equipment or drugs out of hours.	**Met**
	Action taken as confirmed during the inspection: A protocol was in place for timely access to any specialist equipment or drugs out of hours.	

4.3 Is care safe?

The nurse in charge 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 rotas for weeks commencing 20 and 27 June and 4 July 2016 evidenced that the planned staffing levels were adhered to.

Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The nurse in charge informed us that there were systems in place for the safe recruitment and selection of staff, and staff consulted confirmed that they had only commenced employment once all the relevant checks had been completed. Two staff personnel files were viewed and we were able to evidence that all the relevant pre-employment checks had been completed.

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. Staff were mentored by an experienced member of staff during their induction. Records for two staff members were reviewed and found to be completed in full and dated and signed appropriately.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Review of training records evidenced that mandatory training had been completed to date.

Staff clearly demonstrated the knowledge, skills and experience necessary to fulfil their role, function and responsibility.

Discussion with the administrator 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).

Staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding.

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.

Discussion with the nurse in charge confirmed that a range of audits was conducted on a regular basis (refer to section 4.6 for further detail). A sample of falls audits confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends. An action plan was in place to address any deficits identified.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident. Trust representatives, patients' representatives and RQIA were notified appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Comments received in the returned questionnaires from patients, relatives and staff indicated that patients were safe and protected from harm. Some comments received are detailed below:

"I feel safe and secure"
"staff are all very approachable and friendly"

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.4 Is care effective?

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. Risk assessments informed the care planning process.

As stated in section 4.2, patient's religious preferences/ spiritual needs had not been documented in end of life care plans. This recommendation has been stated for the second time.

There was evidence that, generally care records were kept under review and adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. The recent recommendations made by the dietician and SALT had not been included in the care plans of two patients on therapeutic diets. The specific dietary requirements for these two patients were discussed with catering and care staff and we were assured that while the care records had not been updated, the patients were receiving the prescribed diets. A recommendation has been made with regard to care records.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate. There was evidence also of regular communication with patients' representatives regarding the patients' ongoing condition.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. The nurse in charge also confirmed that regular quarterly staff meetings were held and records were maintained.

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.

Discussion with the nurse in charge and review of records evidenced that patient meetings were held on a monthly basis. Minutes were available.

Patients spoken with expressed their confidence in raising concerns with the home's staff/ management. Some comments received as follows:

- "I do have a say in what happens to me"
- "the menu choice is very good"

Areas for improvement

Care records should be kept under review and adhere to recommendations prescribed by other healthcare professionals such as speech and language therapist and dieticians.

Patient's religious preferences/ spiritual needs should be documented in end of life care plans.

Number of requirements	**0**	**Number of recommendations**:	**2***

*Includes one recommendation that has been stated for a second time.

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely.

Observation of the lunch time meal confirmed that patients were given a choice in regards to, food and fluid choices and the level of help and support requested. Staff were observed to offer patients reassurance and assistance appropriately.

The daily menu was displayed in the dining rooms and offered patients a choice of two meals for lunch and dinner. A choice was also available for those on therapeutic diets. Patients all appeared to enjoy their lunch.

Discussions with staff confirmed that they had a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients spoken with were complimentary regarding the care they received and life in the home. Those 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.

Discussion with the nurse in charge confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. We were informed that regular staff meetings were held and patient meetings were held every month. The minutes of patients' meetings were available in the home.

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

Some comments received from patients:

- "the girls are all very good and kind"
- "I can make choices on a daily basis about my care"
- "the girls choose my clothes. Very good though"
- "I can't think of anything that needs improved. I'm very happy here"

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

Discussion with the nurse in charge and staff evidenced that there was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities. Staff also confirmed that there were good working relationships and that the registered manager was responsive to any concerns raised.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the nurse in charge, a review of care records and observations confirmed that the home was operating within its registered categories of care.

Review of the home's complaints record and discussion with the registered manager 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.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

There was evidence that a range of audits had been completed on a monthly basis, including care records, accidents/incidents, medication management and infection prevention and control. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Review of records for April, May and June 2016 evidenced that Regulation 29 monthly quality monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Surveys were

conducted to review the quality of nursing and other services provided within the nursing home on a quarterly basis. The views of patients, relatives, staff and other healthcare professionals are sought. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

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.

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

Feedback received in the returned questionnaires confirmed that patients, relatives and staff felt the service was well led.

Areas for improvement

Two recommendations have been made with regard to care records. One has been stated for the second time.

Number of requirements	**0**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Sylvia Ewart, nurse in charge and with Sharon Colhoun, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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 person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements – None

Recommendations

Recommendation 1 **Ref**: Standard 4.4 **Stated:** First time **To be completed by:** 15 August 2016	The registered person should ensure that care records are kept under review and adhere to the recommendations prescribed by other healthcare professionals such as speech and language therapist and dieticians. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: New audit to be commenced in relation to therapeutic diets-copy attached
Recommendation 2 **Ref**: Standard 20.2 **Stated:** Second time **To be completed by:** 15 August 2016	The registered manager should ensure that patient's religious preferences/ spiritual needs are documented in end of life care plans. **Ref: Section 4.2**
	Response by registered person detailing the actions taken: All done. All care records updated to include this in clients care plans

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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