Unannounced Care Inspection Report
18 March 2021

Knockagh Rise

Type of Service: Nursing Home
Address: 236 Upper Road, Greenisland, BT38 8RP
Tel No: 028 9085 5930
Inspectors: Gillian Dowds and Philip Lowry

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

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

1.0 What we look for

2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 29 persons.

3.0 Service details

Organisation/Registered Provider: Knockagh Rise Ltd **Responsible Individual:** Ruth Elizabeth Logan	**Registered Manager and date registered:** Diane Brown – 10 January 2020
Person in charge at the time of inspection: Diane Brown	**Number of registered places:** 29 There shall be a maximum of 4 named residents receiving residential care in category RC-I
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 22

4.0 Inspection summary

An unannounced inspection took place on 18 March 2021 from 09.45 to 18.30 hours. Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

The inspection sought to assess progress with issues raised in the previous quality improvement plan.

The following areas were examined during the inspection:

- staffing
- the internal environment and infection prevention and control practices (IPC)
- care delivery
- care records
- governance and management.

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	*3	*6

*The total number of areas for improvement includes one under regulation which have been stated for a second time; three under standards stated for a second time and two under standards that will be stated for a third time.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Diane Brown, 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.

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.

During the inspection the inspector met with eight patients and seven staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. No responses were received.

The inspector provided the deputy manager with 'Tell us' cards which were then 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**.**

The following records were examined during the inspection:

- duty rota from 15 to 28 March 2021
- incident/accident records
- a sample of monthly monitoring reports
- a sample of governance records
- complaints/compliments records
- three patients' care records
- a sample of food and fluid intake charts, bowel monitoring and repositioning records
- COVID-19 information
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC)

- monthly quality monitoring reports
- visitor declaration
- a sample of cleaning schedules
- RQIA registration certificate.

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

6.0 The inspection

6.1 Review of areas for improvement from previous inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 25 September 2020.

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 13 (7) **Stated:** First time	The registered person shall ensure in regard to infection prevention and control that the • excess equipment is removed from patients bedrooms • a system is in place for decontamination of the manual handling equipment between use.	**Met**
	Action taken as confirmed during the inspection: A review of the environment and equipment evidenced that this area for improvement was met.	
Area for improvement 2 **Ref**: Regulation 12 (1) (a) (b) **Stated:** First time	The registered person shall ensure that the record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.	**Not met**
	Action taken as confirmed during the inspection: A review of one patient's wound management evidenced gaps in the recording of the wound care provided. We also evidenced that the care plan was not fully reflective of the care required. This area for improvement has not been met and has been stated for a second time.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 12 **Stated:** Second time	The registered person shall review the existing fluid management arrangements in the home to ensure that the daily fluid targets are reflective of individualised assessed need. Assessed fluid targets should be recorded in patients' individual care records and actual fluid intake reviewed by a registered nurse where appropriate.	**Partially met**
	Action taken as confirmed during the inspection: A review of the management of hydration in the home evidenced that this area for improvement has not been fully met. This will be discussed further in section 6.2.4 This area for improvement has not been met and has been stated for a third time.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** Second time	The registered person shall ensure that monthly care plan reviews and daily evaluations of care are meaningful; patients centred and include the oversight of supplementary care.	**Partially met**
	Action taken as confirmed during the inspection: A review of records evidenced that some improvement was identified in the daily evaluation of care, however, in some of the records reviewed the monthly evaluations lacked detail. This area for improvement has not been fully met and has been stated for a third time.	
Area for improvement 3 **Ref**: Standard 4 **Stated:** Second time	The registered person shall ensure that for those patients who require bowel monitoring: • Contemporaneous recording of bowel management charts are maintained. • Nursing staff evaluate the effectiveness of this care.	**Met**
	Action taken as confirmed during the inspection: Records reviewed evidenced that this area for improvement was met as stated.	

Area for improvement 4 **Ref**: Standard 41 **Stated:** First time	The registered person shall ensure a review of the staffing arrangements in the home is adequate to meet the dependency needs of the patients.	**Partially Met**
	Action taken as confirmed during the inspection: Following the previous inspection a review of the staffing arrangements had been undertaken and staffing levels were adequate to meet the needs of the patients. However, due to comments during the inspection a further review was requested. Staffing will be discussed further in section 6.2.1 This area for improvement has not been fully met and has been stated for a second time.	
Area for improvement 5 **Ref**: Standard 5 **Stated:** First time	The registered person shall ensure staff are aware of individual restrictive practice care plans, with specific reference to lap belts.	**Not met**
	Action taken as confirmed during the inspection: On the day of inspection we observed one patient who had a lap belt in use. There were no care records available to support the reasoning for or direct the care of this restrictive practice. This area for improvement has not been met and has been stated for a second time.	
Area for improvement 6 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that fluid thickening agents kept in the home are stored in a secure place.	**Not met**
	Action taken as confirmed during the inspection: Thickening agents were observed accessible to patients within three identified bedrooms. This was discussed with the manager at the time of the inspection and removed. This area for improvement has not been met and has been stated for a second time.	

6.2 Inspection findings

6.2.1 Staffing

During the inspection we observed that patients' needs were met by the number and skill mix of staff on duty.

Patients spoken to were generally positive about the staffing levels in the home, although, one patient stated that they felt they had to wait a while for the call bell to be answered. Some staff spoken with felt that the afternoon staffing levels could be improved. We discussed staffing further with the manager who advised that the staffing levels were kept under review. However due to the comments made by one patient and staff a further review of the staffing arrangements is required and an area for improvement in this regard stated for a second time.

Staff spoken with were aware of their role in safeguarding and told us the procedure they followed if they were to raise a concern. Staff confirmed that they had received training in relation to this and were aware of the homes whistleblowing policy.

Staff told us that they felt well equipped to carry out their role and that they received updates on the use of personal protective equipment (PPE) and infection prevention and control (IPC) measures during the COVID-19 pandemic.

6.2.2. Care delivery

We observed that the patients were well cared for; they were well presented and nicely dressed. Staff were aware of their patients' needs, they were friendly and attentive. Patients were content and the atmosphere in the home was calm and relaxed.

Patients said;

- "I like it here; it's like my second home."
- "I am getting on ok."
- "I'm really happy."

A visiting area had been set up with visiting arranged following the current regional guidelines in this area. The manager told us visiting was booked in advance through an online booking system and a health declaration completed. The activity therapist ensured that virtual visits and telephone calls were maintained. Visitors to the home had their temperatures checked, were required to perform hand hygiene and PPE was available.

We observed that some of the patients in their bedrooms did not have their call bell within reach to call staff if they required attention. This was addressed by the manager at the time of the inspection.

During the inspection we observed that one patient had a lap belt in position when seated in their specialised chairs. This was queried with the manager who advised that these belts were only to be used when transporting patients to another area and not for continuous use. The manager addressed this at the time of the inspection. An area for improvement identified from the previous inspection in this regard will therefore be stated for a second time.

We observed that thickening agents were accessible in various patients' bedrooms; this was discussed with the manager and an area for improvement was stated for a second time.

We observed the serving of lunch in the dining area and to those patients who had their lunch in their bedrooms. The meal on offer was well presented and smelled appetising. Staff were observed to offer patients assistance as required, they took time to ensure patients were not rushed, offered a selection of drinks and alternative choices if required. Staff changed their PPE and carried out hand hygiene at appropriate times throughout the mealtime. Patients spoken with told us that the meal was very nice.

6.2.3 The internal environment and infection prevention and control practices

Signage was in place at the entrance of the home to reflect the current guidance on COVID-19. Staff and visitors entering the home had their temperatures checked on arrival. Patients' temperatures were also recorded in line with the guidance.

PPE was available at various stations throughout the home and stations were well stocked. Staff assured us they had sufficient stocks of PPE at all times. Staff were observed to be mostly compliant with wearing of their PPE, however, on a small number of occasions we observed staff that had their mask under their chin. This was discussed with the manager and addressed at the time of the inspection. One incident was reported to the manager for further follow up.

We reviewed the home's environment; this included observations of a sample of bedrooms, bathrooms, lounges, storage areas, sluices, treatment rooms and dining rooms. We observed that the home was warm, clean, tidy and fresh smelling throughout. Patients' bedrooms were personalised and the home was tastefully decorated. Corridors and fire exits were clear of clutter and obstruction. We observed the storage of continence wipes and pads in the downstairs toilet and observed that some of the foot operated bins in the sluice rooms were broken. We discussed this with the manager who agreed to address this.

Thickening agents were observed accessible to patients within three identified bedrooms. This was discussed with the manager at the time of the inspection and removed. An area for improvement was stated for a second time.

We viewed the allocated visiting area in the home that had been set up in keeping with the current visiting guidance. The manager advised us that visiting was booked through an online service and health declarations were completed by visitors

Seating in the lounges and dining rooms had been arranged in such a way as to allow for social distancing. Some patients preferred to take meals in their bedroom and staff were happy to facilitate this choice.

The manager told us frequently touched points are cleaned regularly over the 24 hour period and deep cleaning was carried out as necessary in addition to the normal cleaning schedule in the home.

6.2.4 Care records

We reviewed the wound care records for one patient. These records evidenced that an initial and ongoing wound assessment had been recorded. We observed gaps in the recording of the ongoing wound care evaluation and the wound care plan was not fully reflective of the care required. An area for improvement previously identified on wound care recording was therefore stated for a second time.

We reviewed the daily and monthly evaluation of care and evidenced some improvement of the details recorded of the daily evaluation of care. The monthly evaluations lacked a person centred approach and the oversight by the registered nurses of the supplementary care records was inconsistent. This was discussed with the manager who told us that she had discussed this with the nurses at a recent staff meeting and that this was being addressed. The minutes of the meeting were viewed. An area for improvement previously identified twice in this regard was therefore partially met and will now be stated for a third time.

We reviewed the management of patients' hydration in the home. Fluid targets were not recorded on the appropriate care plans and the manager advised that they were currently in the process of updating the care records. The minutes of a recent staff meeting were viewed where this had been discussed and how it would be addressed. An area for improvement will therefore be stated for a third time.

We reviewed the care plans for two patients who required a modified diet. The records viewed had been updated to reflect the current speech and language therapist (SLT) guidelines and were written reflecting the international dysphagia diet standardisation initiative (IDDSI) guidance. We also observed a care plan was in place for a patient who was at risk of choking; a relevant risk assessment was also in place.

Patients' weights were recorded on at least a monthly basis; we evidenced that referrals were made to the appropriate healthcare professionals if weight loss occurred and recommendations regarding, for example, fortified diets were included in care plans.

Food and fluid intake records reviewed were completed, however, did not evidence the evening supper for the patients. This was discussed with the manager who assured us that the patients received the supper in the evening and would address the recording of this with the staff. This will be reviewed at the next inspection.

We reviewed the accident and incident records and it was positive to note that there was a low incidence of falls within the home. The patient care records for one patient who had an unwitnessed fall evidenced that no consideration to the potential of a head injury was given and neurological observations had not been recorded. We discussed falls management further with the manager and an area for improvement was identified.

6.2.5 Governance and management arrangements

We reviewed a sample of governance audits in the home. These audits identified areas in the home that required improvement; we observed that action plans were developed and timeframes for completion were visible. However we discussed further development of the auditing processes in the home to include weight audits and restrictive practice. Progress of this will be reviewed at the next inspection.

We reviewed a sample of the monthly monitoring reports and observed that these were done remotely during the start of the COVID-19 pandemic; however, these were now being undertaken again within the home. We observed that if these reports identified any deficits an action plan was devised and reviewed. In the reports however we identified that there was no consultation with the patients' relatives and this was recorded as none present. We discussed this further with the manager and an area for improvement was identified.

The manager told us that face to face and online training was provided and staff were reminded when training was due. The manager said that face to face training had previously not taken place due to the pandemic but that dates had been booked to recommence. We observed that some areas of mandatory training compliance rates were low. This was discussed further following the inspection and the updated matrix was viewed. It was requested that the training matrix would be submitted to RQIA in one month as further training had been booked.

We observed that there was a system in place to manage complaints and these also were included in the monthly monitoring reports. However, we observed that some of the complaints recorded lacked detail and outcome / level of satisfaction was not recorded. This was discussed with the manager and an area for improvement was identified.

Areas of good practice

Area of good practice were observed in the personalisation of patients' bedrooms and development of the visiting area. Further areas of good practice were identified in relation to staff interaction with patients and the teamwork within the home.

Areas for improvement

Areas for improvement were identified in relation to falls management, consultation for the monthly monitoring reports and complaint recording.

	Regulations	Standards
Total number of areas for improvement	2	1

6.3 Conclusion

On the day of inspection patients appeared comfortable and content in their surroundings. Staff treated the patients with kindness and compassion. We observed positive interactions between patients and staff. Staff were knowledgeable about their roles in relation to adult safeguarding.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Diane Brown, manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 12 1 (a) (b) **Stated:** Second time **To be completed by:** 1 June 2021	The registered person shall ensure that the record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. Ref: 6.1 and 6.2.4
	Response by registered person detailing the actions taken: Supervisions have been completed with all trained staff regarding accurate recording of wound management file and care plans. Current guidelines for wound management and wound care formulary added to the wound care file - wound care file updated.
Area for improvement 2 **Ref:** Regulation 13 1 (b) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that all unwitnessed falls are managed in line with current best practice and that neurological observations are obtained. Ref: 6.2.4
	Response by registered person detailing the actions taken: All trained staff notified verbally and in written form of the best practice for mangement of unwitnessed falls. Supervisions have been completed. Home manager will continue to monitor falls.
Area for improvement 3 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** 30 June 2021	The registered person shall ensure that the monthly monitoring reports include consultation with the patients' relatives/ representatives. Ref: 6.2.5
	Response by registered person detailing the actions taken: Following discussion with the independent consultant, she will re-establish regular contact with the residents' next of kin and will record her consultation in the monthly monitoring report, as this had been restricted during Covid 19. The home manager also contacts next of kin monthly to ascertain feedback and any concerns.

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 12 **Stated:** Third time **To be completed by:** 1 June 2021	The registered person shall review the existing fluid management arrangements in the home to ensure that the daily fluid targets are reflective of individualised assessed need. Assessed fluid targets should be recorded in patients' individual care records and actual fluid intake reviewed by a registered nurse where appropriate. Ref:6.1 and 6.2.4
	Response by registered person detailing the actions taken: Fluid management records reviewed - individual targeted amounts calculated monthly and evidenced in care plans. Fluid balance charts completed daily and signed by the nurse in charge at the end of each 24hour period. Totals of individuals identified as not meeting targets will be recorded in the diary and passed on during handover and recorded on new audit forms. G.P's contacted and informed of any consistantly low targets - staff allocated daily to promote fluids with identified individuals.
Area for improvement 2 **Ref**: Standard 4 **Stated:** Third time **To be completed by:** 1 June 2021	The registered person shall ensure that monthly care plan reviews and daily evaluations of care are meaningful; patients centred and include the oversight of supplementary care. Ref: 6.1 and 6.2.4
	Response by registered person detailing the actions taken: All trained staff verbally and in writing informed that all care plan evaluations and daily progress notes must be written with a more person centered approach and in greater detail, taking into consideration supplimentary records. Home manager will continue to audit care plans on a monthly basis and implement action plans for trained staff to complete.
Area for improvement 3 **Ref**: Standard 41 **Stated:** Second time **To be completed by:** Immediately and ongoing	The registered person shall ensure a review of the staffing arrangements in the home is adequate to meet the dependency needs of the patients. Ref:6.1.and 6.2.1
	Response by registered person detailing the actions taken: The staffing levels are monitored daily and are reflective of the current dependancy levels of the residents.

Area for improvement 4 **Ref**: Standard 5 **Stated:** Second time **To be completed by:** 30 June 2021	The registered person shall ensure staff are aware of individual restrictive practice care plans, with specific reference to lap belts. Ref: 6.1.and 6.2.2
	Response by registered person detailing the actions taken: All staff informed verbally and in writing of the protocol on restrictive practice and use of lapbelts - care plans completed on all residents who require use of lap belts and lap belt consent forms completed following discussions with next of kins. Random audits to be carried out by the home manager and supervisions completed as required.
Area for improvement 5 **Ref**: Standard 30 **Stated:** Second time **To be completed by:** Immediately and ongoing	The registered person shall ensure that fluid thickening agents kept in the home are stored in a secure place. Ref: 6.1.and 6.2.3
	Response by registered person detailing the actions taken: Training arranged for all staff on the use and storage of thickening agents. Room inspection audits completed weekly to ensure thickening agents are not being stored in bedrooms.
Area for improvement 6 **Ref**: Standard 16 **Stated:** First time **To be completed by:** 30 June 2021	The registered person shall ensure records are kept of all complaints and includes details of all communications with the complainants; the result of any investigation; the action taken and whether or not the complainant was satisfied with the outcome; and how this level of satisfaction is determined. Ref: 6.2.5
	Response by registered person detailing the actions taken: Complaints record file has been updated and will be addressed if any further complaints are received.

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

The Regulation and Quality Improvement Authority

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