# Unannounced Care Inspection Report
# 11 August 2016

# Hawthorn House

**Type of Service: Nursing Home**
**Address: 16-16a Hawthornden Road, Belfast BT4 3JU**
**Tel No: 02890473027**
**Inspector: Aveen Donnelly**

## 1.0 Summary

An unannounced inspection of Hawthorn House took place on 11 August 2016 from 09.15 to 16.00 hours.

The inspection sought to assess progress with 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?**

A robust system for mandatory training was in place and staff were knowledgeable regarding their responsibilities in adult safeguarding. The environment was found to be clean and comfortable. Systems were in place to ensure sufficient staffing levels and safe recruitment practices. Concerns were identified with the completion of falls risk assessments when patients had fallen; and the management of odours was problematic in one identified area of the home. Two recommendations have been made in this regard in order to drive improvement.

**Is care effective?**

Systems were in place to enable good communication amongst staff in the home and there was evidence that regular staff meetings were held to discuss concerns. Patients and relatives spoken with were confident in raising concerns with the manager and staff. Although there was evidence of patient/representative involvement in the development of care plans, care records were not consistently reviewed on a regular basis. A requirement has been made in this regard in order to drive improvement.

**Is care compassionate?**

There was evidence of good relationships between staff and patients and staff were noted to be delivering care in a patient and timely manner. All those consulted with commented positively on the care provided and a number of comments are included in the report. No areas for improvement were identified in this domain.

**Is the service well led?**

There was evidence that systems were in place for incident reporting, auditing and management of safety alerts. Monthly monitoring visits were carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and an action plan was put in place with evidence that issues had been addressed month on month. No areas for improvement were identified in this domain; however, weaknesses identified in relation to the risk assessment and care plans, will impact on the 'well led' domain.

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** | 1 | 2 |

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

## 1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 19 April 2016. 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:**<br>Four Seasons Healthcare<br>Maureen Claire Royston | **Registered manager:**<br>Kerrie Wallace |
| **Person in charge of the home at the time of inspection:**<br>Kerrie Wallace | **Date manager registered:**<br>30 June 2010 |
| **Categories of care:**<br>NH-I, NH-PH, NH-PH(E), NH-TI | **Number of registered places:**<br>32 |

## 3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

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, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with five patients, three care staff, two registered nurses and four patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home from 1 August to 8 August 2016
- five patient care records
- staff training records
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff member's personnel record
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff meetings held since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures.

## 4.0 The inspection

### 4.1 Review of requirements and recommendations from the most recent inspection dated 27 April 2016

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

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

## 4.2 Review of requirements and recommendations from the last care inspection dated 20 January 2016

| Last care inspection recommendations | | Validation of compliance |
|---|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 4<br><br>**Stated:** First time | The registered manager should ensure that all relevant risk assessments and care plans are completed/updated within five days of admission to the home. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>A review of patient care records evidenced that risk assessments and care plans had been completed within the required period. | |

## 4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and stated 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 the week commencing 1 August 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

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 consulted confirmed that they received induction; and described the induction programme as being “very good”. One completed induction programme was reviewed. 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 staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons’ monthly monitoring visit in accordance with regulation 29.

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. Competency and capability assessments were also completed with all registered nurses who were given the responsibility of being in charge of the home.

There were systems in place for the recruitment and selection of staff. A review of one personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their PIN numbers were checked on a regular basis, with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with AccessNI and a register was maintained which included the reference number and date received.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manager and review of records confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. A review of the monthly monitoring reports, in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, evidenced that the staff's awareness of the regional safeguarding protocols was tested during the visits, to ensure that the staff were able to identify what constituted abuse and was reportable. This is good practice and is commended.

Review of five patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process. A concern was identified regarding the frequency with which the assessments and care plans were reviewed. Refer to section 4.4 for further information.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last inspection confirmed that these were appropriately managed. However, the risk assessments were not consistently reviewed in regards to any changes of circumstances. For example, a review of the accident and incident records confirmed that, although care management and patients' representatives were notified appropriately, the falls risk assessments and care plans were not consistently completed following each incident. A recommendation has been made in this regard.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. The areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. We observed that odour management was problematic in one corridor area of the home. Patients' representatives consulted with also stated that at times, pervading incontinence odours existed in the identified area. It is recommended that the management of odours in the identified area is reviewed and eliminated.

Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

**Areas for improvement**

A recommendation has been made that the falls risk assessment is reviewed in response in changes to the residents' condition and the care plan amended accordingly.

A recommendation has been made that the management of odours in the identified area is reviewed and eliminated.

| Number of requirements: | 0 | Number of recommendations: | 2 |
|---|---|---|---|

## 4.4 Is care effective?

A review of five patient care records evidenced that although a range of validated risk assessments were completed as part of the admission process; these were not consistently reviewed on a regular basis. For example, the majority of one patient's risk assessments and care plans had not been updated between 5 March 2016 and 3 August 2016. As previously discussed in section 4.3, the care plan for one patient's risk of falling had not been reviewed in response to the patient having fallen. In another patient's care record, there was also no evidence that a care plan had been developed in relation to the treatment of a urinary tract infection. There was evidence in two of the five care records reviewed, that although they had updated on a regular basis, a number had not been formally re-written since October 2012. A requirement has been made in this regard.

A review of the records evidenced that in one patient care record, gaps were evident in the risk assessment forms and in the daily progress notes. This is not in accordance with NMC best practice guidelines on record keeping. The competency and capability assessment for the registered nurse was reviewed and included a section on record keeping standards. Following the inspection, the registered manager confirmed to RQIA by email on 24 August that supervision had been undertaken with the registered nurse, to ensure that they were aware of the NMC guidelines on record keeping.

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. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Supplementary care charts, such as repositioning and bed rails checks, evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities; and that communication between all staff grades was effective. 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 registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent general staff meeting was held on 9 May 2016. Discussion with the registered manager confirmed that formal patients and relatives meetings were not being held due to regular non-attendance. The manager maintained an 'open door' policy with relatives and this was very evident at the inspection. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. The registered manager also obtains daily feedback from patients' and their representatives, to ascertain their views on the home environment and the care of their relative. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

A notice board displaying information for relatives is also displayed in the front foyer area and included the home's mission statement and ethos of care; the health and safety policy statement; and whistleblowing information.

**Areas for improvement**

A requirement has been made that care records are kept under review and reviewed at any time necessary to do so having regard to any change of circumstances and in any case not less than annually.

| **Number of requirements:** | **1** | **Number of recommendations:** | **0** |
|---|---|---|---|

## 4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. 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.

Menus were displayed clearly in the dining room and were correct on the day of inspection. We observed the lunch time meal being served in the dining room. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. The lunch served appeared very appetising and patients spoken with stated that it was always very nice.

Patients 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.

A list of activities was displayed and included manicures, games, reminiscence, walks, armchair exercises, singalongs and floral arrangements. A violinist had also been arranged to perform for the patients. One patient stated that "you would get lost with the activities, there are so many to choose from". A leaflet of all the planned activities for the upcoming week had been provided to each patient.

Patients consulted with also stated that they knew how to use their nurse call bells and that staff usually responded promptly. Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. These systems included a 'Quality of Life' (QOL) feedback system which was available at the reception area. This was an iPad which allowed relatives/representatives, visiting professionals and/or staff to provide feedback on their experience of Hawthorn House. A portable iPad was also available to record feedback from patients. The registered manager explained that when feedback is received via this system, an automatic email is sent to the management who then must respond to any comments made. Anyone completing feedback has the option to remain anonymous or leave their name. Management have the option to contact people who leave their contact details to gain further clarification on the feedback received. We were informed that all of the comments received were positive. The annual quality audit report had also been completed in April 2016.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included: "my mother received the best of care, enjoyed the company of the other residents and was cared for by wonderful staff".

The care plan detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patient. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met. There was evidence that the staff sat with a patient, who was nearing end of life, when the family members were not present and this provided "strong comfort" to the family members. 'Water lily' symbol was used to discretely communicate that a patient's death had occurred.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. Some comments received are detailed below:

**Staff**

"We are trying our best".
"I believe it is a good home".
"It is very good here".
"I love it here".

**Patients**

"I couldn't get better".
"It is satisfactory".
"They are all very good to me here, I couldn't fault them".
"It is fine here. I get everything I need".

**Patients' representatives**

"'I have no concerns. It is very good".
"I am very pleased with the gentle dignity they have allowed (my relative) to maintain".
"It's very good".
"We are extremely happy. The girls are very good".

In addition to speaking with patients, relatives and staff, questionnaires were provided to the registered manager for distribution; ten for staff and relatives respectively; and five for patients. Two relatives, two patients and eight staff had returned their questionnaires within the timescale for inclusion in this report. No written comments were provided on the returned questionnaires.

**Areas for improvement**

No areas for improvement were identified during the inspection.

| Number of requirements: | 0 | Number of recommendations: | 0 |
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## 4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

All those consulted with provided positive comments in relation to the approachability of the registered manager. One staff member stated the registered manager was “very friendly and accommodating”. Two relatives also provided comment on the registered manager’s management style. Comments included:

“She is fantastic, her door is always open and she always makes time to talk to us”.
“She is very open to any concerns, which is very reassuring to us as a family”.

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

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis. Staff confirmed that they had access to the home’s policies and procedures.

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. Staff, patients and patients’ representatives spoken with confirmed that they were aware of the home’s complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- accident analysis
- wound analysis audit
- medication audits
- care records
- infection prevention and control
- hand hygiene audit
- PPE audit
- Mattress and cushion audit
- environment audits
- complaints analysis
- health and safety audit
- hoist and sling audit
- food safety audit
- quality dining audit
- bedrail audit
- restraint audit
- housekeeping
- human resources
- home governance
- information governance
- weight loss.

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.

Discussion with the registered manager confirmed that a range of audits were conducted on a regular basis (refer to section 4.6 for further detail). An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were appropriately managed.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

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 monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives.

The monthly monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. Discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

**Areas for improvement**

No areas for improvement were identified in this domain; however, weaknesses identified in relation to the risk assessment and care plans, will impact on the 'well led' domain.

| Number of requirements: | 0 | Number of recommendations: | 0 |
|---|---|---|---|

## 5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the registered 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 may enhance service, quality and delivery.

## 5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements 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

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| **Statutory requirements** | |
| **Requirement 1**<br><br>**Ref**: Regulation 16(1)(b)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>08 October 2016 | The registered persons must ensure care records are kept under review and reviewed at any time necessary to do so having regard to any change of circumstances and in any case not less than annually.<br><br>**Ref: Section 4.4** |
| | **Response by registered provider detailing the actions taken:**<br>All records currently up to date, monthly monitoring audit in place for RN staff to complete, ongoing monitoring by Manager and monthly monitoring by Regional manager during Reg 29 visit |
| **Recommendations** | |
| **Recommendation 1**<br><br>**Ref**: Standard 22.6<br><br>**Stated:** First time<br><br>**To be completed by:**<br>08 October 2016 | The registered persons should ensure that the falls risk assessment is reviewed in response in changes to the residents' condition and the care plan amended accordingly.<br><br>**Ref: Section 4.3** |
| | **Response by registered provider detailing the actions taken:**<br>RN staff to complete following each incident and monitored by manager, Regional manager to audit during monthly Reg 29 visit. |
| **Recommendation 2**<br><br>**Ref**: Standard 44.1<br><br>**Stated:** First time<br><br>**To be completed by:**<br>08 October 2016 | The registered provider should ensure that the management of odours in the identified area is reviewed and eliminated.<br><br>**Ref: Section 4.3** |
| | **Response by registered provider detailing the actions taken:**<br>Odour identified and replacement flooring ordered. |

***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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