Unannounced Care Inspection Report

7 February 2017

Movilla House

Type of Service: Nursing Home
Address: 51 Movilla Road, Newtownards, BT23 8RG
Tel No: 02891819399
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Movilla House took place on 7 February 2017 from 10:00 hours to 15:30 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

A review of the staffing provision and a general inspection of the home indicated that the delivery of care was safe.

One requirement in regard to staff recruitment records was made as result of the previous care inspection. This requirement is now stated for a second time. No further requirements were made with regard
to the delivery of safe care.

Is care effective?

We reviewed the care records of four patients. A recommendation was made that a comprehensive assessment of patient need was completed as part of the admission process .

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Care records were regularly reviewed and updated, as required, in response to patient need.

We discussed how patient and care needs were communicated between staff. Staff advised that they received a handover report at the start of each shift and were of the opinion that there was effective teamwork within the home.

Is care compassionate?

We arrived in the home at 10:00 hours. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were sitting in the lounges or their bedrooms as was their personal preferences.

Patients and relatives spoken with commented positively in regard to the care they received and communication in the home. The following comments were provided:

There were no areas of improvement identified in the delivery of compassionate care

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. 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, a review of care records and observations confirmed that the home was operating within the categories of care registered.

No areas for improvement were identified with the well led domain.

The term 'patients' is used to describe those living in Movilla House which is registered to provide both nursing and residential care.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1*	3*

*One requirement and two of the recommendations were made as a result of the previous inspection and are now stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Tracey Anderson, registered manager, and Jenny Bell, general 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 12 January 2017. Other than those actions detailed in the QIP there were no further actions required to be taken. 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: Movilla House Ltd Derek Alfred Bell	**Registered manager:** Tracey Anderson
Person in charge of the home at the time of inspection: Tracey Anderson	**Date manager registered:** 19 September 2016
Categories of care: RC-I, NH-I, NH-PH, NH-PH(E), NH-TI No more than 2 persons in category RC-I.	**Number of registered places:** 50

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection we met with 15 patients individually and with the majority in small groups, two nurses, three care staff, two domestic assistants, a laundry assistant and five patients relatives.

The following information was examined during the inspection:

- five patient care records
- medicine administration records
- staff duty roster for the week commencing 6 February 2017
- staff induction records
- staff recruitment records
- complaints record.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 January 2017

The most recent inspection of the home was an unannounced medicines inspection. The completed QIP was returned and approved by the pharmacist 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 27 September 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 21(1)(b) **Stated:** First time	The registered person must ensure that all information required in regard to the selection and recruitment of staff is obtained prior to the commencement of employment. **Ref section 4.3**	**Not Met**
	Action taken as confirmed during the inspection: Two personnel files of staff recently employed were reviewed; neither contained all of the information required in regard to the selection and recruitment of staff. This requirement has not been met and is stated for a second time. The deficits in the files were discussed at length with the registered manager and general manager. Prior to the conclusion of the inspection they had commenced work to create a checklist of all the information required in regard to the selection and recruitment of staff.	
Requirement 2 **Ref**: Regulation 16(1) **Stated:** First time	The registered person must ensure that a written nursing plan is prepared to direct the care required to meet the patient's assessed need.	**Met**
	Action taken as confirmed during the inspection: A review of five care records evidenced that care plans were in place to direct the care required to meet the patient's assessed need. This requirement has been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 12 **Stated:** Second time	It is recommended that the serving of the evening tea is reviewed to ensure it meets individual patient needs. This review should include the opinion of patients and the deployment of staff. RQIA should be notified of the outcome of this review.	**Met**
	Action taken as confirmed during the inspection: Staff, patients and relatives spoken with confirmed that evening tea was now served from 16 45 hours. Staff explained that working patterns and deployment of staff had been reviewed to ensure they were able to meet the patient's individual needs. No concerns were identified with the serving of meals during this inspection. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	It is recommended that a record of the date the Access NI certificates are checked should be maintained to evidence that the registered manager had checked the certificate prior to the candidate commencing employment.	**Met**
	Action taken as confirmed during the inspection: Selection and recruitment files reviewed contained the date the Access NI certificates were received and checked. Records evidenced that the outcome of the checks had been received prior to the candidates commencing employment. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 39 **Stated:** First time	It is recommended that completed induction programme contain the name and designation of the staff who have completed the form. They should also be signed by the registered manager to confirm that the induction process had been satisfactorily completed.	**Met**
	Action taken as confirmed during the inspection: We reviewed two completed induction programmes. These programmes had been signed by staff and by the registered manager. This recommendation has been met.	

Recommendation 4 **Ref**: Standard 4.9 **Stated:** First time	It is recommended that contemporaneous notes are kept of all nursing interventions, activities and procedures carried out in relation to each patient. Repositioning charts should be accurately maintained to evidenced care delivery.	**Not Met**
	Action taken as confirmed during the inspection: Two patients repositioning charts reviewed did not evidence that care was delivered as planned. This recommendation is stated for a second time.	
Recommendation 5 **Ref**: Standard 35.6 **Stated:** First time	It is recommended that a review is undertaken of the systems in place for data inputting to care records to ensure that they fully support the recording of contemporaneous records. Records should accurately reflect the actual time care is delivered and not the time the entry is recorded.	**Partially Met**
	Action taken as confirmed during the inspection: The general manager and registered manager confirmed that work was ongoing with the suppliers of the IT system to ensure that the system fully supports the recording of contemporaneous records. This recommendation is assessed as partially met and is stated for a second time.	
Recommendation 6 **Ref**: Standard 12 **Stated:** First time	It is recommended that snacks are available for all patients' at each customary interval.	**Met**
	Action taken as confirmed during the inspection: Observation of the morning and afternoon tea trolley evidenced that snacks were available for all patients at each customary interval. Staff confirmed that a range of snacks were available every day. This recommendation has been met.	

Recommendation 7 **Ref**: Standard 28 **Stated:** First time	It is recommended that the medicine administration records are accurately completed and the appropriate dosage intervals maintained for all prescribed medicines.	**Met**
	Action taken as confirmed during the inspection: A review of medication recording sheets evidenced the time teatime mediations were administered. The time medications administered outside the usual medication rounds was also recorded to evidence that appropriate dosage intervals were maintained. This recommendation has been met.	
Recommendation 8 **Ref**: Standard 7.6 **Stated:** First time	It is recommended that when patient opinion is sought, action is taken to address any issues raised. **Ref section 4.5**	**Met**
	Action taken as confirmed during the inspection: We reviewed the minutes of patient meetings held from September 2016. The minutes contained an action plan of the issues raised during the previous meeting and of the action taken to address the issues. This was reviewed at the beginning of the next meeting and patients' comments recorded. This recommendation has been met.	
Recommendation 9 **Ref**: Standard 16.11 **Stated:** First time	It is recommended that the recording of complaints is further developed to include how the complainants' level of satisfaction was determined. **Ref section 4.6**	**Met**
	Action taken as confirmed during the inspection: A review of the complaints record evidenced that the registered manager had checked that the complainant was satisfied that the complaint had been addressed. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home. A review of the staffing roster for week commencing 6 February 2017 evidenced that planned staffing levels were adhered to. In addition to nursing and care staff, the registered manager confirmed that administrative, catering, domestic and laundry staff were also on duty daily. No concerns regarding staffing provision within the home were raised during discussions with patients, relatives and staff.

We also sought relatives and staff opinion on staffing via questionnaires. None were returned prior to the issue of this report.

A general inspection of the home was undertaken to examine a number of patients' bedrooms, lounges, bathrooms and toilets. The home was fresh smelling, clean and appropriately heated. There were no issues identified with infection prevention and control practice.

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?

We reviewed the care records of four patients. At the time of admission a dependency rating scale was completed for each patient. This tool identified the level of assistance each patient required but did not identify patient need. There was no comprehensive assessment of need completed. A recommendation was made. A range of validated risk assessments were completed as part of the admission process. Initial plans of care were based on the pre admission assessment and referral information.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Care records were regularly reviewed and updated, as required, in response to patient need.

We discussed how patient and care needs were communicated between staff. Staff advised that they received a handover report at the start of each shift. Staff were of the opinion that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with patients, relatives and their colleagues.

Areas for improvement

A comprehensive, holistic assessment of patients' nursing needs should be commenced at the time of admission to the home.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

We arrived in the home at 10:00 hours. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were sitting in the lounges or their bedrooms as was their personal preferences. Staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preference to sit throughout the day.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:

“The staff are fabulous, there’s nothing is too much trouble.”
“I am very happy here.”
“I have everything I need thank you.”

We spoke with the relatives of five patients. Everyone commented positively with regard to the standard of care and communication in the home. The following comments were provided:

“This is a fabulous home.”
“It’s the wee things that make all the difference.”
“If something is not quite right you only have to say”
“I would give this place 11 out of ten.”

Ten questionnaires were issued to staff and relatives, none were returned prior to the issue of this report.

Areas for improvement

No areas for improvement were identified with the delivery of compassionate care during this inspection.

Number of requirements	0	Number of recommendations	0

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. 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, a review of care records and observations confirmed that the home was operating within the categories of care registered. There were no patients accommodated for residential care at the time this inspection.

The registered manager confirmed that the general manager was in the home daily to provide support and assistance as required.

Areas for improvement

No areas for improvement were identified during the inspection.

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 Tracey Anderson, registered manager and Jenny Bell, general manager as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref**: Regulation 21(1)(b) **Stated:** Second time **To be completed by:** 7 March 2017	The registered person must ensure that all information required in regard to the selection and recruitment of staff is obtained prior to the commencement of employment. **Ref Section 4.2**
	Response by registered provider detailing the actions taken: An employment checklist has been compiled and is being strictly adhered to. I am signing everything off such as PIN numbers, Access NI checks prior to commencement of first shift. All gaps in employment are discussed at interview and the same are documented. Tow references are sought and one from most recent employer, where this has been an issue it has been discussed with the inspector
Recommendations	
Recommendation 1 **Ref**: Standard 4.9 **Stated:** Second time **To be completed by:** 7 March 2017	It is recommended that contemporaneous notes are kept of all nursing interventions, activities and procedures carried out in relation to each patient. Repositioning charts should be accurately maintained to evidenced care delivery. **Ref section 4.2**
	Response by registered provider detailing the actions taken: Repositioning charts are accurately maintained, there is now a method in place to record the time the care was delivered
Recommendation 2 **Ref**: Standard 35.6 **Stated:** Second time **To be completed by:** 7 March 2017	It is recommended that a review is undertaken of the systems in place for data inputting to care records to ensure that they fully support the recording of contemporaneous records. Records should accurately reflect the actual time care is delivered and not the time the entry is recorded. **Ref section 4.2**
	Response by registered provider detailing the actions taken: A review of epicare has been undertaken, there is now a method in place to record the time food and fluid are given and at present, they are working on placing the same method for all other aspects of care as well as other areas that I felt were needed

Recommendation 3 **Ref**: Standard 4.1 **Stated:** First time	It is recommended that a comprehensive, holistic assessment of patients' nursing needs is be commenced at the time of admission to the home. **Ref section 4.4**
To be completed by: 7 March 2017	**Response by registered provider detailing the actions taken:** The basic needs assessment is now completed within 24 hours of admission for all residents. This has also been completed for all current residents. Care plans are completed within 5 days of admission and are developed from this basic assessment

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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