



The Regulation and
Quality Improvement
Authority

Nicholson House
RQIA ID: 1274
8 Antrim Road
Lisburn
BT28 3DH

Inspector: Sharon McKnight
Inspection ID: IN021930

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**Unannounced Care Inspection
of
Nicholson House**

23 June 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 23 June 2015 from 12 30 to 15 00 hours.

The inspection sought to assess progress with the issues raised during and since the previous inspection.

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. One recommendation stated as result of the previous care inspection on 8 January 2015 had not been met and has been stated for a second time as detailed in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/ Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 8 January 2015.

1.2 Actions/ Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Ms Pauline Adair, deputy manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Joseph Andrew Johnston Ruth Mary Johnston	Registered Manager: Ruth Johnston
Person in Charge of the Home at the Time of Inspection: Pauline Adair, deputy manager	Date Manager Registered: 1 April 2005
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	Number of Registered Places: 32

Number of Patients Accommodated on Day of Inspection: 31	Weekly Tariff at Time of Inspection: £621.00 - £652.50
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3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/ Process

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

- discussion with the deputy manager
- discussion with staff
- discussion with patients
- discussion with relatives
- review of records
- observation during a tour of the premises
- evaluation and feedback.

Prior to inspection the following records were analysed:

- 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 previous care inspection report.

The inspector met with six patients individually and with the majority generally, one registered nurse, four care staff and six relatives.

The following records were examined during the inspection:

- audits of care record
- accident and incident reports
- care records of six patients
- staff duty roster
- complaints record.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 8 January 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last care (Same specialism) Inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
<p>Requirement 1</p> <p>Ref: Regulation 17 (1)</p> <p>Stated: Second time</p>	<p>It is required that the registered person shall ensure that audits are completed on all care records and the outcomes of any deficits identified are addressed.</p> <p>The audit process must be an ongoing process to ensure care records are maintained in keeping with regulatory requirements.</p> <p>Action taken as confirmed during the inspection: Care records were audited by the registered manager as part of the established programme of audit within the home. Review of audit records evidenced that this requirement has been met. Care records reviewed were in keeping with regulatory requirements.</p>	Met
<p>Requirement 2</p> <p>Ref: Regulation 19(2) schedule 4(12) (b)&(c)</p> <p>Stated: Second time</p>	<p>It is required that incidents of pressure ulcers, grade 2 and above, must be reported to RQIA in accordance with best practice guidelines.</p> <p>Action taken as confirmed during the inspection: Review of the notifications submitted to RQIA and discussion with the deputy manager evidenced that this requirement had been met.</p>	Met

<p>Requirement 3</p> <p>Ref: Regulation 19(1)(a), schedule 3, 2(k)</p> <p>Stated: Second time</p>	<p>The registered person shall maintain contemporaneous notes of all nursing provided to the patient.</p> <p>Repositioning charts must be accurately maintained to evidence the care delivered.</p> <p>Repositioning charts must contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning.</p> <p>Action taken as confirmed during the inspection:</p> <p>The three patients' repositioning charts reviewed evidenced that patients were repositioned regularly. There was documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning. This requirement has been met.</p>	<p>Met</p>
Last Care Inspection Recommendations		Validation of Compliance
<p>Recommendation 1</p> <p>Ref: Standard 19.1</p> <p>Stated: First time</p>	<p>The "Bladder function assessment" should be completed for all patients who have identified continence needs in their activity of daily living assessment</p> <p>The type of continence pad and size of pants are recorded in the patient's care records.</p> <p>Action taken as confirmed during the inspection:</p> <p>Three care records reviewed contained a completed "Bladder function assessment". The type of continence pad and size of pants was recorded in the patient's care records. This recommendation has been met.</p>	<p>Met</p>
<p>Recommendation 2</p> <p>Ref: Standard 1.1</p> <p>Stated: First time</p>	<p>In keeping with patient dignity, each patient should have continence pants supplied solely for their personal use.</p> <p>Action taken as confirmed during the inspection:</p> <p>The deputy manager explained that they have been sourcing methods of individualising continence pants but the recommendation has not been fully addressed yet. The recommendation has not been met and is stated for a second time.</p>	<p>Not Met</p>

Recommendation 3 Ref: Standard 19.2 Stated: First time	Publications on the management of bladder and bowel continence and catheter and stoma care should be readily available in the home to inform and guide staff on best practice.	Met
	Action taken as confirmed during the inspection: Publications on the management of bladder and bowel continence and catheter and stoma care were available in the home to inform and guide staff on best practice. This recommendation has been met.	

5.3 Inspection findings

Is Care Safe? (Quality of Life)

Review of staffing, observation of care delivery and discussion with staff, patients and relatives evidenced that staffing levels were appropriate to meet the needs of the patients in a timely manner.

The deputy manager confirmed that there was a rolling programme of mandatory training, for example moving and handling, fire awareness and infection control, provided throughout the year. Additional training opportunities was provided by the local and health and social care trust and staff were supported by the management of the home to attend these trainings. Staff spoken with commented positively, regarding the provision of training available and in particular the recent dementia training.

Review of the records of accidents and incidents evidenced that accidents were managed appropriately. All recorded accidents had been reviewed and signed by the registered manager in keeping with good governance arrangements. A review of notifications to RQIA evidenced that the home notified RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

Is Care Effective? (Quality of Management)

The registered manager has been registered with RQIA from 2005. She has well established systems in place to ensure that the delivery of care provided was in accordance with legislative requirements and DHSSPS care standards.

Review of three care records evidenced that a holistic assessment of patient need alongside a range of risk assessments, for example moving and handling, nutrition and pain assessments, were completed for patients. Assessments and care plans were reviewed and updated regularly. Care records evidenced that patients and/ or their representatives were informed of changes to patient need and/ or condition and the action taken by staff in response to need.

Is Care Compassionate? (Quality of Care)

Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required. Good relationships were evident between patients and staff. Those patients who were unable to verbally express their views were observed to be well groomed and were relaxed and comfortable in their surroundings. A review of bed side charts evidenced that those patients who were being nursed in bed, were attended by staff on a regular basis.

Discussion took place with six patients individually and with the majority of others in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were positive.

Five relatives confirmed that they were happy with the standard of care and communication with staff in the home. They confirmed that the staff kept them informed of any changes to their relatives' condition and consulted with relevant healthcare professionals in a timely way.

Staff spoken with stated that they were happy working in the home and were satisfied that they were enabled to delivery care in a timely manner. They commented positively in regard to the care delivery in the home, management and the support and training available. Staff were knowledgeable regarding individual patient need.

Areas for Improvement

There were no areas for improvement identified during this inspection.

Number of Requirements:	0	Number of Recommendations:	0
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6. Quality Improvement Plan

Whilst no issues were identified during this inspection, one recommendation made as a result of the previous inspection has not been met, has been stated for a second time and is detailed in the QIP. Details of the QIP were discussed with Ms Pauline Adair, Deputy 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/ Registered Person

The QIP must be completed by the registered person/ 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. 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 weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Recommendations

Recommendation 1
In keeping with patient dignity, each patient should have continence pants supplied solely for their personal use.

Ref: Standard 1.1

Stated: Second time

To be Completed by:
31 July 2015

Response by Registered Person(s) Detailing the Actions Taken:
Continence pants supplied for each Resident and supply retained in individual drawers in bedrooms.

Registered Manager Completing QIP	Ruth Johnston	Date Completed	18.08.2015
Registered Person Approving QIP	Andrew Johnston	Date Approved	14.09.15
RQIA Inspector Assessing Response	Sharon McKnight	Date Approved	14-09-15

Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

Please provide any additional comments or observations you may wish to make below: