Unannounced Care Inspection Report
23 August 2016

Nicholson House

Type of Service: Nursing Home
Address: 8 Antrim Road, Lisburn, BT28 3DH
Tel No: 028 9267 4126
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Nicholson House took place on 23 August 2016 from 10.30 to 14.45 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?

There was evidence of competent and safe delivery of care. The home was found to be warm, well decorated and clean throughout. Relevant checks were conducted within the recruitment process prior to a staff member commencing employment. Mandatory training was provided for staff to attend and a recommendation has been made to develop a system to monitor and ensure compliance levels were met by staff. Staff consulted and observation of care delivery and interactions with patients clearly demonstrated that they were knowledgeable regarding the needs of the patients in the home.

Is care effective?

There was evidence of positive outcomes for patients. Staff demonstrated a high level of commitment to ensure patients received the right care at the right time. Staff spoken with understood their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager.

Although there was evidence that staff meetings were held they were infrequent and a recommendation has been made in this regard.

Recommendations have also been made in regards to the care planning process and the maintaining of records to monitor fluid intake and/or output for patients with indwelling urinary catheters.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients were very praiseworthy of staff and a number of their comments are included in the report. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

Although there were systems in place to monitor and report on the quality of nursing and other services provided there is a need for these to be further developed to ensure robustness and that effective outcomes are achieved.

The registered manager was available to patients and their relatives and operated an 'open door' policy for contacting her. Representatives also commented on the high visibility of the registered manager.

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	0	6

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ruth Johnston, 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 on16 May 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.

There were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered person: Nicholson House/Mr Joseph Andrew Johnston & Mrs Ruth Mary Johnston	**Registered manager:** Mrs Ruth Mary Johnston
Person in charge of the home at the time of inspection: Ruth Johnston	**Date manager registered:** 01 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 32

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the last care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the 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. The inspector also met with six patients individually and greeted the majority of others in small groups, four care staff, two registered nurses and two relatives.

Questionnaires for patients (five), relatives (10) and staff not on duty (10) to complete and return were left for the registered manager to distribute. Reference to comments received have been included throughout the report and also refer to section 4.5.

A poster indicting that the inspection was taking place was displayed on the front door of the home and invited visitors and relatives to speak with the inspector.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staff roster
- training records
- staff recruitment records
- NMC and NISCC registers
- records of quality audits
- complaints and compliments records
- incident and accident records
- records of staff meetings
- regulation 29 monitoring reports
- annual quality report
- three patient care records.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 16 May 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 16 December 2015

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. Review of the staffing rota from 15 to 26 August 2016, evidenced that the planned staffing levels were adhered to. The staffing rota did not always identify the registered nurse in charge in the absence of the registered manager. This was brought to the attention of the registered manager who addressed this immediately.

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

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

A discussion with the registered manager and a review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff were mentored by an experienced member of staff during their induction. Records for one staff member were reviewed and found to be completed in full and dated and signed appropriately.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of registered nurses and care staff were appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

Review of the training matrix/schedule for 2015/2016 indicated that training was planned to ensure that mandatory training requirements were met. Training outcomes for 2015 indicated that a number of staff had not completed training in some mandatory areas. A discussion with the registered manager confirmed that there was no system in place to monitor staff compliance with mandatory training requirements. A recommendation has been made in this regard.

A discussion with the registered manager and the deputy manager clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safe guarding. Further discussion with some staff indicated a lack of knowledge in this area of practice, specifically in relation to the systems and processes involved in reporting an adult safeguarding incident. Whilst staff spoken with had completed adult safeguarding training this had not been embedded into practice. A review of the training programme indicated that this information was included.

This matter was discussed with the registered manager and it was agreed that supervision should be undertaken with staff commensurate with their roles and responsibilities to ensure that they are knowledgeable in this regard and appropriate actions are taken to address any learning needs. A recommendation has been made.

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients' bedrooms observed evidenced personalisation and were attractive and comfortable. The home is currently making improvements to the building which will further enhance the existing homes environment and experience for patients living there.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were in the majority adhered to although the following observations were made. Chairs and trolleys were being stored in bathroom areas. The trolleys observed had continence products (still in packaging), towels and other items. This observation was discussed with the registered manager who advised that the trolleys were stored in this area however that nothing should be stored on them. The registered manager agreed to address this immediately. In addition, one staff member was observed wearing nail polish, a discussion with the staff member indicated that they knew that this was against infection prevention and control guidance and the homes policy. The care staff member agreed to remove same immediately and this matter was brought to the attention of the registered manager who advised that this was not common practice as staffs' uniform policy (which includes nail polish) is closely monitored. The registered manager agreed to address this matter and monitor closely.

Areas for improvement

A recommendation has been made to develop a system to monitor and ensure compliance with mandatory training requirements and other areas of training identified by the home.

A recommendation has been made that staff are provided with supervision in regards to the processes for reporting adult safeguarding commensurate with their roles and responsibilities. Records of supervision should be retained.

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

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required for the majority of records examined. One of the care records examined did not have a pain assessment in place even though the patient was receiving treatment for pain management. A discussion with the deputy manager advised that the patient had recently been admitted and this was an oversight. The explanation given was acknowledged by the inspector as the other records examined were found to be completed.

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.

Generic care plans were in place and although the majority of care interventions recorded were appropriate there was evidence that in some instances the care plan did not accurately reflect the assessed needs of patients and lacked a person centred approach. The following shortfalls were identified; one care record reviewed was not reflective of the patient's dietary requirements and did not include information recorded in the SALT assessment (speech and language therapist assessment). This information was discussed with the registered nurse who advised that the patient did not comply with the recommendations made by SALT. A review of information recorded in the daily progress notes did confirm this information however there was no evidence that this information had been shared with SALT to review the patients' needs accordingly. A recommendation has been made.

Another patient's care record was reviewed in relation to the management of continence. The patient had an indwelling catheter inserted to manage urinary retention. A discussion with the registered nurse advised that the patients intake and output where not being monitored as this was considered unnecessary even though , a review of daily progress records indicated the patients urinary output was poor. This practice was discussed with the registered manager who advised that a record had been previously maintained to monitor same however was unaware that this had been discontinued. A recommendation has been made in this regard.

A review of records and a discussion with the registered manager indicated that there was no robust system in place to monitor care records, to ensure that they were reviewed, kept up to date and reflected the current needs of patients in keeping with best practice. Further detail in regards to care plan audits is discussed in section 4.6.

Discussion with staff confirmed that nursing and care staff were required to attend a handover at the beginning of each shift which provided staff with appropriate information to care for the patients. Information received in returned staff questionnaires indicated that effectiveness of this process was determined by the staff actually conducting the handover and was not consistent across the team. This information was shared with the registered manager post inspection, who agreed to respond to the information provided and take appropriate actions to ensure consistency of approach.

A discussion with staff and the registered manager and a review of records pertaining to staff meetings evidenced that these were not held on a regular basis. Records indicated that a staff meeting was held in January 2015 and there were no subsequent meetings until May 2016.

The registered manager advised that the home planned to hold meetings quarterly; however this had not been actioned. Responses received in returned staff questionnaires also confirmed that meetings were held infrequently. A recommendation has been made in this regard.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Discussion with the registered manager confirmed that patient and/or relatives meetings were not held formally. The registered manager advised that they were available in the home on a daily basis and the home operated an 'open door policy'. This was evidenced during the inspection process and it was very apparent that the registered manager knew the patients and relatives and vice versa. The registered manager advised that care management meetings also provided a forum for relatives and patients to ascertain their views on the home environment and care provision and other related services.

Relatives spoken with during the inspection process and in responses received from completed questionnaires confirmed that if they had any concerns they could raise these with the registered manager.

There was information available to staff, patients, representatives in relation to advocacy services.

Areas for improvement

The registered provider should ensure that the care planning process in operation meets the assessed needs of patients and reflects the current assessment of needs and care interventions required.

A recommendation has been made that records are maintained of fluid intake and/or output for any patient who has had an indwelling catheter inserted to manage urinary output. Records should be maintained in accordance with best practice guidelines.

A recommendation has been made that staff meetings are conducted quarterly at a minimum.

Number of requirements	0	**Number of recommendations**	3

4.5 Is care compassionate?

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

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

On this occasion the arrangements for the provision of activities was not reviewed in detail at this inspection. The activities co-ordinator was on duty and there was an activity programme displayed on the notice board. The home had planned an outing for patients to go to 'Bangor' the day following the inspection and it was evident from conversations held that both the patients and staff were looking forward to the day trip. Responses received in returned staff questionnaires indicated that there was a need for more activities to provide further stimulation for patients. This information has been shared with the registered manager for consideration. Staff were observed chatting to patients in the lounge and dining room and responding to patients individually. It was evident from patients' response to staff that they enjoyed the company and interaction with staff.

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. Views and comments recorded for the most recent Annual Quality report were analysed and an action plan was developed and shared with staff, patients and representatives.

In addition to the discussions and observations made at the inspection, questionnaires were provided by RQIA to the registered manager for distribution as previously referred to in section 3.0.

At time of issuing this report, one patient, seven staff and two relatives returned the questionnaires within the specified timeframe and some comments made have been referred to throughout the report. Responses received from patients, representatives and staff would indicate a high level of satisfaction with this service.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

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

A copy of the complaints procedure was displayed in the home. 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. Representatives spoken with and who responded by questionnaire, confirmed that they were aware of the home's complaint procedure. Staff and representatives confirmed that they were confident that staff and management would manage any concern raised by them appropriately.

Numerous thank you cards were received form relatives and all comments made were very positive in regards to the care received by their loved one and also to them.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. However, a review of accident and incidents records evidenced that some had not been reported appropriately. A discussion with the registered manager indicated that there had been some ambiguity in regards to information provided to them in this regard. Based on the information provided it was acknowledged that there had been a misunderstanding and the registered manager agreed to submit the identified notifications retrospectively and going forward agreed to submit the required information in accordance with legislation, standards and RQIA's guidance on reporting notifiable events. This will continue to be monitored at subsequent care inspections.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. 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. Following a discussion with the registered manager it was agreed that the some of the audits undertaken needed to be completed more frequently to ensure the quality of care and other services delivered. For example, as previously discussed in section 4.5 care records audits were not been undertaken in a systematic manner and as a result the shortfalls highlighted at this inspection had not been identified. A recommendation has been made in this regard to drive the quality improvements required in this area of practice.

Discussion with the registered manager and review of records evidenced that monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, and staff and Trust representatives. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

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

Also, as discussed in the preceding sections, it was evident that the registered manager maintained a highly visible profile in the home and continued to works as a registered nurse on the floor to ensure they knew the needs of the patients and were also able to monitor staff practices.

Areas for improvement

A recommendation has been made that audits to include care audits are completed in a more systematic manner to drive the quality improvements required.

Number of requirements	0	**Number of recommendations**	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ruth Johnston, 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/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: No requirements were made at this inspection

Recommendations

Recommendation 1 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 25 November 2016	The registered provider should ensure that systems are in place to monitor and ensure staffs compliance with mandatory training requirements and other areas of training identified by the home. **Ref Section:4.3**
	Response by registered provider detailing the actions taken: System put in place to monitor staff compliance with training.
Recommendation 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 25 October 2016	The registered provider should ensure that staff meetings take place on a regular basis and at a minimum quarterly. Records are kept which include: • The date of all meetings • The names of those attending • Minutes of discussions; and • Any actions agreed. **Ref section: 4.3**
	Response by registered provider detailing the actions taken: Staff Meeting held on 20.09.2016 and further date scheduled for Dec 2016.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 25 October 2016	The registered provider should ensure that the care planning process in operation meets the assessed needs of patients and reflects the current assessment of needs and care interventions required. **Ref Section:4.4**
	Response by registered provider detailing the actions taken: Care plans updated to reflect assessed needs of Residents. This is ongoing work.
Recommendation 4 **Ref**: Standard 4 Criteria 8 **Stated:** First time **To be completed by:** 30 September 2016	A recommendation has been made that records are maintained of fluid intake and/or output for any patient who has had an indwelling catheter inserted to manage urinary output. Records should be maintained in accordance with best practice guidelines. **Ref Section: 4.4**
	Response by registered provider detailing the actions taken: Implemented.

Recommendation 5 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure supervisions are completed with staff commensurate with their roles and responsibilities in regards to adult safeguarding procedures to ensure that they are knowledgeable in this regard and appropriate actions are taken to address any learning needs. **Ref Section: 4.3**
	Response by registered provider detailing the actions taken: Supervision recorded with staff nurse identified so that the knoweldge in adult safe guarding procedures was understood.
Recommendation 6 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 25 November 2016	The registered provider should ensure that robust systems are in place to monitor and report on the delivery of nursing care and other services provided, in particular, the auditing processes in relation to care records. **Ref Section: 4.4 & 4.6**
	Response by registered provider detailing the actions taken: New audit process to be introduced specifically for careplans commencing October 2016.

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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