The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
21 and 22 February 2017

Oakridge Care Home

Type of Service: Nursing Home
Address: 14 Magheraknock Road, Ballynahinch, BT24 8TJ
Tel no: 028 9756 5322
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Oakridge Care Home took place on 21 February 2017 from 09.30 to 16.45 hours and on 22 February 2017 from 09.30 to 14.00 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?

RQIA were suitably informed of notifications under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A safe system for monitoring compliance with mandatory training was in place. Staff confirmed that they completed an induction programme on commencement of employment to the home and there was evidence of orientation and inductions completed by new agency staff on their first day of employment in the home. One recommendation was made in this domain regarding the management of high dusting and one recommendation made at the previous inspection in regards to moving and handling practices has been stated for a second time.

Is care effective?

Patients and staff demonstrated confidence and awareness in raising any potential concerns to the relevant people. Evidence was available to confirm that staff meetings were held regularly. There was also good evidence of engagement with patients' representatives. One requirement was made in relation to wound management and a second requirement was made in regard to care planning.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report. Many compliments had been received by the home in relation to the care and compassion provided to patients/relatives and some of these comments are contained within this report. One recommendation has been made in regards to a mealtime review.

Is the service well led?

Appropriate certificates of registration and public liability insurance were on display. Records of complaints received confirmed that they had been managed appropriately and systems were in place to monitor the quality of nursing. No requirements or recommendations were made in this 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	2	3*

*The total number of recommendations includes one recommendation which has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Kelly Kilpatrick, 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 4 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: Oakridge Care Home Spa Nursing Homes Ltd Christopher Arnold	**Registered manager:** Kelly Kilpatrick
Person in charge of the home at the time of inspection: 21 February 2017: Nichola Boyd (Senior Registered Nurse) 22 February 2017: Kelly Kilpatrick	**Date manager registered:** 24 June 2016
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI, NH-DE A maximum of forty (40) patients in the EMI Unit. A maximum of eighteen (18) patients in the General Nursing Unit.	**Number of registered places:** 58

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 previous care inspection
- the previous care inspection report and the returned QIP
- pre inspection assessment audit.

During the inspection we met with10 patients individually and others in small groups, three patient representatives, four care staff, three registered nurses and one ancillary staff member.

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

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Nine patient, nine staff and nine patient representative questionnaires were left for completion.

The following information was examined during the inspection:
- validation evidence linked to the previous QIP
- five patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- competency and capability assessments for nurse in charge
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- duty rota for the period 13 to 26 February 2017

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 4 January 2017

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

4.2 Review of requirements and recommendations from the last care inspection dated 16 – 17 June 2016

Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 18 Criteria (6) **Stated:** Second time	It is recommended that where restrictive practices are used, an assessment and a corresponding care plan are documented in the care record to reflect this. The care plan should include the reason for the restrictive practice and the actions taken to ensure the health and welfare of the patient as a result of the restrictive practice. This is in relation to the removal of call bells from identified patients' rooms.	**Met**
	Action taken as confirmed during the inspection: A review of patient's bedrooms evidenced that there was appropriate nurse call provision in place.	
Recommendation 2 **Ref:** Standard 47 Criteria (3) **Stated:** First time	The registered manager should observe staffs moving and handling of patients within the home to ensure training is embedded into practice.	**Not Met**
	Action taken as confirmed during the inspection: Observation of moving and handling practices evidenced that this recommendation has not been met. See section 4.3 for further information. This recommendation has not been met and will be stated for a second time.	
Recommendation 3 **Ref**: Standard 4 Criteria (9) **Stated:** First time	The registered provider should ensure that where a patient has a fluid target, this target will be met and were there are deficits recorded to the target; these will be documented, along with actions taken to address the deficit, in the patients' daily evaluation.	**Met**
	Action taken as confirmed during the inspection: There was evidence within two patient care records reviewed that staff were monitoring patient fluid intake.	

Recommendation 4 **Ref**: Standard 4 Criteria (4) **Stated:** First time	The registered provider should ensure when recommendations are made from other health professionals; these recommendations are recorded within the patients' care plan and implemented. **Action taken as confirmed during the inspection**: Recommendations from other professionals made within three patient care records reviewed had been followed up by staff.	**Met**
Recommendation 5 **Ref**: Standard 36 **Stated:** First time	The registered person should make sure a system is in place to ensure that all policies are subject to a systematic three yearly review. **Action taken as confirmed during the inspection**: Discussion with the regional manager and a review of a sample of policies evidenced that a system was in place to ensure a systematic three yearly review of policies.	**Met**

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. A review of the staffing rota from 13 to 26 February 2017 evidenced that the planned staffing levels were adhered to. Discussion with staff evidenced that three staff members had concerns regarding staffing levels specifically at mealtimes and during night duty. One respondent in a relative's questionnaire indicated that they did not feel there were enough staff on duty to meet the needs of patients at all times. These concerns were forwarded to the registered manager for review. Discussion with patients evidenced that there were no concerns regarding staffing levels.

Discussion with staff and review of records, confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. An induction booklet was completed and signed by the new employee and the staff member responsible for completion of the induction. There was also evidence of a documented induction and orientation programme for new agency staff, which both registered nurses and care staff completed prior to commencing their first day of employment in the home.

Discussion with the registered manager and review of training records evidenced that a system was in place to monitor staff attendance at mandatory training. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

A 2017 mandatory training plan was utilised within the home. However, during a review of the home, moving and handling practices were observed where staff, on two separate occasions, were not in compliance with current best practice guidelines. This was discussed with the registered manager and a recommendation made in the previous inspection in regard to moving and handling practice has been stated for a second time.

Competency and capability assessments of the nurse in charge of the home in the absence of the registered manager had been appropriately completed.

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 confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures.

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.

Review of notifications forwarded to RQIA from 17 June 2016 confirmed that these were appropriately managed. Accidents and incidents were reviewed monthly to identify any potential patterns or trends. Inspection of accident records evidenced that an unwitnessed fall had occurred. Records indicated that central nervous system (CNS) observations were taken immediately following the incident and monitored for 24 hours. The management of two patients following a fall were a head injury may have occurred was observed to have been conducted in compliance with best practice guidance and both had been recorded well.

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 majority of patients' bedrooms were personalised with photographs, pictures and personal items. Bedrooms and communal areas were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were well maintained. However, there was considerable evidence of dust accumulated on top of wardrobes in patients' bedrooms. This was discussed with the registered manager and a recommendation was made.

Areas for improvement

It is recommended that the schedule for cleaning patients' bedrooms includes the dusting of high areas such as the tops of patients' wardrobes.

Number of requirements	0	Number of recommendations	2*

4.4 Is care effective?

Review of five 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. Care plans had been personalised to meet the individual needs of the patients and had been reviewed monthly. However, there was evidence of conflicting care plans within two patient care records reviewed. For example, patient 'A' fluid intake had been determined by a care plan drafted in February 2016 which indicated the patient currently required fluids to be thickened before drinking due to a swallowing difficulty. A second care plan within the patient's care records indicated the patient was able to drink normal (un-thickened) fluids. Both care plans had been reviewed in January 2017.

Three care plans within patient ‘B’ care records indicated the need for the use of a fall out mat due to the patient being a high risk of falling from bed. However, a care plan review, conducted in June 2016, indicated an alternative to a fall out mat to be used and this equipment was observed in use on inspection. Although, the care records indicated the continued use of a crash mat. This was discussed with the registered manager and a requirement was made to ensure all care plans were reviewed to ensure that they reflect the current care needs of patients.

Review of records pertaining to the management of wounds evidenced that registered nurses were not adhering to regional guidelines and the care planning process. A number of deficits were identified in the recording of patient ‘C’ and patient ‘D’ wound care records. Deficits were also identified in respect of the wound care records for patient ‘D’. These deficits were discussed in detail with the registered manager and a requirement was made to ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.

Discussion with the registered manager confirmed that a general staff meeting was conducted quarterly. There was evidence meetings conducted on 24 August 2016 and 24 January 2017. Minutes of the meetings were available and included details of attendees; dates; topics discussed and decisions made. Furthermore, there was evidence that three registered nurse meetings had been conducted since 18 August 2016 and three carers meetings had been scheduled in September 2016. The registered manager also confirmed that they aimed to host patient and relatives’ meetings on a six monthly basis. There was evidence that a patient and relatives meeting had been conducted on 5 December 2016.

The registered manager confirmed that they operate an ‘open door policy’ and are available to discuss any issues with staff, patients and/or relatives. The registered manager also confirmed that they would undertake a daily walk around the home and would avail of the opportunity to engage with patients and relatives at this time. A ‘relatives’ noticeboard was maintained at the front door of the home and a monthly newsletter was published in the home to inform patients and relatives of any relevant information.

Staff consulted 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. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Areas for improvement

It is required that care plans were reviewed to ensure that they reflect the current care needs of patients.

It is required that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.

Number of requirements	2	Number of recommendations	0

4.5 Is care compassionate?

Three registered nurses, four carers and one ancillary staff member was consulted to ascertain their views of life in Oakridge Care Home. All but one staff consulted confirmed that when they raised a concern, they were happy that the home's management would take their concerns seriously. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Four of the questionnaires were returned within the timescale for inclusion in the report.

Some staff comments were as follows:
"It's hard work but I like it."
"It's good, I like it here."
"It's nice here."
"It can be stressful but I enjoy working here."
"I really like it here."
"It's alright."

Ten patients were consulted and the patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Nine patient questionnaires were left in the home for completion. One patient questionnaire was returned within the timeframe.

Some patient comments were as follows:
"The staff are very good and the food is good."
"It's very good here."
"The home is very nice."

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.

Three patient representatives were consulted with on the day of inspection. Nine relative questionnaires were left in the home for completion. Eight relative questionnaires were returned. All respondents indicated that they were satisfied or very satisfied with the care provided in the home.

Some relatives' comments were as follows:
"The care here is excellent."
"The staff are great. They give that extra personal touch."
"I have no qualms on the care here. The place is beautifully kept."
"At times there are not enough staff on duty."

Staff interactions with patients were observed to be compassionate, caring and timely. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

The serving of lunch was observed on a first floor dining room. Lunchtime commenced at 14.00 hours. Food was served from a bain-marie when patients were ready to eat or be assisted with their meals. Staff were observed to encourage patients with their meals. A registered nurse was observed administering medications from a medicine trolley in the dining room during the mealtime. This practice should be discouraged to allow patients to focus on nutrition and not to associate mealtimes with administration of medications. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors were required.

Patients were observed to be assisted in an unhurried manner and patients who became easily distracted from their meals were managed compassionately and appropriately. Condiments were not available as required on tables and patients were not seen to be offered condiments during their meal. This issue is included in the recommendation raised regarding the dining experience.

A range of drinks were offered to the patients. However, three jugs of readymade orange juice was observed stored uncovered in an adjoining kitchenette and one jug had been stored uncovered on a sideboard in the dining room. Three jugs of milk were stored uncovered in a fridge in the dining room. A staff member confirmed that the jugs had been delivered to the areas at some time during the morning period. The clear plastic drinking glasses used by patients appeared cloudy and worn. The food served appeared nutritious and appetising. At 15.00 hours one patient still required assistance with a meal. Staff confirmed that a fresh meal would be obtained from the kitchen to give to the patient.

The mealtime experience was discussed with the registered manager and a recommendation was made to review the findings from the inspection and to ensure that the mealtimes are conducted in accordance with the DHSSPS Care Standards for Nursing Homes 2015 and best practice guidance such as the PHA Nutritional Guidelines and Menu Checklist for residential and nursing homes 2014.

Areas for improvement

It is recommended that the patients' mealtime experience is reviewed to ensure that it is in accordance with DHSSPS Care Standards for Nursing Homes 2015 and best practice guidance.

Number of requirements	0	Number of recommendations	1

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.

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

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. The complaints procedure was displayed at reception. The registered manager confirmed that any learning gained from complaints was discussed during staff meetings.

A compliments file was maintained to record and evidence compliments received.

Some examples of compliments received are as follows:
"Many many thanks to everyone at Oakridge for all the great care and kindness shown to our mother."
"A big thank you for everyone's hard work and dedication in caring for … We appreciate the kindness and love you gave her."

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, monthly audits were completed in accordance with best practice guidance in relation to wound analysis, care records, accidents, complaints and infection prevention and control. The registered manager confirmed that care record audits in the home would be conducted by another registered manager from the provider group (Spa Nursing Homes). This manager would review four care records and the registered manager would review a further two. An action plan to address shortfalls would be discussed with the patient's named nurse or other registered nurse on duty to address. The audit would be signed and dated by the registered manager when the actions taken were reviewed.

However, two requirements have been made on record keeping with regards to wound management and on care planning as discussed in section 4.4. Concerns have also been identified with staffs moving and handling practices and with the mealtime experience. A further concern was identified with regard to high dusting in patient's bedrooms.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

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 Kelly Kilpatrick, 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 via web portal 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.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Statutory requirements</td></tr>
<tr><td rowspan="2">Requirement 1

Ref: Regulation 16 (1) (2) (b) (c) (d)

Stated: First time

To be completed by:
28 February 2017</td><td>The registered persons must ensure that care plans are reviewed to confirm that they reflect the current care needs of patients.

Ref: Section 4.4</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
Nursing staff will continue to review care plans to ensure they reflect the resident's current care needs. The Home Manager will monitor this through the auditing process.</td></tr>
<tr><td rowspan="2">Requirement 2

Ref: Regulation 19 (1) (a) Schedule 3 (1) (a) (b) (3) (K)

Stated: First time

To be completed by:
28 February 2017</td><td>The registered person must ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.

Ref: Section 4.4</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
Further supervisions have been carried out with nursing staff in regards to wound management to ensure that records are maintained appropriately. This will be monitored by the Home Manager through the auditing process.</td></tr>
<tr><td colspan="2">Recommendations</td></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 47 Criteria (3)

Stated: Second time

To be completed by:
23 February 2017</td><td>The registered manager should observe staffs moving and handling of patients within the home to ensure training is embedded into practice.

Ref: Section 4.2, 4.3</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
Further supervisions have been carried out with all staff and manual handling training is up to date within the home. The Home Manager will continue to monitor regularly and further training and supervisions will be carried out as required.</td></tr>
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<table>
<tr><td rowspan="2">Recommendation 2

Ref: Standard 44
Criteria (1)

Stated: First time

To be completed by:
28 February 2017</td><td>The registered person should ensure that the schedule for cleaning patients’ rooms includes the dusting of high areas such as the tops of patients’ wardrobes.

Ref: Section 4.3</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
Cleaning schedules include high dusting. Supervisions have been completed with all domestic staff. The housekeeper and Home Manager will monitor this area.</td></tr>
<tr><td rowspan="2">Recommendation 3

Ref: Standard 12

Stated: First time

To be completed by:
7 March 2017</td><td>The registered person should ensure that the patients’ mealtime experience is reviewed to ensure that it is in accordance with DHSSPS Care Standards for Nursing Homes 2015 and best practice guidance.

The following areas should be reviewed:
storage of drinks
medicine rounds conducted during mealtimes
availability of condiments
use of worn drinking glasses
Ref: Section 4.5</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
The Home Manager has reviewed the mealtime experience. Nursing staff do not administer medications during the lunch time and evening meals, unless necessary. Condiments are now available at meals. The storage of drinks and glasses has been reviewed and will be replaced as required.</td></tr>
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Please ensure this document is completed in full and returned via web portal

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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