Our Lady's Home
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Unannounced Care Inspection
of
Our Lady's Home

15 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 15 July 2015 from 10 30 to 18 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, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to section 1.2 below.

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 the 19 March 2015.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent action record regarding the competency and capability of registered nurses who are given the responsibility of taking charge of the home in the absence of the registered manager was issued for the attention of the registered person at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	4

The details of the Quality Improvement Plan (QIP) within this report were discussed with Heather Taggart and Anne Marie Lowry, nursing sisters, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Diocese of Down and Connor Paul Shevlin	**Registered Manager:** See below
Person in Charge of the Home at the Time of Inspection: Heather Taggart	**Date Manager Registered:** Sharon Meenagh, temporary manager, has been in post from 5 February 2015.
Categories of Care: NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 86
Number of Patients Accommodated on Day of Inspection: 82	**Weekly Tariff at Time of Inspection:** £628.00 - £672.00

3. Inspection Focus

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

In addition to the progress examined, information was received by RQIA from a relative regarding care delivery. The relative was advised of the DHSSPS complaints process and advised to speak with the relevant healthcare Trust.

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Following discussion with RQIA senior management, it was agreed that, as an inspection to Our Lady's Home was already scheduled, the focus would be extended to include the pre admission assessment process, security of patient records, complaints management and laundry arrangements.

4. Methods/Process

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

- Discussion with patients
- Discussion with relative
- discussion with staff
- review of records
- observation during a tour of the premises
- evaluation and feedback.

Prior to inspection the following records were analysed:

- inspection report and quality improvement plan from the previous care inspection on 19 March 2015
- incident reports submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005
- records of contacts with RQIA, in regard to the home.

During the inspection, the inspector met with ten patients, eight registered nurses, eleven care staff, two housekeeping staff, two social activity staff and five patient's visitors/representative.

The following records were examined during the inspection:

- patients' care records and associated care charts.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced finance inspection dated 1 July 2015. Given the short timescale between inspections a report of the finance inspection had not been issued at the time of this inspection.

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

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 19(1)(a), schedule 3, 2(k) **Stated:** Second time	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence care delivered. Repositioning charts must also contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning.	**Met**
	Action taken as confirmed during the inspection: There were two systems in place for recording the repositioning of patients. In a number of the units there was an individual book stored in the patients bedroom. In another unit there were daily sheets in use and these were stored at the nursing station. The charts which were stored at the nursing station had some omissions. However as the repositioning charts reviewed generally evidenced that patients were repositioned regularly this requirement is assessed as met. A recommendation is made that the storage of repositioning charts is reviewed to support entries being recorded at the time of care delivery.	
Requirement 3 **Ref**: Regulation 29 (5) (a) **Stated:** Second time	A copy of the report of the unannounced monthly visit must be forwarded to RQIA until further notice.	**Met**
	Action taken as confirmed during the inspection: A copy of the report of the unannounced monthly visits was being forwarded to RQIA and will continue to be until further notice. This requirement has been met.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 25.12 **Stated:** Second time	It is recommended that the action plan from the previous visit should be reviewed at the next visit and all areas commented on.	**Met**
	Action taken as confirmed during the inspection: There was evidence in the monthly report, required under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005 that issuing arising are being reviewed at the subsequent visit. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 13.6 **Stated:** Second time	It is recommended that further training is provided for all registered nurses in the regional procedure for the protection of vulnerable adults. The training must be reflective of their role and responsibility as the nurse in charge of the home. The acting manager must ensure that training is embedded into practice.	**Carried forward for review at a future inspection.**
	Action taken as confirmed during the inspection: Training records were not reviewed during this inspection. However the nurse in charge of the home was aware of the action to take, and the appropriate reporting procedures. This recommendation will be reviewed at a future inspection.	
Recommendation 3 **Ref**: Standard 19.1 **Stated:** First time	Care plans should be further developed to include the following: • Individualised interventions to meet patients assessed need • The specific type of continence products that patients required	**Partially Met**
	Action taken as confirmed during the inspection: Care records reviewed had personal interventions prescribed. However the specific type of continence products that patients required was not included. This recommendation was assessed as partially met and is stated for a second time.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 4 **Ref**: Standard 16.4 **Stated:** First time	All treatment given should be recorded in the care records	**Met**
	Action taken as confirmed during the inspection: Review of care records evidenced that care provided was recorded. This recommendation has been met.	
Recommendation 6 **Ref**: Standard 19.2 **Stated:** First time	Best practice guidance 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.	**Met**
	Action taken as confirmed during the inspection: The nurse in charge confirmed that best practice guidance was available in the home. 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 five relatives evidenced that staffing levels were appropriate to meet the needs of the patients in a timely manner; acknowledgement was made of the substantial use of registered nurses supplied by nursing agencies. Recruitment was ongoing for registered nurses and the home was attempting to block book nurses from agencies to mitigate against inconsistency of care. A significant period of time was spent with the nursing sisters discussing the impact of the current difficulties the home is experiencing with recruitment and retention of nurses.

Discussion took place regarding the nurse in charge of the home in the absence of the registered manager. One nursing sister had identified herself as the nurse in charge of the home. The nurse in charge was not identified on any of the duty rotas; staff throughout three of the five units within the home did not know there was a nurse identified to take charge of home.

Following discussion with the nursing sister it was acknowledged by the inspector and the member of staff that they had limited understanding of the extent of the role and did not have the necessary operational knowledge to fulfil it competently. The two nursing sisters spoken with were not aware of any competency and capability assessment being completed with registered nurses who were left in charge of the home in the absence of the manager. It is required that the registered person must ensure that any nurse who is given the responsibility of being in charge of the home for any period in the absence of the manager has been assessed as competent and capable to undertake this role. It is recommended that the registered nurse identified to take charge of the home in the absence of the registered manager is clearly identified on the duty rotas throughout the home.

A review of notifications to RQIA evidenced that the home notified RQIA of patient related incidents in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. However a complaint made against a member of staff, alleging staff misconduct, had not been notified. Whilst confirmation was provided that appropriate action had been taken with the staff member it is required that allegations of staff misconduct are notified to RQIA.

Is Care Effective? (Quality of Management)

There are currently temporary management arrangements in place. The temporary manager was supported by four unit sisters. There were systems in place, for example a 24 hour managers' report which was completed at the end of each 12 hour shift, to inform the manager of the day to day operation of the home. This written report provided the manager with an overview of hospital admissions, GP visits and staffing issues. Staff spoken with confirmed that the manager visited each unit at the commencement of her shift for a verbal report. Relatives and patients spoken with confirmed that they knew who the manager was and how to contact her if they had concerns.

Review of four care records evidenced that a range of assessments and risk assessments, for example moving and handling, nutrition and pain assessments, had been completed for patients.

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 ten 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 relative confirmed that they were happy with the standard of care and communication with staff in the home. They confirmed that they were confident that any issues raised with the manager or nursing sisters would be addressed.

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.

Staff in the dementia unit commented on the absence of a nursing sister in their unit; active recruitment was ongoing. The staff team reported that, when the manager was off they felt isolated and had to deal with issues independently. Through discussion it became aware that that they did not know that, in the absence of the manager, there was designated nurse in charge of the home to support them. Staff were confident that any issues brought to the attention of the manager would be addressed.

Number of Requirements:	2	**Number of Recommendations**:	1

5.4 Additional Areas Examined

5.4.1 Pre admission assessment process

The nursing sisters confirmed that pre admission assessments were generally completed by them on a pre-admission visit. Discussion with three of the nursing sisters evidenced that they had a good understanding of the categories of care the home was registered for and the importance of the comprehensive assessments provided by the commissioning healthcare trust.

5.4.2 Security of patients records

Patients care records were maintained on a computerised system, with a terminal located in each nursing office throughout the home. As previously discussed in a number of the units, individualised booklets containing care charts, for example fluid intake charts, repositioning charts, were held in patients bedrooms. These booklets were stored in a wall mounted document holder and the inspector was satisfied that given the nature of the information recorded, the storage was appropriate.

The nursing sister on one unit stated that the storage of records had recently been reviewed to ensure that patent records, for example behaviour charts, were not left in communal areas but returned to the nursing office for safe storage.

5.4.3 Complaints management

Three nursing sisters spoken with were knowledgeable of how to respond appropriately to complaints and the reporting procedure within the home.

5.4.4 Laundry services

Nursing sisters and housekeeping staff confirmed that there were laundry staff on duty seven days a week providing a full range of laundry services daily. Confirmation was given that there were arrangements in place to provide cover when laundry staff were on leave.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Heather Taggart and Anne Marie Lowry, nursing sisters 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	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 20(3) **Stated:** First time **To be Completed by:** 12 August 2015	The registered person must ensure that any nurse who is given the responsibility of being in charge of the home for any period in the absence of the manager has been assessed as competent and capable to undertake this role.
	Response by Registered Person(s) Detailing the Actions Taken: All nurses given responsibility of being in charge of the Home are being assessed as competent and capable to undertake the role.
Requirement 2 **Ref:** Regulation 30(1)(g) **Stated:** First time **To be Completed by:** 12 August 2015	The registered person must ensure RQIA are notified of all events within the home in keeping with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.
	Response by Registered Person(s) Detailing the Actions Taken: All nursing Sisters on each Unit have been made aware of the importance of reporting all events in keeping with Regulation 30 of the Nursing Home regulations and have passed this on to their nurses.
Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be Completed by:** 26 August 2015	It is recommended that the storage of repositioning charts is reviewed throughout the home to support entries being recorded at the time of care delivery.
	Response by Registered Person(s) Detailing the Actions Taken: Repositioning chartsare held in individualised booklets in each resident's room to support entries being recorded at time of delivery.
Recommendation 2 **Ref**: Standard 13.6 **Stated:** Second time **To be Completed by:** 26 August 2015	It is recommended that further training is provided for all registered nurses in the regional procedure for the protection of vulnerable adults. The training must be reflective of their role and responsibility as the nurse in charge of the home. The acting manager must ensure that training is embedded into practice.
	Response by Registered Person(s) Detailing the Actions Taken: Vulnerable Adult Training for Nurses is ongoing by the registered manager and Unit Sisters.

Recommendations	
Recommendation 3 **Ref**: Standard 19.1 **Stated:** Second time **To be Completed by:** 26 August 2015	Care plans should be further developed to include the following: • Individualised interventions to meet patients assessed need • the specific type of continence products that patients required.
	Response by Registered Person(s) Detailing the Actions Taken: Care plans are being further developed to include individualised interventions for each patient and include specific continence products for each patient.
Recommendation 4 **Ref**: Standard 41 **Stated:** First time **To be Completed by:** 12 August 2015	It is recommended that the registered nurse identified to take charge of the home in the absence of the registered manager is clearly identified on the duty rotas throughout the home.
	Response by Registered Person(s) Detailing the Actions Taken: The designated registered nurse to take charge of the Home in the absence of the Registered Manager is clearly identified on the Duty Rotas on each Unit and the "In-Charge" file.

Registered Manager Completing QIP	Sharon Meenagh	**Date Completed**	7/9/15
Registered Person Approving QIP	P G Shevlin	**Date Approved**	7/9/15
RQIA Inspector Assessing Response	Sharon McKnight	**Date Approved**	10-09-15

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