Unannounced Care Inspection Report
13 and 18 June 2019

Somerton Private Nursing Home

Type of Service: Nursing Home (NH)
Address: 77 Somerton Road, Belfast, BT15 4DE
Tel No: 0289077 6786
Inspector: Julie Palmer
Estates Support Officer: Gemma McDermott

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 26 patients.

3.0 Service details

Organisation/Registered Provider: Somerton Private Nursing Home **Responsible Individuals:** Henry Enda McCambridge Paul Henry McCambridge	**Registered Manager and date registered:** Dhimi Daniel 15 January 2018
Person in charge at the time of inspection: Dhimi Daniel	**Number of registered places:** 26
Categories of care: Nursing Home (NH) DE – Dementia	**Number of patients accommodated in the nursing home on the day of this inspection:** 25

4.0 Inspection summary

An unannounced inspection took place on 13 June 2019 from 09.10 hours to 16.25 hours. The inspection was undertaken by the care inspector. The estates support officer also visited the home on 18 June 2019 from 11.15 hours to 12.00 hours.

The inspection assessed progress with all areas for improvement identified in the home since the last care and premises inspections and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staffing, risk management, the environment, care delivery, communication, the culture and ethos of the home, activities, governance and management arrangements.

Areas requiring improvement were identified in relation to updating the relevant documentation following a fall, management of pressure relieving mattresses and recording the effects of medication given in the management of distressed reactions.

Patients described living in the home as being a good experience. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Dhimi Daniel, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent inspection dated 14 November 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 14 November 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including estates, pharmacy or finance issues, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

A lay assessor was present during this inspection and their comments are included within this report. A lay assessor is a member of the public who will bring their own experience, fresh insight and a public focus to our inspections. Comments received by the lay assessor are included within this report.

The following records were examined during the inspection:

- duty rota for all staff from 10 to 23 June 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- four patients' care records including food and fluid intake charts and repositioning charts
- a sample of governance audits/records
- complaints and compliments record
- a sample of monthly monitoring reports from November 2018
- staff supervision and appraisal schedule
- annual quality report
- registered nurse competency records
- RQIA registration certificate

Areas for improvement identified at the last care and premises inspections were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of outstanding areas for improvement from previous inspections

Areas of improvement identified at the previous care inspection have been reviewed. Of the total number of areas for improvement, all were met.

Areas of improvement identified at the previous estates inspection have been reviewed. Of the total number of areas for improvement, all were met.

There were no areas for improvement identified as a result of the last medicines management inspection.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed the planned daily staffing levels for the home and that these were subject to monthly review to ensure the assessed needs of the patients were met. A review of the staffing rota from 3 to 16 June 2019 evidenced that the planned daily staffing levels were adhered to.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Staff attended to patients' needs in a timely and caring manner; call bells were answered promptly and patients who were in their rooms were observed to have call bells within reach.

Feedback from patients, relatives and staff during and/or following the inspection was generally very positive in regard to staffing levels; one completed staff questionnaire did indicate that the staff member was very unsatisfied, although there were no additional comments to tell us why they felt this way. Comments from patients' relatives included the following:

- "Very good, awfully nice staff."
- "I can go home knowing he is safe and that is a great feeling."

Also, staff told the inspector that, typically, short notice sick leave was managed by using other available staff who would work these required shifts; one staff member commented "We work well together".

Review of two staff recruitment and induction files evidenced that appropriate pre-employment checks had been completed to ensure staff were suitable to work with patients in the home.

Discussion with staff and review of records confirmed they had completed a period of induction when they commenced employment in the home. Staff spoken with also confirmed that they received regular supervision and a yearly appraisal. Review of the staff supervision and appraisal schedule and the nurses' competency and capability schedule evidenced that staff were supported to carry out their role and were competent to do so.

Review of records confirmed there was a system in place to monitor the ongoing registration status of nursing staff with the NMC and care staff with NISCC.

Discussion with staff confirmed they were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding, their duty to report concerns and the home's whistleblowing policy. Staff were aware that the registered manager was the Adult Safeguarding Champion for the home.

Infection prevention and control (IPC) measures were observed to be adhered to within the home. Personal protective equipment (PPE) such as gloves and aprons were readily available and stations were well stocked. Staff were observed to use PPE appropriately and to carry out hand hygiene as necessary.

Discussion with the registered manager and review of records confirmed that, on at least a monthly basis, falls occurring in the home were analysed to identify if any patterns or trends were emerging and an action plan was devised if necessary.

The use of potentially restrictive practices, such as bedrails, was also reviewed and validated risk assessments and care plans were completed prior to use. There was evidence of consultation with the patient and/or their representative and consent was obtained where appropriate.

We reviewed the home's environment; this included observations of a sample of bedrooms, bathrooms, lounges, the dining room, laundry, treatment room, sluice and storage areas. The home was found to be warm, well decorated and fresh smelling throughout. Patients' bedrooms were tastefully decorated and had been personalised with items such as pictures and ornaments that were meaningful to them.

An area for improvement had been identified at the previous care inspection regarding effective cleaning of the domestic store and hopper. Review of the environment confirmed this area for improvement had been met. The home was observed to be clean and tidy throughout. A patient spoken with commented on how "lovely and clean" the home was.

Fire exits and corridors were observed to be clear of clutter and obstruction. Review of training records confirmed that staff were provided with two fire safety training sessions per year.

We reviewed arrangements to ensure that the mandatory training needs of staff, including manual handling training, were robust. The registered manager confirmed that a system had been introduced to monitor mandatory training along with a training schedule for staff. Review of records evidenced that all staff had received face to face moving and handling training since the previous care inspection and the majority of them had also completed online training in this area. We observed that staff were compliant with mandatory training requirements and they told us that they had sufficient time to undertake such training. These areas for improvement had been met.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

We observed the daily routine in the home and it was obvious that staff knew the patients well and treated them with dignity and respect. Patients received the right care at the right time and staff had a good understanding of their care needs. Staff demonstrated effective communication skills and were sensitive to the differing needs of patients in this area.

Patients spoken with during the inspection were satisfied that their care needs were met. Patients who were unable to express their views appeared to be content and settled, both in their surroundings and in their interactions with staff.

We reviewed four patients' care records and these evidenced that individualised care plans were in place to direct the care required and reflected the assessed needs of the patients. We reviewed the management of nutrition, falls, wounds and pressure area care. Care records reviewed contained details of patients' assessed care needs in these areas and a daily record was maintained to evidence the care which was being provided.

Discussion with the registered manager and review of records confirmed that patients' weights were monitored on at least a monthly basis. There was evidence of staff making contact with other healthcare professionals, such as the dietician or speech and language therapist (SALT), if required and subsequently following their recommendations. Patients' nutritional needs were identified and validated risk assessments were in place to direct care planning and delivery. Review of patients' supplementary care charts evidenced that food and fluid intake was recorded and these records were up to date.

We reviewed the management of falls in the home. The care records reviewed evidenced that appropriate risk assessments were in place and these were used to help inform care which was person centred. Staff spoken with demonstrated their knowledge of measures to prevent falls and how to provide care for a patient who had a fall. However, we observed that in the care records reviewed, risk assessments and care plans had not always been updated in the event of a fall; an area for improvement was made.

We reviewed the management of wounds in the home. The care records reviewed evidenced that care plans were in place to direct the care required and these reflected recommendations from other healthcare professionals, such as the podiatrist, where necessary. Recording on wound charts and in the daily records was up to date and confirmed that identified patients' wounds were being dressed as needed.

Validated risk assessments and care plans were in place to direct care for the prevention of pressure ulceration. However, we observed that not all pressure mattresses were maintained at the correct setting for the individual patient's weight. This was brought to the attention of the registered manager and we were reassured that none of the patients had any pressure damage. The registered manager assured us that the settings on all pressure relieving mattresses in use would be reviewed and adjusted immediately. An area for improvement was made in relation to the use and monitoring of pressure relieving mattresses for patients.

We reviewed the management of patients who may display distressed reactions, including the use of prescribed medications. Care plans were individualised and person centred, these included details of possible triggers, the type of distressed reaction and how to help prevent or de-escalate the reaction. However, we observed that when medication was administered to help patients exhibiting these type of reactions, the effect which this had on patients was not consistently documented by staff; an area for improvement was made.

We observed the serving of lunch; there were two sittings in the dining room and staff also took meals on trays to patients who preferred to eat in the lounge or their bedroom. The dining room was pleasantly decorated and the menu was clearly displayed. Staff assisted patients into the dining room and ensured they were offered a choice of drinks throughout the meal. Patients were offered assistance where necessary and those who were able to helped themselves to drinks; staff encouraged patient involvement in meal time tasks and with independent eating where possible.

A nurse was in attendance throughout the meal. The food on offer smelled appetising and was well presented. Staff helpfully assisted patients, they demonstrated their knowledge of patient likes and dislikes, how to thicken fluids and which patients required a modified diet. Patients were offered an alternative choice of meal if they changed their mind. Staff chatted to patients and were caring and considerate. The dining experience was calm, relaxed and unhurried.

Patients spoken with following the meal said they had enjoyed their lunch, comments included:

- "The food is great."
- "Great place, great food."

We observed that staff appeared to work well together and staff spoken with were positive about teamwork and morale in the home. Staff demonstrated their knowledge of their own roles and responsibilities. Staff told us that "everyone seems to get on well" and "teamwork is great".

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the daily routine, risk assessment, teamwork, the meal time experience and communication between patients, staff and other key stakeholders.

Areas for improvement

Areas for improvement were identified in relation to care records regarding falls management, the use of pressure relieving mattresses and managing distressed reactions.

	Regulations	Standards
Total number of areas for improvement	0	3

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 09.10 hours and were met by staff who were friendly and welcoming. We observed daily life in the home throughout the day and noted that staff displayed a consistently pleasant and comforting approach to the patients in their care.

During the inspection we spoke with 19 patients both individually and in small groups. Patients who were unable to communicate their opinions appeared to be content and settled. Patients were well presented in clean clothes that matched and it was obvious that attention had been paid to all aspects of their personal care and grooming. A relative spoken with commented that her husband's shirts were changed daily and were always ironed.

Patients who were able to communicate verbally commented:

- "Very friendly staff, no complaints."
- "Nothing is too much trouble."
- "Activities are great, I love football."

The lay assessor observed an activity session in one of the lounges; the activity co-ordinator encouraged patients to join in and it was evident from their smiles that they were enjoying themselves and having fun. Staff spoken with said that the "activities are fantastic" and we observed that they also joined in to assist and cheer on the patients.

The activity co-ordinator spoke enthusiastically about her role and was obviously keen to ensure that the interests of all patients were catered for. It was clear from discussions with staff that they knew the patients very well and took an interest in their life histories and backgrounds.

Activities provided in the home included singing, dancing, ball games, hand massage, manicures, games, painting, crafts, pet therapy sessions and a monthly visit from a 'music man'.

Local community involvement was encouraged; nursery school children visit once a month and visits were arranged from local churches on a regular basis.

Staff demonstrated their knowledge of when to provide comfort and support to the patients in their care and we observed very pleasant and caring interactions throughout the day. Staff spoken with were passionate about providing the right care for patients, they told us:

- "I love it here."
- "I love it here, I find it very friendly and homely."
- "I like it here, I like this kind of work."

Observation of care delivery evidenced that staff treated patients with dignity and respect. Patients were offered choice and the daily routine appeared to be flexible according to patients' needs and wants. We observed that staff knocked on bedroom and bathroom doors before entering and ensured doors were closed when delivering care to preserve patients' privacy.

Patients' visitors spoken with commented positively about their experience of how their loved ones were cared for, they said:

- "The care is excellent."
- "Brilliant, haven't a bad word to say."
- "No complaints at all."
- "… is fine here, well looked after."
- "… health has improved since she came in here."

Thank you cards were displayed in the office for the attention of staff. A relative had written on a card we viewed "Thank you for all the care and love and nursing that wee … got in your care".

We reviewed the annual quality report for 2018; it was informative and included the views of patients, their relatives and staff. A relatives' meeting was held in May 2019 and a record was maintained. Patients' visitors told us they were satisfied with the levels of consultation and communication they received in respect of their relatives.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their relatives and the activities on offer.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was displayed in the entrance hall of the home. Discussions with staff and observations confirmed that the home was operating within the categories of care registered.

There has been no change in management arrangements since the last inspection. A review of the duty rota evidenced that the registered manager's hours and the capacity in which these were worked were clearly recorded.

Discussion with staff, patients and visitors confirmed that the registered manager's working patterns allowed for plenty of opportunities to meet with her if necessary and that she was accessible and approachable. One relative told us that "we had an issue recently and it was dealt with very quickly". Staff, patients and patients' visitors were all on first name terms with the registered manager.

Discussion with the registered manager and review of a selection of governance audits evidenced that systems were in place to monitor and evaluate the quality of nursing care and other services provided in the home and to ensure action was taken as a result of any deficits identified to drive quality improvement. Audits were completed to review areas such as accidents/incidents, IPC measures, falls, complaints, care plans and wounds.

Review of the complaints record evidenced that systems were in place to ensure complaints were appropriately managed. The complaints procedure was displayed in the home and patients and patients' visitors spoken with were aware of the process.

Staff spoken with were aware of the home's whistleblowing policy and their responsibilities around reporting concerns.

Reporting incidents that occur in the home to RQIA had been identified as an area for improvement at the previous care inspection. Discussion with the registered manager and review of records evidenced that the system in place to ensure notifiable events were investigated and reported to RQIA or other relevant bodies appropriately was robust. A record of any notifiable events reported to RQIA or other relevant bodies was maintained.

The monthly monitoring reports completed by the registered provider had been identified as an area for improvement at the previous care inspection. We reviewed the reports completed since November 2018. The reports included a review of the previous action plan, comments and feedback from patients, patients' visitors and staff, an overview of events that had occurred in the previous month, an environmental review, quality improvement areas and an action plan. This area for improvement had been met.

We observed that staff understood the different communication needs of patients in the home and effectively and sensitively met their needs in this area. Staff were observed to be kind, caring and considerate towards patients; they responded to non-verbal cues and gestures where necessary.

Review of records evidenced that staff meetings were held on a quarterly basis and staff told us that they felt their views and opinions were listened to and respected.

Assessment of premises

A current fire risk assessment for the premises was in place and the significant findings had been addressed in a timely manner. The fire risk assessment was undertaken by a company holding professional body registration for fire risk assessors.

The servicing of the fire alarm and detection system, the emergency lighting installation and fire-fighting equipment was being undertaken in accordance with current best practice guidance. Extensive user checks were also being documented and maintained.

A current risk assessment with regard to the control of legionella bacteria in the premises' hot and cold water systems was in place and the significant findings were being addressed within timescales stipulated by the risk assessor. The servicing of these systems and the user checks were being maintained in accordance with current best practice guidance.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Dhimi Daniel, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 22 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all relevant risk assessments and care plans are updated as part of the post falls assessment carried out within 24 hours of a fall. Ref: 6.4
	Response by registered person detailing the actions taken: All nurses received supervision with regards to the identified issue and audit will be carried out by home manager
Area for improvement **Ref**: Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure pressure relieving mattresses in use in the home are maintained at the appropriate setting for the individual patient in accordance with NICE best practice guidelines on management and prevention of pressure ulceration. A robust system should be introduced to monitor these settings. Ref: 6.4
	Response by registered person detailing the actions taken: Identified issue were discussed with all staff and developed a check list for matress settings to ensure pressure relieving mattress in use in the home are maintained at right setting for the individual patient
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that where medication is administered for the management of distressed reactions, the effect and/or side effects of this is recorded. Ref: 6.4
	Response by registered person detailing the actions taken: Reminded all nurses to ensure the reason and effect of medication administered for the management of distessed reaction is documented in the specified recording sheet and medication administration sheet of respective service users

Please ensure this document is completed in full and returned via Web Portal

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