Unannounced Care Inspection Report
26 July 2018

The Somme

Type of Service: Nursing Home
Address: 121 Circular Road, Belfast, BT4 2NA
Tel no: 028 9076 3044
Inspector: James Laverty

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 50 persons.

3.0 Service details

Organisation/Registered Provider: Board of Directors **Responsible Individual:** Charles Jonathan Kitson	**Registered Manager:** Leigh Patience
Person in charge at the time of inspection: Upon arrival: Staff Nurse Brenda Mallen 09.00 onwards: Leigh Patience	**Date manager registered:** 29 June 2017
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of registered places:** 50 comprising NH-I, NH-PH, NH-PH(E), NH-TI

4.0 Inspection summary

An unannounced inspection took place on 26 July 2018 from 06.30 to 16.00 hours.

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 Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and since the last inspection 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 monitoring the professional registration of staff, fire safety, communication with the multi-professional team and staff communication.

One area for improvement under regulation was stated for a second time in relation to the nutritional care of patients.

One area for improvement under the standards was identified in relation to falls management.

Patients said that they were well cared for and expressed confidence in the ability and willingness of staff to meet their care needs. No negative comments concerning nursing care or service delivery were expressed by patients during the inspection.

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	*1	1

*The total number of areas for improvement includes one regulation which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Leigh Patience, 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.

4.2 Action/enforcement taken following the most recent inspection dated 18 December 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 18 December 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

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report
- pre-inspection audit

During the inspection the inspector and lay assessor met with 10 patients, five staff and one patient's relative. Questionnaires were left in the home to obtain feedback from patients and patients' representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA directly.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records for the period 2018/19
- incident and accident records
- one staff recruitment and induction file
- six patients' care records;
- one patients' food/fluid balance supplementary care records
- the matrix for staff supervision and appraisal
- a selection of governance audits relating to infection control; supplementary care charts and care records
- complaints records
- adult safeguarding records and notifiable incidents to RQIA
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 18 December 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector who validated it during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 18 December 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 29 **Stated:** Second time	The registered persons must ensure that a robust system of monthly quality monitoring visits is completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes 2015.	**Met**
	Action taken as confirmed during the inspection: Review of monthly monitoring visit reports for both June 2018 and July 2018 confirmed that a robust system of monthly quality monitoring was in place and that such visits had recently been completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes 2015. Review of the June 2018 report did highlight one factual inaccuracy which was highlighted to the registered manager. The need to ensure that such reports are completed in a consistent and accurate manner at all times was emphasised.	

Area for improvement 2 **Ref:** Regulation 12 (1) (a)(b), **Stated:** First time	The registered persons must ensure the following in relation to the provision and delivery of nutritional care: • that food and fluid intake records are completed contemporaneously, accurately and consistently by staff, • that patients' weights are recorded contemporaneously, accurately and consistently by staff, • that nutritional assessments are completed accurately and with appropriate action being taken by nursing staff in response to the outcome of such assessments, • that staff provide nutritional care in compliance with all recommendations made by the multiprofessional care team, • that daily nursing records accurately reflect the nutritional status of patients.	**Partially met**
	Action taken as confirmed during the inspection: Review of the care record for one patient who required a modified diet and ongoing nutritional care confirmed that a person centred and comprehensive care plan and relevant risk assessment were in place and had been reviewed in a timely manner by nursing staff. Care records further evidenced that the patient's weight had been recorded regularly. However, deficits were noted in regards to other components found within the care record relating to nutritional care and these are discussed further in section 6.5. This area for improvement has been partially met and has been stated for a second time.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 35 **Stated:** Second time	The registered persons shall ensure that a more robust system of audits is implemented to ensure the home delivers services effectively in accordance with legislative requirements, minimum standards and current best practice, specifically in relation to auditing supplementary care records.	**Met**

	Action taken as confirmed during the inspection: Discussion with the registered manager and review of supplementary care record audits did confirm that a system of auditing, specifically relating to supplementary care records, had been implemented. While the audits which had been completed by the registered manager were completed effectively, there remained shortfalls in relation to the standard with which staff had completed some food/fluid supplementary care records. This is discussed in the preceding area for improvement and also in section 6.5. The need to embed further into practice any learning derived from the aforementioned audits was stressed.	
Area for improvement 2 **Ref**: Standard 46 **Stated:** First time	The registered persons shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk and spread of infection.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment and discussion with the registered manager confirmed that this area for improvement had been satisfactorily addressed.	

6.3 Inspection findings

6.4 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 levels were subject to a monthly review to ensure that the assessed needs of patients were met. Discussion with the registered manager further confirmed that contingency measures were in place to manage short notice sick leave when necessary. The registered manager advised that from 9 to 22 July 2018 there were no occasions when planned staffing levels were not fully adhered to due to. Discussion with patients and staff provided assurances that they had no concerns regarding staffing levels.

Discussion with the registered manager and review of governance records evidenced that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through a process of both bi-annual supervision and annual appraisal.

Discussion with the registered manager indicated that training was planned to ensure that mandatory training requirements were met. Additional face to face training was also provided, as required, to ensure staff were enabled to meet the assessed needs of patients. Staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

Review of governance audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. However, weaknesses were found within the care record of one patient who had sustained an unwitnessed fall. This is considered further in section 6.5.

Discussion with the registered manager evidenced that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The registered manager also confirmed that an 'adult safeguarding champion' (ASC) was identified for the home. The registered manager advised that the ASC position report would be compiled within expected timescales.

Review of notification records evidenced that all notifiable incidents were reported to the Regulation and Quality Improvement Authority (RQIA) in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records evidenced that there were effective arrangements for monitoring and reviewing the registration status of nursing staff with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC). Records confirmed that the registered manager had reviewed the registration status of staff on a monthly basis.

An inspection of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Patients' bedrooms, lounges and dining rooms were found to be warm and comfortable. The majority of patients' bedrooms, were personalised with photographs, pictures and personal items. Discussion with the registered manager highlighted that the main dining area within the home had been recently refurbished and that this had been well received by both patients and their relatives/representatives. No patients who were spoken with throughout the inspection expressed any concerns regarding the environment of the home. Furthermore, one patient spoke in enthusiastic terms about how they had been actively involved with gardening activities within a newly created interior courtyard area.

Deficits with regards to the delivery of care in compliance with infection, prevention and control best practice standards were noted, namely: two crash mats which were in use by patients were noted to be torn and unlaminated signage was observed within the reception area. These deficits consequently impacted the ability of staff to deliver care in compliance with IPC best practice standards and guidance. The registered manager agreed to address these shortfalls immediately.

Fire exits and corridors were observed to be clear of clutter and obstruction. Observation of staff on the day of inspection also evidenced that they adhered to safe fire practices and that fire training was consistently embedded into practice.

It was noted that a portable oxygen cylinder was located within one patient's bedroom. Discussion with the registered manager confirmed that the patient used this oxygen equipment within their bedroom on occasion. The importance of ensuring that appropriate signage is erected, as necessary, which alerts patients/staff and/or visitors to the presence of oxygen being used was emphasised.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example bed rails and alarm mats. There was also evidence of consultation with patients' relatives/representatives, as appropriate. Comprehensive and person centred care plans were in place for the management of restrictive practices.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to monitoring the professional registration of staff and fire safety.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Discussion with staff and the registered manager evidenced that nursing/care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' conditions and that they were encouraged to contribute to the handover meeting.

Staff who were spoken with stated that that if they had any concerns, they could raise these with their line manager and/or the registered manager. Staff spoke positively about working within the home.

Upon arrival to the home, the inspector was advised by nursing/care staff that one patient had already been assisted with personal care and getting dressing. Observation of this patient at 06.59 evidenced that the patient was fully dressed in their day clothes (excluding their shoes) although was asleep and lying in bed under their duvet. The patient's bedroom curtains were observed to be open with the result that the room appeared to be bright and not conducive to sleep. Discussion with two care staff on duty confirmed that the patient had received such assistance at approximately 06.30 hours. The inspector was not assured following discussion with nursing/care staff that the care which had been provided to the patient at approximately 06.30 hours was sufficiently patient centred. This practice was immediately highlighted to the registered

manager following her arrival to the home and the need to ensure that all routines within the home are person centred, specifically, assisting patients with washing and dressing each morning, was stressed. It was further agreed that all morning interventions should be clearly and consistently evidenced within the nursing record. All other observations of patients throughout the home did not highlight any concerns with regards to early morning staff practices/routines. While it was noted that signage erected by the registered manager included details of those patients who should be assisted with being showered and dressed by night staff on duty, discussion with nursing staff and the registered manager confirmed that such assistance should only be carried out in a patient centred manner and at the direction/oversight of nursing staff on duty.

Review of care records evidenced multi-disciplinary working and collaboration with professionals such as GPs, Tissue Viability Nurses (TVN) dieticians and speech and language therapists (SALT). Regular communication with representatives within the daily care records was also found.

Care records also evidenced that a range of validated risk assessments were used and informed the care planning process. Such risk assessments and care plans for one patient were found to have been written and kept under review by nursing staff in a timely manner. This practice is commended.

Review of the care record for one patient who required ongoing wound care evidenced that relevant care plans and risk assessments had been completed in a comprehensive manner by staff. However, it was noted that while the patient's wound had been photographed by nursing staff in keeping with best practice, the method used by staff to facilitate the photographic referencing of wounds was inadequate. It was also found that some supplementary wound care records had been partially completed. While discussion with nursing staff and review of the care record confirmed that the patient's wound had not deteriorated, the need to satisfactorily address these weaknesses was agreed with the registered manager. This will be reviewed during a future care inspection.

Review of the care record for one patient who was assessed as being at a moderate risk of pressure sores confirmed that a person centred and detailed care plan was in place which would assist staff in the delivery of effective pressure area care. Discussion with staff and review of the care record highlighted that staff were aware of the need to reposition the patient. The regular repositioning of the patient was periodically referenced within daily nursing records by registered nursing staff. However, while the care plan directed staff to assist the patient with repositioning every three to four hours, there were no supplementary repositioning records to evidence that such care had been delivered in a consistent manner in keeping with the aforementioned care plan. Nursing and care staff stated that the patient was regularly repositioned and confirmed that that the patient's skin was intact. The need to ensure that repositioning care charts are maintained in accordance with best practice guidance and which evidence the delivery of prescribed care was highlighted to both nursing staff and the registered manager. This will be reviewed during a future care inspection.

In addition, care records for one patient who had experienced an unwitnessed fall were reviewed. It was noted that a falls risk assessment had been completed along with a relevant and person centred care plan. However, review of daily nursing entries highlighted that staff had not documented the recording of any clinical observations as part of their post falls management of the patient. The need to ensure that nursing staff document the post falls management of patients in a comprehensive and accurate manner at all times was stressed. An area for improvement under the standards was made.

Weaknesses were also noted with regards to the provision of nutritional care to patients. Review of the care record for one patient who required a modified diet and ongoing nutritional care confirmed that a person centred and comprehensive care plan and relevant risk assessment were in place and had been reviewed in a timely manner by nursing staff. Care records further evidenced that the patient's weight had been recorded regularly. However, it was found that supplementary food/fluid intake records were either incomplete and/or did not evidence that staff had reviewed the patient's fluid intake against the identified daily fluid target. It was also noted that the patient's daily fluid intake was inaccurately referenced within daily nursing entries. These shortfalls were highlighted to the registered manager and an area for improvement was stated for a second time.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication with the multi-professional team and staff communication.

Areas for improvement

One area for improvement under regulation in relation to nutritional care was stated for a second time.

One area for improvement under the standards was identified in relation to falls management.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 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.

Staff interactions with patients were observed to be compassionate and caring. All patients were positive in their comments regarding the staffs' ability to deliver care and respond to their needs and/or requests for assistance. Discussion with the registered manager and staff confirmed that they were aware of the need to deliver care in a holistic and person-centred manner.

Feedback received from several patients during the inspection included the following comments:

- "I'm very happy with the home … the Matron is my go-to person."
- "The care here is … fantastic."
- "The staff are lovely."

Feedback received from one patient's relative highlighted some dissatisfaction with the dining experience of the patient and it was agreed that they would raise these concerns directly with the registered manager. The registered manager was also advised of this feedback during the inspection.

In addition to speaking with patients, patients' relatives and staff, RQIA provided 10 questionnaires for patients and 10 questionnaires for patients' relatives/representatives to complete. A poster was also displayed for staff inviting them to provide online feedback to RQIA.

At the time of writing this report, no questionnaires have been returned within the specified timescales. Questionnaire comments received after specified timescales will be shared with the registered manager as necessary.

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.

There were systems in place to obtain the views of patients and their representatives in relation to the delivery of care and the management of the home.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Observation of the breakfast time meal evidenced that patients were given a choice in regards to the meals being served. The dining area appeared to be clean, tidy and appropriately spacious for patients and staff. Staff demonstrated a good knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plans and associated SALT dietary requirements. Discussion with the registered manager and chef evidenced that efforts had been made to make modified meals more attractive for those patients requiring such a diet. Photographic evidence of such meals demonstrated that modified meals had been presented in a manner to closely resemble dishes which patients could recognise and were visually appetising. This practice is commended.

It was noted that one kitchenette area within the home lacked appropriate signage for patients and/or visitors. This was highlighted to the registered manager who agreed to ensure that relevant signage was erected.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication with patients and promoting the dining experience for patients especially those requiring modified diets.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 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.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. All staff spoken with were able to describe their roles and responsibilities and confirmed that there were good working relationships within the home. Staff also stated that management was responsive to any suggestions or concerns raised. 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 registered manager confirmed that there was a system in place to ensure that policies and procedures for the home were systematically reviewed on a three yearly basis.

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.

Patients spoken with confirmed that they were aware of the home's complaints procedure and that they were confident the home's management would address any concerns raised by them appropriately. It was also confirmed with the registered manager that any expression of dissatisfaction should be recorded appropriately as a complaint. It was noted that the complaints policy which was on display within the main reception area had an incorrect telephone number for RQIA and this was highlighted to the registered manager. Discussion with one patient highlighted that they had recently expressed some dissatisfaction with the responsible person concerning issues regarding the premises. However, this had not been recorded within the complaints record. It was stressed to the registered manager that any expressions of dissatisfaction must be recorded and managed within the complaints process.

Discussion with the registered manager and a 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.

A review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and Trust representatives. An observation concerning one factual inaccuracy within a monthly monitoring report is discussed in section 6.2.

Staff recruitment information was available for inspection and records for one staff member evidenced that all relevant checks including enhanced AccessNI checks were sought, received and reviewed prior to them commencing work in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The registered manager confirmed that the equality data collected was managed in line with best practice guidance.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and that minutes were maintained. Staff confirmed that such meetings were held and that the minutes were made available.

A 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 IPC practices, patients' care records and falls. The registered manager stated that such audits were regularly completed by both herself and the deputy manager. Review of care plan audits which was conducted for two patients on 11 April 2018 highlighted that while the audits had correctly identified some deficits which were referenced within a corresponding action plan, there was no evidence that the action plan had been effectively reviewed with corrective actions having been taken. Another audit which focused on infection control and which had been conducted on 26 March 2018 also highlighted that the produced action plan had not been effectively reviewed. The need to ensure that any action plans produced as a result of such auditing are effectively reviewed in a timely manner was stressed. This will be reviewed during a future care inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the selection and recruitment of staff and staff meetings.

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 Leigh Patience, 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 12 (1) (a)(b), **Stated:** Second time **To be completed by:** With immediate effect	The registered persons must ensure the following in relation to the provision and delivery of nutritional care: • that food and fluid intake records are completed contemporaneously, accurately and consistently by staff • that daily nursing records accurately reflect the nutritional status of patients Ref: 6.5
	Response by registered person detailing the actions taken: Daily entries are always made by care and nursing staff in relation to food and fluid intake through the homes epicare system. Auidts of monitoring charts are completed with action plans and time scales applied.
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 nursing staff document the post falls management of patients in a comprehensive and accurate manner at all times, including the recording of clinical and/or neurological observations as appropriate. Ref: 6.5
	Response by registered person detailing the actions taken: A comprehensive post falls management plan is in place for all residents. These procedures are also included within RN induction programs and moving and handling traing sessions. Whilst post fall observations are always recorded within the incident form nursing staff have also been advised to ensure this information is dupicatred within the nursing records on the comouterised epicare system.

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

The Regulation and Quality Improvement Authority

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