Unannounced Nursing Home Care Inspection Report 21 April 2016

Wheatfield House

Address: 20 Wheatfield Gardens, Belfast, BT14 7HU
Tel No: 0289039 1555
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Wheatfield House took place on 21 April 2016 from 09.20 to 16.30.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Weaknesses were identified in the delivery of safe care, specifically in relation to compliance with the recruitment process for staff; the daily monitoring of patient whereabouts and the arrangements for monitoring the registration status of nursing and care staff in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). Notifications to RQIA were being appropriately managed and a system was in place to monitor mandatory training compliance. Three requirements and one recommendation have been stated to secure compliance and drive improvement.

Is care effective?

There was evidence that patient care records were well maintained. Validated risk assessments informed the care plans and care plans were reviewed monthly. Photographs within patient care records have not been dated. As the photographs have not been dated, it cannot be established if they are recent or not. Staff meetings are conducted quarterly. One recommendation has been made in this domain.

Is care compassionate?

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

Appropriate actions had been taken by the registered manager in the management of complaints. Audits reviewed evidenced actions taken to address shortfalls identified and this had been verified by the registered manager. One recommendation has been stated in the well led domain. In total three requirements and two recommendations have been made in the other three domains as detailed above.

This inspection was underpinned by 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	3	3

Details of the QIP within this report were discussed with the registered manager, Edward McLoughlin, 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 estates inspection dated 19 April 2016. The QIP has not yet due to be returned, but will be assessed by the estates inspector on receipt. Enforcement action was not required following 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: Edward John McLoughlin	**Registered manager:** Edward John McLoughlin
Person in charge of the home at the time of inspection: Edward John McLoughlin	**Date manager registered:** 1 April 2005
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 22

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 quality improvement plan (QIP)
- pre inspection assessment audit.

During the inspection the inspector met with five patients individually and others in small groups, four care staff, one registered nursing staff and one ancillary staff.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- complaints records

- compliments records
- competency and capability records
- registered nurse induction template
- incidents / accidents records
- minutes of staff meetings
- a selection of audit documentation
- two recruitment files
- monthly quality monitoring reports
- duty rota from 10 to 23 April 2016

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 April 2016

The most recent inspection of the home was an unannounced estates inspection dated 19 April 2016. The QIP has not yet due to be returned but will be assessed by the estates inspector on receipt. The returned QIP will be validated by the estates inspector at the next estates inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 21 December 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 19 (2) Schedule 4 (7) **Stated:** Third time	The staff duty rota must accurately and fully reflect the hours worked by any staff member and in what capacity.	**Met**
	Action taken as confirmed during the inspection: The duty rota for weeks commencing 10 and 17 April 2016 were reviewed and fully reflected the hours worked by staff members and the capacity in which the hours were worked.	

Requirement 2 **Ref:** Regulation 15 (1) (a) (b) (c) **Stated:** Second time	The registered person must ensure that all patient care risk assessments are carried out and where possible involve patients/representatives.	**Met**
	Action taken as confirmed during the inspection: Following the inspection on 21 December 2015 all patients' next of kin were contacted by telephone and asked to verify the plans of care within patients' care records. All care records now contain a Next Of Kin Acknowledgement Form to be signed. Representatives also sign the care plan index within the care records verifying the plans of care in place.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 39 Criteria (1) (4) **Stated:** Second time	The registered person should ensure the induction programme for newly appointed staff is role specific in meeting the needs to fulfil the post.	**Met**
	Action taken as confirmed during the inspection: New induction templates were reviewed on inspection and were evidenced to be role specific to fulfil the needs of the post.	
Recommendation 2 **Ref:** Standard 21 Criteria (11) **Stated:** Second time	The registered person should ensure that bowel function, reflective of the Bristol Stool Chart is recorded on admission as a baseline measurement and thereafter in the patients'/residents' daily progress records.	**Met**
	Action taken as confirmed during the inspection: A review of progress records in five patient care records evidenced that bowel management recorded was reflective of the Bristol Stool Chart.	
Recommendation 3 **Ref:** Standard 41 **Stated:** Second time	The registered person should ensure staff meetings occur at least three monthly.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager, staff and a review of records evidenced that staff meetings had occurred on 6 January and 5 April 2016 from the last inspection date.	

Recommendation 4 **Ref:** Standard 41.2.7 **Stated:** First time	The registered manager or designated representative should sign the duty rota as reviewed and approved. **Action taken as confirmed during the inspection**: A review of duty rotas from weeks commencing 10 and 17 April 2016 evidenced that the registered manager had dated, signed and approved the duty rota.	**Met**
Recommendation 5 **Ref:** Standard 12 **Stated:** First time	The patients' dietary register should be updated to include the actual dietary requirement to meet the need of the patient. **Action taken as confirmed during the inspection**: The patients' dietary register has now been changed to a "Dysphagia Modified Diet Information chart" which includes the patients' names, date assessed, texture of diet and liquid stage assessment. Each individual patient had a personal place mat detailing all their dietary requirements.	**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 that the assessed needs of the patients were met. A review of the staffing rota for weeks commencing 10 and 17 April 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. As previously stated in section 4.2, the induction programme has now been reviewed and a role specific booklet has been developed for completion in meeting the needs to fulfil the staff role. Staff performance was monitored through supervision, appraisal and competency and capability assessments. The competency and capability forms for nurse in charge of the home in the absence of the registered manager were signed by the registered nursing staff and verified by the registered manager. We identified a concern when a nurse in charge could not account for the whereabouts of all patients within the home. Some patients had attended a day care facility and some patients had left the home with staff for an arranged outing. The remainder of patients had stayed in the home. This was discussed with the registered manager who gave assurances that a more robust system of communication within the home would be developed to account for the whereabouts of all patients accommodated in the home at all times. A requirement was made.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended and/or completed mandatory training. The online training matrix informed the registered manager, at any time, of the percentage of staff who had completed training on a specific topic. The system was also able to identify, in advance, when training was due to lapse and identified staff who had not completed the training. The training matrix was reviewed monthly and staff were reminded to complete training by the registered manager. Additional online training requested by the registered manager included training on dementia care, palliative care, person centred care, wound care and communication.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice. One staff member explained how recent training on distressed reactions had greatly assisted them with a technique in calming a patient who had displayed a distressed reaction.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was not appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). The registered manager would check the NMC registered status of registered nurses online. The last documented check was on 30 June 2015. A requirement was made to ensure registration compliance checks with professional bodies were carried out at minimum on the date of expiry of registration.

A review of the recruitment process evidenced that this was not being managed in accordance with Regulation 21 of The Nursing Homes Regulations (Northern Ireland) 2005. The recruitment procedures were discussed with the registered manager and the files of two recently recruited staff were reviewed. One file reviewed included a written reference from the present/most recent employer however a second written reference was not present within the file. The second file did not include any evidence of written references or record of references given. This was discussed with the registered manager who confirmed that two references for the interviewee were obtained by the registered manager via telephone and the references were taken verbally. The verbal references were not followed up with written references. A requirement was made. Neither of the two files reviewed included any evidence of an interview having been conducted. Questions asked and responses given were not evident within the records. This was discussed with the registered manager who confirmed the interviews had been conducted verbally with the interviewees and records of the interview had not been completed. A recommendation was made. Access NI checks had been carried out appropriately prior to the staff members employment.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

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

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA were appropriately managed.

Two infection prevention and control compliance issues were discussed with the registered manager. Pull cords in two communal rooms were not covered and uncovered bins were in use in communal rooms. This was discussed with the registered manager who gave assurances that these areas would be rectified.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounge/s, dining room/s and storage areas. The home was found to be warm, fresh smelling and clean throughout. Patients, their representatives and staff spoken with were complimentary in respect of the home's environment. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

A requirement is made to ensure key staff within the home are fully aware of the whereabouts of patients at all times.

A requirement is made to ensure a more robust system is developed to check the registration status of registered nurses and carers to ensure registration is current and not lapsed.

A recommendation is made to ensure all interviews conducted within the recruitment process are documented and evidenced within the recruitment file.

A requirement is made to ensure two written references, including one from the current/most recent employer, are checked and maintained within the recruitment file.

Number of requirements	**3**	**Number of recommendations**:	**1**

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Care plans had been reviewed monthly. Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as speech and language therapist (SALT) or dieticians. There was good evidence in two files reviewed were the care plans were updated immediately after a SALT review. However, a recommendation was made to ensure photographs included within the care records for identity purposes include the date the photograph was taken to allow for subsequent updates.

Supplementary care charts such as food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Records are stored in the nursing station on the ground floor which is kept permanently locked when not in use.

Patients and their representatives were involved where appropriate in the assessment and care planning process. Please refer to section 4.2, for further information.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals, for example General Practitioner's (GP), SALT, dietician and TVN.

Discussion with the registered manager confirmed that staff meetings were now held on a quarterly basis and records were maintained. This was reviewed as validation from the previous QIP and meetings were evidenced as having been conducted in January and April 2016.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the registered manager and review of records evidenced that relatives' meetings were held on a quarterly basis. However, the registered manager highlighted that quite often only one person attends. The registered manager also confirmed that they operate an open door policy to allow relatives and patients to speak with them at any time.

No patient representatives were available for consultation on the day of inspection. Patients spoken with expressed their confidence in raising concerns with the home's staff/management. Patients consulted knew the registered manager.

An offsite premises solely for the purpose of activities was reviewed on the day of inspection. The activities conducted here were decided by the patients attending. Activities included papier-mâché, seasonal collages, painting, reading magazines or attending organised outings. Tea and coffee facilities were available and patients had the option to watch television if they wished. The activity facility was to be commended. Staff confirmed that there was also a programme of activities for patients remaining in the home.

Areas for improvement

It was recommended that patient photographs included within the patients' care records for identity purposes include the date the photograph was taken to allow for subsequent updates.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. 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 to RQIA. The respondents agreed that the care in the home was commendable. On inspection one registered nurse, four carers and one ancillary staff were consulted to ascertain their views of life in Wheatfield House.

Some staff comments are as follows:
'My favourite job I've ever had. I love it here.'
'It's a good team here.'
'I'm very comfortable working with the residents.'
'We are all like one big family.'

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. There was evidence that an annual patient satisfaction survey had been completed in 2014 and 2015.

Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Consultation with five patients individually, and with others in smaller groups, confirmed that they were happy living in Wheatfield House. 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. Nine patient questionnaires were left in the home for completion. Two completed patient questionnaires were returned within the timeframe.

Some patient comments are as follows:
'I love it. All the staff are brilliant. We go out for lunch and shopping.'
'It's good here. I'm sometimes bored during the day but I'm happy here.'
'It's really nice here.'
'I like it here.'

There were no patient representatives available for consultation on the day of inspection. Seven relative questionnaires were left in the home for completion. One relative questionnaire was returned within the timeframe. The answers provided within the questionnaire were all positive.

Areas for improvement

No areas for improvement were identified during the inspection under the compassionate domain.

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

4.6 Is the service well led?

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

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 DOH Care Standards for Nursing Homes 2015. Staff were knowledgeable of the complaints process.

A compliments file had been maintained within the home and the compliments had been shared with staff.

A review of notifications of incidents to RQIA during the previous inspection year/or since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to care records, infection prevention and control, complaints and incidents/accidents. The monthly infection prevention and control audit and the bus cleanliness audit were reviewed on inspection. Action plans had been developed to address shortfalls identified within the audits. The registered manager had signed and dated the action plan when the shortfall had been addressed.

Urgent communications, safety alerts and notices were reviewed by the registered manager on receipt and where appropriate, were shared with staff. However, a system was not in place to ensure that all relevant staff had read the communication or had been notified about it. A file on alerts received was maintained within the home. A recommendation has been made for a safe system and procedures to be developed to ensure appropriate management of urgent communications, safety alerts and notices.

Discussion with the registered manager and review of records evidenced that monthly quality monitoring reports were completed. An action plan was generated within the report to address any areas for improvement. A review of the previous action plan was also included within the report. Copies of the reports were available for patients, their representatives, staff and trust representatives. However, it was discussed during feedback that the report should include unique identifiers of patients consulted for traceability.

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

Weaknesses were identified around safe systems for care, as previously stated in section 4.3, around staff recruitment procedures and arrangements for monitoring the registration status of nursing and care staff which was not appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). Systems of communication within the home such as management of urgent communications, safety alerts and notices require development to ensure they are effective. These deficits have impacted on the well led domain.

In considering the findings from this inspection and that three requirements and two recommendations have been made regarding safe, effective and compassionate care, this would indicate the need for more robust management and leadership in the home.

Areas for improvement

It is recommended that the system to manage urgent communications, safety alerts and notices is reviewed to ensure that these are shared with all relevant staff.

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

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Edward McLoughlin, Registered Manager, 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the 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 by the registered manager. 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 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13 (1)(a) **Stated:** First time **To be completed by:** 19 April 2016	The registered person must ensure that key staff are aware of the whereabouts of patients under their care at all times. **Ref: Section 4.3** **Response by registered person detailing the actions taken:** There is a file in the home that all staff have been advised to access to view the whereabouts of patients in the home in which this information is contained and regularly updated. Staff are also informed and advised during handover of patients whereabouts plus any planned outings, times, and with whom they are travelling with including expected time of return.
Requirement 2 **Ref:** Regulation 21 **Stated:** First time **To be completed by:** 22 April 2016	The registered person must ensure that a robust system is in place to evidence the registration status of registered nurses and carers in their employ. Checks must occur, at minimum, the date of expiry from NMC or NISCC registration. **Ref: Section 4.3** **Response by registered person detailing the actions taken:** There is a file which is kept in the managers office that contains the dates of registration and dates of renewal of all nursing and care staff that are registered and regulated by the NMC and NISCC.
Requirement 3 **Ref:** Regulation 21 **Stated:** First time **To be completed by:** 22 April 2016	The registered person must ensure two written references have been obtained on any person applying to work in the home including a reference from their present or most recent employer if any. **Ref: Section 4.3** **Response by registered person detailing the actions taken:** The registered manager will ensure that all new employees have two written references from their present or most recent employer if any and same to be filed in the employees personal file in the home.

Recommendations	
Recommendation 1 **Ref**: Standard 38 Criteria (2) **Stated:** First time **To be completed by:** 30 June 2016	The registered person should ensure that evidence of an interview or other suitable tool to determine the persons suitability to post, is maintained within the recruitment file of the candidate. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: The registered manager will ensure that there is evidence of an interview or other suitable tool that determins the persons suitability to commence or be employed in a post, and this information will be kept in the personal recruitment file of the candidate/employee.
Recommendation 2 **Ref**: Standard 37 Criteria (4) **Stated:** First time **To be completed by:** 30 June 2016	The registered person should ensure that photographs within patients' care records are up to date with evidence of date taken. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: The registered person has ensured and taken measures to update residents photographs within their care records and dated same to evidence this.
Recommendation 3 **Ref:** Standard 17 **Stated:** First time **To be completed by:** 30 June 2016	The registered person should ensure a system is in place to manage urgent communications, safety alerts and notifications. **Ref: Section 4.6**
	Response by registered person detailing the actions taken: The registered person has taken action to ensure a system is in place to manage urgent communications, safety alerts and notifications.A file is kept in the managers office containing this information which is accessible to all staff, and during handover, any new communications or alerts will be communicated with staff and evidence of same distributed and actioned. A hard copy of any email or notification will be printed and displayed in the staff notice board in the clinical room.

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

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

Assurance, Challenge and Improvement in Health and Social Care