Unannounced Care Inspection Report
14 June 2016

Slemish House

Type of Service: Nursing
Address: 28 Broughshane Road, Ballymena, BT43 7DX.
Tel No: 02825649772
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Slemish House took place on 14 June 2016 from 09:45 hours to 17:00 hours.

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?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

One area of improvement to ensure that any wear and tear to the décor of home is addressed was identified. A recommendation was made.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that that the outcome of care delivery was positive for patients. A review of care records confirmed that patients were comprehensively assessed and care plans created to prescribe care. There were arrangements in place to monitor and review the effectiveness of care delivery. We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Patients, relatives and staff were of the opinion that the care delivered provided positive outcomes.

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

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding day to day issues affecting them. Patients spoken with commented positively in regard to the care they received.

One area of improvement was identified to ensure that any suggestions for improvement received through the annual quality assurance questionnaire are addressed and the action taken included in the summary report. A recommendation was made.

Is the service well led?

There was evidence of good leadership in Slemish House and effective governance arrangements. Staff spoken with were knowledgeable regarding the line management structure within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. There were systems in place to monitor the quality of the services delivered.

There were no areas of improvement identified in the domain of well led.

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 Department of Health, Social Services and Public Safety(DHSSPS) Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**2**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Dorothy McKeefry, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent type e.g. care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 15 October 2015. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

There were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/ registered provider: Christopher Walsh	**Registered manager:** Dorothy Mc Keefry
Person in charge of the home at the time of inspection: Dorothy Mc Keefry	**Date manager registered:** 27 January 2014
Categories of care: NH-I, NH-PH, NH-PH(E)	**Number of registered places:** 45

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with nine patients individually and with the majority of others in small groups, two registered nurses, three care staff, two laundry assistants and seven relatives/ visitors.

Ten questionnaires were issued to relatives and staff with a request that they were returned within one week from the date of this inspection.

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

The following information was examined during the inspection:

- three patient care records
- staff duty roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- records of patient/relatives meetings

- quality assurance questionnaire returns
- reports of monthly visits undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 October 2015.

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

4.2 Review of requirements and recommendations from the last care inspection dated 15 October 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 36 **Stated:** First time **To be Completed by:** 31 December 2015	It is recommended that policies and procedures are reviewed in line with minimum standards and, up to date, regional guidance and staff should be made aware of the content of the revised policies/ procedures, including regional guidance, commensurate with their role and function.	**Met**
	Action taken as confirmed during the inspection: The policy entitled Palliative Care and dated 2 June 2016, was reviewed. The policy referenced GAIN guidelines and DHSSPS best practice guidance. The registered manager confirmed that at the time of the review the policy had been displayed and staff had been asked to sign to confirm that they had read the policy and understood its content. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 13 June 2016 evidenced that the planned staffing levels were adhered to.

In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic and laundry staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients and relatives commented positively regarding the staff and care delivery.

The registered manager and registered nurses spoken with were aware of who was in charge of the home when the registered manager was off duty. The nurse in charge was not identified on the staffing roster for the week of the inspection. However they were identified on the duty rosters for a number of weeks prior to the inspection. This was discussed with the registered manager and, prior to the conclusion of the inspection, the staffing roster was amended to clearly identify who was in charge of the home in her absence. It was also confirmed that this information would be included on all future rosters. A review of records evidenced that a competency and capability assessment had been completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

Discussion with the registered manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed. The registered manager was knowledgeable regarding the management of the Northern Ireland Social Care Council (NISCC) registration process for newly employed care staff and confirmed that newly appointed staff were supported to complete their application as part of the induction process.

The recruitment procedures were discussed with the registered manager who confirmed that recruitment records were maintained by the Human Resources (HR) administrator. We met with them and reviewed two personnel files; one member of staff had commenced employment; the recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. The second file contained only one reference; this member of staff was currently on induction. The HR administrator explained that once the Access NI check was received, they would commence staff classroom based induction while waiting for references; the staff member would not commence employment until any outstanding references had been received. The HR administrator was knowledgeable of the information and documentation required and we were assured that they were knowledgeable of the information and documentation required. Confirmation was received on 1 July 2016 that work was ongoing to secure a second reference; in the absence of a second reference the future employee had not yet commenced employment.

The record maintained of Access NI checks was reviewed. The records included the date the certificate was issued, the registration number of the certificate and that date the certificate was checked by the home. Records evidenced that the outcome of the Access NI check had been confirmed prior to the candidate commencing employment.

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. There was induction ongoing during the inspection. We met with the senior care assistant who was leading the induction; they were enthusiastic about their role and explained that they had received enhanced training to provide them with the necessary skills and knowledge to induct newly appointed care assistants.

The induction had two parts – a number of days which were classroom based followed by a period working supernumery with the staff team. We spoke with one member of staff who was completing the classroom based induction. They spoke positively regarding the support they were receiving and the effectiveness of the induction process. The registered manager confirmed that on completion of the induction programme they would meet with the member of staff and sign the record to confirm that the induction process had been satisfactorily completed.

Mandatory training was provided by the home in classroom based sessions. The registered manager had systems in place to monitor staff attendance and compliance with training. These systems included a training matrix to facilitate an over view and the signing in sheets from each training to evidence staff attendance.

A review of attendance at mandatory training evidenced good compliance with moving and handling training held in June 2016 and infection prevention and control training held in March 2016. Mandatory training for 2016 was ongoing.

Training opportunities were also provided by the local health and social care trust and external agencies such as The Royal College of Nursing (RCN). The registered manager explained the home was a participant in the Northern Health and Social Care Trust (NHSCT) nursing home education and development initiative “In Reach”; a programme to deliver training to staff. One of the aims of the initiative was to provide training to the registered nurses in an attempt to reduce patients’ attendance at local hospitals for routine procedures. Training offered included PEG tube insertion and catherisation.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses, care staff and laundry staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient’s individual care plans.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of accidents to identify any trends or patterns.

A general inspection of the home was undertaken to examine a random sample of patients’ bedrooms, lounges, bathrooms and toilets. The majority of patients’ bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. There were areas in the home where the décor was damaged and in need of repair. Arrangements should be put in place to ensure that any wear and tear to the décor is addressed. A recommendation was made.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for improvement

Arrangements should be put in place to ensure that any wear and tear to the décor of the home is addressed.

Number of requirements	0	Number of recommendations:	1

4.4 Is care effective?

We reviewed three patients' care records with regard to the admission process, skin care and the prevention of pressure ulcers and the management of wound care. The day to day maintenance of care records was also considered for each patient.

A review of one care record evidenced that a comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home. The holistic assessment contained good detail of the outcome of each area assessed, the patient's individual needs and also what the patient could do for themselves. The individualised information in this assessment was commended. Initial plans of care were generated within 24 hours of admission. As previously discussed a range of validated risk assessments were also completed as part of the admission process.

Wound management in respect of one patient was reviewed. Details of the wounds and frequency with which they required to be re-dressed were recorded in patient's care plan. The care record contained an initial wound assessment and an assessment of the wound following each dressing renewal. Review of completed wound assessment records evidenced that prescribed dressing regimes were adhered to. The registered nurse spoken with were knowledgeable regarding the patient's wound, dressing regime and the progress of the wounds. The tissue viability nurses (TVN) and podiatrist from the local health and social care trust were also involved in the patient's care. Care records were updated to reflect recommendations made following reviews by the TVN and podiatrist.

We reviewed the delivery of care to minimise the risk of the patients acquiring pressure ulcers. There was evidence in the care record of appropriate assessment to identify the risk of the development of pressure ulcers and care plans were in place to manage the level of risk identified. Repositioning charts evidenced that positional changes were carried out regularly. Care records were regularly reviewed and updated, as required, in response to patient need.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians.

There was evidence within the care records of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Additional records such as repositioning charts and food and fluid intake charts 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.

Observations evidenced that call bells were answered promptly and patients requesting assistance in the lounge areas or their bedrooms were responded to appropriately. Patients were confident of the ability of staff to meet their need effectively and in a timely manner. Patients were satisfied that staff responded to call bells promptly.

The serving of lunch was observed in the dining room on the ground floor. Tables were nicely set with cutlery, condiments and napkins. There was a nice atmosphere in the dining room; one group of ladies were enjoying the social aspect of lunch, with friendly conversation throughout the meal. Staff explained they encouraged patients with similar needs to sit together Staff were observed to encourage and gentle prompt patients to eat their meal in addition to providing full assistance to those patients who required this level of support. Patients who had their lunch in the lounge or bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. Lunch was observed to be well organised with all of the patients being attended to in a timely manner. There was a choice of three dishes; all were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

The registered manager confirmed that staff meetings were held regularly staff. Records of the issues discussed and agreed outcomes were maintained. The most recently recorded meeting with staff teams, for example registered nurses, care staff, kitchen and housekeeping staff were held on a number of dates in January, February and March 2016. Minutes of these meetings, detailing the areas discussed, were available. The registered manager explained that they also met informally with staff on a regular basis. The importance of keeping a record of informal meeting to share with all staff was discussed. Records evidenced that a number of staff meeting took place throughout 2015.

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

Areas for improvement

No areas for improvement were identified in the assessment of effective care.

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

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from

time to time. Staff spoken with were knowledgeable regarding patients likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:

"I find the staff friendly and helpful at all times."
"I am happy as Larry here."
I am kept very comfortable and get everything I need."

Patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. As previously discussed in section 4.4 observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

We spoke with the relatives of three patients who all commented positively with regard to the standard of care, the attentiveness of staff and communication in the home. They confirmed that they were made to feel welcome into the home by all staff and were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. The registered manager has regular, daily contact with the patients and any visitors and was available, throughout the day, to meet with both on a one to one basis if needed. The most recent patient's meeting had taken place on 18 May 2016. The record of the meeting reflected that issues discussed. Records evidenced that a relatives meeting took place on 6 April 2016.

A quality assurance questionnaire is sent out annually to relatives and patients. These were last sent in May 2016. The following are examples of comments included in the returned questionnaires:

"I ve absolutely no complaints about the home. I love being here."
"Well I ve all the comfort I could want."
"Would like more variety – crisp bacon, chops etc."
"Tea is sometimes weak and tepid…"

A summary report, with the statistical analysis of the responses received and the comments made was available. The report did not include what action had been taken to address the comments of dissatisfaction/suggestions for improvement.

This was discussed with the registered manager who explained that where patients or relatives had included their name on the returned questionnaire they would address the comments individually. Where comments cannot be identified with a patient or relative they should be addressed generally and the action taken included in the summary report. A recommendation was made.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"…we were over whelmed by the kindness and the compassion shown, not only to her, but to the whole family."

"…she loved living here from the moment she moved in…she had always good things to say about all of you."

"Thank you… for spending time on the telephone with me and keeping me up to date …"

Ten relative questionnaires were issued; eight were returned prior to the issue of this report. All of the respondents were satisfied with the delivery of safe, effective and compassionate care and were of the opinion that the service was well led. The following comments were provided:
"Most of the time he is well/safe – but has had a recent fall."
"Home provides good care with little or no interaction with staff – he is generally well cared for."
"Some staff are very compassionate …"

Ten questionnaires were issued to nursing, care and ancillary staff; seven were returned prior to the issue of this report. All of the staff were very satisfied or satisfied with the delivery of safe, effective and compassionate care and that the service was well led. No additional comments were provided.

Areas for improvement

Any comments of dissatisfaction received through the annual quality assurance questionnaire should be addressed and the action taken included in the summary report.

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

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were displayed and available in the reception area of the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home.

Staff spoken with were knowledgeable regarding the line management arrangements and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships; staff stated that management were responsive to any suggestions or concerns raised.

Patients and representatives spoke with were aware of the home's complaints procedure. Patients and their representatives confirmed that they were confident that staff and/or management would address any concern raised by them appropriately. Patients were aware of who the registered manager was and reported that they would have daily contact.

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint, details of the investigation and action taken, if any. The record also indicated how the registered manager had concluded that the complaint was closed. There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included care records, wound management and the maintenance and accidents. Discussion with the registered manager confirmed that where an area for improvement was identified there was evidence of re-audited to check that the required improvement had been completed.

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any identified areas for improvement.

It was observed that the registered manager had robust systems to ensure they had oversight of the governance systems in the home. The registered manager spoke of the necessity of staff having access to all relevant information in her absence. Files were observed to be well organised, clearly labelled and easy to access.

Areas for improvement

No areas for improvement were identified in the assessment of the domain of well led.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Dorothy McKeefry, Registered Manager as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the (Insert Service Type). The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises, RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to nursing.team@rqia.org.uk by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 44.1 **Stated:** First time **To be completed by:** 12 July 2016	It is recommended that arrangements are put in place to ensure that any wear and tear to the décor of the home is addressed. **Ref section 4.3**
	Response by registered provider detailing the actions taken: The issue of wear and tear has been addressed and an ongoing programme is continuing to ensure a high standard of décor is maintained.
Recommendation 2 **Ref**: Standard 7.1 **Stated:** First time **To be completed by:** 12 July 2016	It is recommended that any comments of dissatisfaction received through the annual quality assurance questionnaire should be addressed and the action taken included in the summary report.
	Response by registered provider detailing the actions taken: Any comments of dissatisfaction received through the annual quality assurance questionnaire will be addressed and action taken, details of which will be included in the summary report.

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