Inspection Report

20 October 2021

Slemish Nursing Home

Type of service: Nursing (NH)
Address: 28 Broughshane Road, Ballymena, BT43 7DX
Telephone number: 028 2564 9772

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Healthcare Ireland (Belfast) Limited **Responsible Individual:** Ms Amanda Celine Mitchell	**Registered Manager:** Mrs Dorothy McKeefry **Date registered:** 27 January 2014
Person in charge at the time of inspection: Veronica McAllister, Deputy Manager	**Number of registered places:** 45
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.	**Number of patients accommodated in the nursing home on the day of this inspection:** 36
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 45 patients. The home is over two floors. Patient bedrooms are located over the two floors. Patients have access to a communal lounge, dining room and outside spaces.	

2.0 Inspection summary

An unannounced inspection took place on 20 October 2021, from 9.30 am to 4.00 pm by a care inspector.

The inspection assessed various aspects of the running of the home to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

One area for improvement has been identified as part of this inspection as detailed in the quality improvement plan.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from patients and staff are included in the main body of this report.
The findings of this report will provide the Manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Dorothy McKeefry, Manager and Veronica McAllister, Deputy Manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection nine staff and five patients were spoken with individually and others were engaged with in small groups in communal areas. No staff survey responses were received within the allocated timeframe. Three patient questionnaires were returned with a very satisfied response to all questions regarding care provision in Slemish Nursing Home. One comment included in a questionnaire from a patient described the staff as friendly, kind and caring.

Patients spoken with on an individual basis told us that they were happy with the care and services provided in Slemish Nursing Home. One patient said they were "perfectly happy, I have no complaints".

Messages of thanks including any thank you cards received were kept and shared with staff.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Slemish Nursing Home was undertaken on 1 December 2020 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to help protect patients.

Staff were provided with an induction programme relevant to their department and to prepare them for working with the patients.

There were systems in place to ensure staff were trained and supported to do their job. The Manager had good oversight of staff compliance with the required training.

Review of governance records provided assurance that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or Northern Ireland Social Care Council (NISCC) and that these registrations were effectively monitored by the Manager on a monthly basis.

The duty rotas accurately reflected the staff working in the home over a 24 hour period. Staff absences were recorded on the rota and the person in charge in the absence of the Manager was clearly highlighted. Staff said that staffing levels were generally satisfactory but occasionally there was an unavoidable shortage due to the ongoing Covid-19 pandemic but that efforts were made to cover shifts; the Manager said that existing staff were very helpful at covering shifts. Staff said they were always busy, teamwork was very good and they felt well supported in their role.

Staff were seen to respond to patients needs in a timely manner and were seen to be warm and polite during interactions. It was clear through these interactions that the staff and patients knew one another well.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly.

Patients' needs were assessed at the time of their admission to the home.
Following this initial assessment care plans were developed to direct staff on how to meet patients' needs; and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them. Patients who required care for wounds had this clearly recorded in their care records.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails and alarm mats. It was established that safe systems were in place to manage this aspect of care.

Patients who were less able to mobilise were assisted by staff to change their position regularly. However, a review of repositioning records evidenced that patients were not always repositioned as prescribed in their care plans. The specific examples were discussed with the Manager and an area for improvement was identified.

Examination of records and discussion with the staff confirmed that the risk of falling and falls were well managed. Review of records confirmed that staff took appropriate action in the event of a fall, for example, they completed neurological observations and sought medical assistance if required. The appropriate care records were reviewed and updated post fall. Staff also completed a post fall review to determine if anything more could have been done to prevent the fall.

Due to the ongoing Covid- 19 pandemic and in an effort to maintain social distance patients have not been using the dining room. Meals are served to patients in their bedroom or in the lounge area whichever they prefer. Ways to try and reinstate the use of the dining area was discussed with the Manager who agreed to review the dining experience. Staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. The patients commented positively about the food. If required, records were kept of what patients had to eat and drink daily.

There was a system in place to ensure that all staff were aware of individual patient's nutritional needs and any modified dietary recommendations made by the Speech and Language Therapist (SALT). Nutritional assessments had been conducted on a monthly basis by staff using the Malnutrition Universal Screening Tool (MUST), and there was evidence that patients' weight was checked at least monthly to monitor weight loss or gain.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. The home was warm, clean and comfortable. Patients' bedrooms were clean, tidy and personalised with items of importance to each patient, such as family photos and sentimental items from home.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

The fire risk assessment available for review was dated 24 September 2020; this was discussed with the Manager who agreed to forward the annual review of the fire risk assessment when available. Email confirmation was received from the Manager that the fire risk assessment was reviewed and updated 25 October 2021 and that the one recommendation has been appropriately addressed.

There was evidence that systems and processes were in place to ensure the management of risks associated with Covid-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Agency (PHA).

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided. Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the Manager and records were kept.

Visiting arrangements were managed in line with DoH and IPC guidance.

5.2.4 Quality of Life for Patients

Discussion with patients and staff confirmed that they were able to choose how they spent their day. Patients could remain in their bedroom or go to the communal lounge when they wished. There was a range of activities provided for patients by activity staff. The range of activities included pampering sessions, games and exercises. Specific Halloween activities had been planned for the end of the month; these included pumpkin carving and a Halloween party. The home was tastefully decorated for Halloween. Patients were observed content and settled listening to music, chatting with staff, reading or watching TV.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the Covid-19 pandemic. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Dorothy McKeefry has been the Registered Manager in this home since 27 January 2014.

Staff demonstrated their understanding of their own roles and responsibilities in the home and of reporting any concerns about patient care or staffs' practices.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. There was evidence of auditing across various aspects of care and services provided by the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

It was established that the Manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

Review of the home's record of complaints confirmed that these were well managed and used as a learning opportunity to improve practices and/or the quality of services provided by the home.

Staff commented positively about the Manager and said she was supportive and approachable. Staff also said that communication within the home was good and that they felt they were kept well informed. Discussions with the Manager and staff, and observations on inspection indicated good working relationships.

The Manager maintained records of regular staff and departmental meetings. The records contained an attendance list and the agenda items discussed. Meeting minutes were available for those staff who could not attend.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

6.0 Conclusion

Patients looked well cared for and were seen to be content and settled in the home. Staff treated patients with respect and kindness. The home was clean and tidy.

One new area for improvement was identified in regard to patient repositioning.

Based on the inspection findings and discussions held RQIA are satisfied that this service is providing safe, effective care in a caring and compassionate manner; and that the service is well led by the Manager.

Thank you to the patients and staff for their assistance and input during the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (April 2015)**

	Regulations	Standards
Total number of Areas for Improvement	0	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Dorothy McKeefry, Manager and Veronica McAllister, Deputy Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in regards to the repositioning of patients: • that patients are repositioned in keeping with their prescribed care • that repositioning records are accurately and comprehensively maintained at all times. Ref: 5.2.2
	Response by registered person detailing the actions taken: New repositioning documentation is in place to promote adherence to prescribed care Supervisions have been carried out with all Care Staff regarding use of this new format and need for accurate, comprehensive maintenance of these charts in keeping with prescribed care. All Nurses have also been reminded of their responsibility to monitor repositioning charts on each shift confirming repositioning assistance is given in keeping with prescribed care. Registered Manager will monitor this on daily walkrounds. Senior team will maintain focus in this area during Reg 29 visits

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

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