The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
19 December 2016

Daisyhill Private Nursing Home

Type of Service: Nursing Home
Address: 50a Ahoghill Road, Randalstown, BT41 3DG
Tel no: 028 9447 9955
Inspector: Lyn Buckley

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Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Daisyhill Private Nursing Home took place on 19 December 2016 from 06:20 to 11:15 hours.

This inspection was carried out to follow up on information received by RQIA, on 15 December 2016, from the Northern Health and Social Care Trust (NHSCT). Issues were raised with them as part of a complaint and adult safeguarding concern. The concerns related to the delivery of care, skin care and the prevention of pressure damage and the day to day management of the nursing home.

Following this inspection RQIA were satisfied that care delivered in Daisyhill Private Nursing Home was of an acceptable standard in relation to the areas inspected. Details of the inspection process and specific findings can be viewed in the body of this report.

This inspection was underpinned by The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Dr Marina Lupari, responsible individual 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 care inspection

The last care inspection was undertaken on 12 September 2016. The actions required to address the QIP were reviewed as part of this inspection. Details can be viewed in section 4.2. 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.

2.0 Service details

Registered organisation/registered person: Town & Country Care Homes Ltd/ Dr Marina Lupari	**Registered manager:** Miss Colleen McWilliams
Person in charge of the home at the time of inspection: Registered Nurse K Zawadka on night duty and Registered nurse G McPherson on day duty.	**Date manager registered:** 29 October 2015
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 25

3.0 Methods/processes

This inspection was carried out following information received by RQIA, on 15 December 2016, from the Northern Health and Social Care Trust (NHSCT). Issues were raised with them as part of a complaint and adult safeguarding concern. The concerns related to the delivery of care, skin care and the prevention of pressure damage and the day to day management of the nursing home. In addition Dr Lupari, responsible individual, confirmed to the Trust that she had not notified RQIA of the adult safeguarding investigation.

It is not the remit of RQIA to investigate complaints or safeguarding allegations made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. Following discussion with senior management, it was agreed that an inspection would be undertaken to review the following areas:

- the management of nutrition and weight loss
- the management of skin integrity
- delivery of personal care
- staffing and management of the home
- management of accidents, incidents and notifiable events
- management of patients' admission to the home

Prior to inspection we analysed the following information:

- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the previous care inspection report
- the returned QIP from the previous care inspection
- notifications received since the previous care inspection undertaken on 12 September 2016

The following records were examined during the inspection:

- staff duty rotas from 28 November to 25 December 2016
- review of accident and incident records
- three patient care records
- patient records pertaining to weight monitoring
- patient records pertaining to the management of constipation
- nurses' desk diary
- resource file for the management of diets and fluids
- monitoring records for accidents and incidents from 1 July 2016
- evidence to validate the previous care inspection's QIP

We also undertook a general inspection of the home's environment which included a review of all bathrooms/shower rooms and communal spaces; and a random sample of patient's bedrooms.

We observed the handover report from night staff to day staff and a morning medicine round.

The majority of patients were greeted as they came to the dining rooms for their breakfast, and two registered nurses and three care assistants were spoken with as part of the inspection process.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent medicines management inspection on 21 November 2016

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 21 November 2016. Details of the inspection outcomes were discussed with the home's aligned care inspector as improvement had been required in relation to the recording of topical medicines for a second time. This was reviewed during this inspection. The QIP from the medicines management inspection was not due for return prior to this care inspection. The QIP, when returned, will be reviewed and followed up by the pharmacist inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 12 September 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13 (7) **Stated:** First time	The registered provider must ensure that basic infection prevention and control measures are adhered to and monitored on a daily basis to ensure compliance. A review of the home's environment and patient equipment must be undertaken with an action plan put in place detailing priority actions and timescales for completion.	**Met**
	Action taken as confirmed during the inspection: A general inspection of the home's environment which included a review of all bathrooms/shower rooms and communal spaces, and a random sample of patient's bedrooms evidenced that this requirement had been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 7 **Stated:** First time	The registered provider should keep light levels throughout the home under review with evidence of feedback from patients, relatives and staff having been taken into account.	**Met**
	Action taken as confirmed during the inspection: Observations and discussion with staff confirmed that lights were 'on' as required and sufficiently bright to ensure they could carry out their duties safely and to ensure that staff and patients could move about the home safely. This recommendation has been met.	

4.3 Inspection findings

4.3.1 Management of nutrition and weight loss

Discussion with staff evidenced that patients were weighed on a regular basis. Review of records confirmed this information. Staff were knowledgeable of patients' nutritional needs and were able to respond to specific enquiries in detail. For example, the reasons why patient might refuse to eat or drink. Review of three patient care records confirmed the information provided during discussion. Patients were weighed on a regular basis and at least each month. Equipment was in place for patients who were able to sit on scales to be weighed and within a hoist for those who were not.

Care plans reviewed relating to nutrition were relevant to the patient assessed needs and were patient focused. They included details of managing the patients' weight and the action to take if a weight loss was identified. Care plans also included specific instruction for the management of enteral feeding or modified consistency diets where required. Care plans were kept under regular review and reflective of instructions from other healthcare professionals such as the dietician and/or the speech and language therapist (SALT).

Daily progress notes lacked confirmation that the nursing staff had evaluated the delivery of care or any subsequent actions taken when a weight loss was identified or a patient had refused a meal/snack. RQIA were satisfied from review of records, discussion with staff and observation of staff and patient interactions during the breakfast time meal, that patients' nutritional needs were being met. However, a recommendation was made regarding the recording of the evaluation of the care delivered and/or required in response to a concern.

The responsible individual discussed improvements put in place since the last inspection in relation to the management of therapeutic diets and thickening agent for food and fluids. The plans and actions were also discussed with nursing and care staff during the handover report from night to day staff. The improvements included the development and use of a resource file containing specific details regarding consistencies of food and fluids and a recorded process to support staff in achieving competency in the delivery of this care.

Areas for improvement

A recommendation was made that nursing staff accurately record their evaluation of care delivered and the subsequent actions taken to address care deficits or concerns.

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

4.3.2 Management of skin integrity and delivery of personal care

Discussion with staff evidenced that patients' skin and pressure areas were monitored on at least a daily basis. Staff were knowledgeable of the signs of pressure damage staff were also aware of the need to record that topical medicines, such as creams and ointments, had to be administered and recorded as prescribed.

Care plans reviewed relating to personal care and skin integrity were found to be reflective of patients' assessed needs and prescribed treatments. Care plans were relevant, detailed and patient focused. Risk assessments relating to the risk of developing pressure ulcers were also in place and regularly reviewed. Care plans in relation to skin care also referred to the nutritional care plan. This is good practice.

Nursing staff confirmed that, where necessary, tissue viability nurses (TVNs) were contacted for advice; care plans were reviewed to ensure they were reflective of any recommendations made by the TVNs. Daily progress notes lacked confirmation that the nursing staff had evaluated the delivery of required pressure area care or the effectiveness of treatment for skin conditions. A recommendation has already been made regarding the daily evaluation of care by nursing staff.

Patients' personal hygiene needs were detailed within their care plans and it was evident that staff knew patients' preferred routines and wishes. Patients were observed to be well presented with attention to details such as nail care, hair styles and male grooming. There were no concerns evidenced during this inspection regarding the standard of personal hygiene and dressing.

Areas for improvement

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

Number of requirements	0	Number of recommendations	0

4.3.3 Staffing and management of the home

Discussion with the responsible individual, nursing and care staff confirmed the number of staff on duty over any 24 hours period and that these levels were kept under review.

Review of duty rotas evidenced that the staffing levels were adhered to.

The registered manager was not on duty at the time of the inspection, therefore the hours worked by the registered manager were discussed with the responsible person. RQIA were satisfied with the explanation given for the registered manager's current working patterns.

It was also confirmed that additional nursing staff had been successfully recruited with the new staff expected to commence their induction to the home by the end of February 2017. Arrangements were in place to ensure the nursing staff were supported through adaptation to their registration with the Nursing and Midwifery Council for the United Kingdom (NMC). Links to enable care staff to undertaken accredited learning which would lead to nurse training had also been explored/considered.

Areas for improvement

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

Number of requirements	0	Number of recommendations	0

4.3.4 Management of accidents, incidents and notifiable events

Review of accidents records dated from 13 August 2016 evidenced that RQIA were notified appropriately. However, RQIA had been notified by the Northern Health and Social Care Trust (NHSCT) on 15 December 2016 that they had had a meeting with Dr Lupari as part of an adult safeguarding investigation into a complaint received from a relative. RQIA had not been notified of this adult safeguarding concern, in accordance with the Nursing Homes Regulations (Northern Ireland) 2005 – Regulation 30. Following discussion with Dr Lupari and one of the organisation's directors a requirement was made.

Following discussion, of a separate issue with the organisation's director, advice and guidance was provided to them in relation to a complaint received by the home from a relative. It was agreed that RQIA would be notified of this issue retrospectively and that the patient's care manager would also be informed to ensure that the relevant health and social care trust were aware of the concerns raised.

The director was aware of the recent procedures issued in September 2016 regarding adult safeguarding and confirmed that he and the responsible individual would be undertaking training to become adult safeguarding champions for the home.

Areas for improvement

A requirement was made that the registered provider must ensure that RQIA are notified, without delay, of events occurring in the nursing home as detailed in regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

Number of requirements	1	Number of recommendations	0

4.3.5 Management of patients' admission to the home.

Review of patient care records and discussion with staff and senior management evidenced that procedures in relation to the admission, assessment and care planning process were in accordance with DHSSPS Care Standards, April 2015.

In the event of a patient being admitted to the nursing home for emergency respite care, the home received a detailed care plan based on a comprehensive assessment of nursing needs from the Trust responsible for the patients care. This information informed the home's nursing assessment undertaken on the day of admission and the development of care plans.

In the care record reviewed the relevant risk assessments had been completed. Nursing staff confirmed that the care planning process would be completed within five days of the admission date.

Areas for improvement

No areas for improvement were identified during the inspection.

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 the QIP were discussed with Dr Marina Lupari, Responsible Individual, 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 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.

5.1 Statutory requirements

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to Web Portal for assessment 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

Statutory requirements	
Requirement 1 **Ref**: Regulation 30 **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that RQIA are notified, without delay, of events occurring in the nursing home as detailed in regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. **Ref: Section 4.3.4**
	Response by registered provider detailing the actions taken: A copy of regulation 30 of The Nursing Homes Regulations (Norther Ireland) 2005 has been provided for all nursing staff to refresh their responsibility for reporting any incidents. Staff Nurse meeting is arranged for Monday 30/1/17 and the reporting of incidents is on the agenda for same. This is also being discussed with each registered nurse as part of their operational supervision. A new operational guidance has been written by the Director of Care to help guide the process. Support is being provided on an ongoing basis with each RN regarding completion of the appropraite RQIA forms.
Recommendations	
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** Immediate action required	The registered provider should ensure that nursing staff accurately record their evaluation of care delivered and particularly the subsequent actions/outcomes taken to address care deficits or concerns. **Ref: Sections 4.3.1 and 4.3.2**
	Response by registered provider detailing the actions taken: Nurse responsibilities have been issued to all registered nursing staff. This is also a subject on the agenda for the upcoming nurses meeting 30/1/17. A copy of NMC standards in record keeping has been the main professional theme within the home this month. A robust operational management system has been introduced by the Director of Care for 2017. Dates for each registered nurse have been issued for the up coming year. An audit system has been agreed with the Director of Care following the completion of a comprehensive auidt of all records across DaisyHill PNH. Responsibilities rest with myself as Manager and my new Deputy Manager for the completion of this. This will ensure closer attention to care planning and evalution by all Registered Nurses. Peer support is being encouraged and an ongoing individual RN learning approach through one-to-one review of care plans via operational supervision.

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