Unannounced Care Inspection Report
17 May 2017

Ladyhill

Type of Service: Nursing Home
Address: 40 Creevery Road, Antrim, BT41 2LQ
Tel no: 02894466905
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Ladyhill Nursing Home took place on 17 May 2017 from 10:40 to 18:15 hours.

The inspection sought to assess progress with any issues raised during and since the last care 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, staff training and development and the environment. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

A requirement was made in relation to staff recruitment records/information to be kept in a nursing home.

Is care effective?

We reviewed the management of nutrition and weight loss, management of an ill patient and pressure area care. Care records contained details of the specific care requirements in each of the areas reviewed and a contemporaneous record was maintained to evidence the delivery of care. Care records also reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT), dieticians and General Practitioners (GPs).

Supplementary care charts such as repositioning, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance and care standards. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records and information.

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

Is care compassionate?

We arrived in the home at 10:40 hours and were greeted by staff who were helpful and attentive. Patients were enjoying a late breakfast or a morning cup of tea/coffee in the dining room, lounge or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice depending on which they preferred and staff were observed assisting patients to drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

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. Discussion with patients confirmed that living in Ladyhill was a positive experience.

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

Is the service well led?

The certificate of registration issued by RQIA was displayed in the foyer of the home.

Review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

Unannounced quality monitoring visits were completed on a monthly basis by an external person on behalf of the provider. However, copies of the quality monitoring visits were not available in the home. A requirement was made.

Discussion with the manager and review of records evidenced that audits were completed to ensure the quality of care and services. The records of audit evidenced that any identified areas for improvement had been addressed and re audited/checked for compliance. Discussion also took place regarding how the audit process could be developed further into a formal system of governance processes. A recommendation was made.

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

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	2	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Dr Marina Lupari, Acting Manager and 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 inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 28 March 2017. Other than those actions detailed in the QIP there were no further actions required to be taken. 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 Limited Dr Marina Lupari	**Registered manager:** See below
Person in charge of the home at the time of inspection: Registered Nurse Lisa Craig initially. Dr Marina Lupari from approximately 11:30 hours.	**Date manager registered:** Dr Marina Lupari is the acting manager since 29 November 2016.
Categories of care: NH-LD and LD(E)	**Number of registered places:** 31

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- 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 five patients individually and greeted others in small groups; one registered nurse, one adaptation nurse, four care staff, one domestic staff, one member of the catering staff. Ten questionnaires for staff and ten for relatives were also left in the home to obtain feedback from relatives and staff not on duty during the inspection.

The following information was examined during the inspection:

- duty rota for all staff from 8 to 21 May 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts

- consultation with patients, relatives and staff
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 28 March 2017.

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 12 January 2017.

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that the assessment of nursing needs is kept under review and revised at any time when it is necessary to do so and in particular when changes in the patient's needs occur. **Action taken as confirmed during the inspection**: Review of three patients' care records evidenced that this requirement had been met.	**Met**
Requirement 2 **Ref:** Regulation 16 **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that the patient's care plan is kept under review and reflects the care delivered to meet the patient's assessed needs. **Action taken as confirmed during the inspection**: Review of three patients' care records evidenced that this requirement had been met.	**Met**

Requirement 3 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that RQIA are notified of any event occurring in the nursing home in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 – regulation 30.	**Met**
	Action taken as confirmed during the inspection: Review of notifications received by RQIA from13 January 2017 and the home's accident/incident records evidenced that this requirement had been met.	
Requirement 4 **Ref:** Regulation13(4) **Stated:** First time **To be completed by:** Immediate action required with completion by 31 March 2017	The registered provider must ensure that where the administration of medicines is delegated to a care assistant, by a registered nurse, that both staff are aware of their responsibilities and that the registered nurse is still accountable for the administration of the medicine. Where there is approval for care assistants to undertake administration of certain medicines such as thickening agents, nutritional supplements or topical medicines; there is evidence that they have been formally trained and deemed competent and capable to do so.	**Met**
	Action taken as confirmed during the inspection: Review of training records and patient medication administration records; and discussion with the manager and staff evidenced that this requirement had been met.	
Requirement 5 **Ref:** Regulation 20 (1) **Stated:** First time **To be completed by:** Immediate action required with completion by 31 March 2017	The registered provider must ensure that until the practice of care assistants managing enteral feeding regimes is reviewed, in conjunction with the identified patients' care manager/dietician, that this practice is ceased due to the risk to patients. Where there is approval for care assistants to undertake this procedure there is evidence that they have been formally trained and deemed competent and capable of delivering enteral feeding.	**Met**
	Action taken as confirmed during the inspection: The manager confirmed that following the last care inspection and further to discussion with the Northern Health and Social Care Trust (NHSCT) the decision was made that care staff would not be involved in the delivery of enteral feeding.	

Requirement 6 **Ref:** Regulation 12(1) (2) and (3) **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that • syringes and water used for enteral feeding are appropriately stored • that single use syringes are used only once and then discarded • that any medicine syringe is used for the named patient only and is not used communally	**Met**
	Action taken as confirmed during the inspection: Observations and discussion with staff evidenced that this requirement had been met.	
Requirement 7 **Ref:** Regulation 19(2) Schedule 4(11) **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that a record of all complaints is kept in the nursing home.	**Met**
	Action taken as confirmed during the inspection: Review of the complaints records evidenced that this requirement had been met.	
Requirement 8 **Ref:** Regulation 14(2) (a)(b) and (c) **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that all parts of the home to which patients have access are free from hazards to their safety; and that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated.	**Met**
	Action taken as confirmed during the inspection: Observation of the home's environment which included a number of bedrooms, bathrooms, storage areas, dining and lounge areas evidenced that this requirement had been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Appendix 1 of DHSSPS Care Standards for Nursing homes (2015). **Stated:** First time **To be completed by:** 28 February 2017	The registered provider should ensure, the patient register in place is accurately maintained in accordance with DHSSPS Care Standards for Nursing homes (2015).	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and review of records confirmed that this recommendation had been met.	

Recommendation 2 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** Immediate action required	The registered provider should ensure that nursing staff clearly record their evaluation of the delivery of care to patients within each individual patient care record. Details of any action taken when prescribed care has had to change should also be clearly recorded. **Action taken as confirmed during the inspection**: Review of three patient records confirmed improvements in the recording of evaluations of care delivery.	**Met**
Recommendation 3 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:**28 February 2017	The registered provider should ensure that records pertaining to food and fluid intake are reviewed to confirm they accurately reflect and meet patient needs and that the record is consistently and accurately maintained. **Action taken as confirmed during the inspection**: Review of three patient care charts pertaining to food and fluid intake confirmed that this recommendation had been met.	**Met**
Recommendation 4 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 March 2017	The registered provider should ensure that the mealtime experience of patients is reviewed and the necessary improvements made; in accordance with regional nutritional guidelines and DHSSPS Care Standards for Nursing Homes. **Action taken as confirmed during the inspection**: Observation of the serving of the lunch time meal and discussion with catering and care staff confirmed that this recommendation had been met.	**Met**

4.3 Is care safe?

The manager and the nurse in charge confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 8 to 21 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Staff said that on occasions staffing levels were affected by short notice leave. However, staff confirmed that this only happened occasionally. We also sought staff opinion on staffing via questionnaires however, none of the 10 questionnaires issued were returned.

Patients spoken with indicated that they were well looked after by the staff.

There were no relatives spoken with during this inspection. We also sought relatives' opinion on staffing via questionnaires. However, none of the 10 questionnaires issued were returned.

Review of two staff recruitment files evidenced that these files were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. However, we had asked to review three recruitment records. A third file/recruitment information was requested but was not maintained in the nursing home as required. A requirement has been made. Discussion took place and advice provided regarding recruitment information being maintained in the nursing home.

A review of records confirmed that the manager had a process in place to monitor the registration status of registered nurses with the Nursing and Midwifery Council for the United Kingdom (NMC). Nursing staff employed were confirmed as being on the 'live' NMC register for nurses. Information regarding care staff registration with the Northern Ireland Social Care Council (NISCC) was not available in the nursing home. A requirement has been made in this regard. RQIA were provided with confirmation of NISCC registration checks by email on 22 May 2017.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2016/17. Records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Mandatory training compliance was monitored by the manager and was also reviewed as part of the monthly quality monitoring process. Additional training was also available to staff to ensure they were able to meet the assessed needs of patients.

Observation of the delivery of care evidenced that training had been embedded into practice. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedures into practice. A safeguarding champion had been identified and training had been undertaken.

Review of three patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

Review of accidents/incidents records from 13 January 2017 and notifications forwarded to RQIA confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and personal protective equipment (PPE) such as gloves and aprons were available throughout the home.

Areas for improvement

A requirement was made in relation to records/information to be kept in a nursing home.

Number of requirements	1	Number of recommendations	0

4.4 Is care effective?

Review of three patient care records evidenced that care plans were in place to direct the care required. Nursing staff demonstrated awareness of the need to review and update care plans when the recommendations made by other healthcare professionals such as, the speech and language therapist (SALT) or the tissue viability nurse (TVN) changed.

We reviewed the management of nutrition and weight loss, management of an ill patient and pressure area care. Care records contained details of the specific care requirements in each of the areas reviewed and a contemporaneous record was maintained to evidence the delivery of care. Care records also reflected that, where appropriate, referrals were made to healthcare professionals such as TVN, General Practitioners (GPs), SALT and dieticians.

Supplementary care charts such as repositioning, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance and care standards.

Discussion with the manager, nursing and care staff and review of records evidenced that external medicines, nutritional supplements and the management of enteral feeding was managed and recorded appropriately and in keeping with practice guidelines and requirements.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records and information.

Review of patient care records confirmed that care management reviews were arranged and undertaken by health and social care trust staff in conjunction with the home. These reviews were generally held annually but could be requested at any time by the patient, their family, trust or nursing home.

Discussion with 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.

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 the manager or the nurse in charge.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held. This information provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

We arrived in the home at 10:40 hours were greeted by staff who were helpful and attentive. Patients were enjoying a late breakfast or a morning cup of tea/coffee in the dining room, lounge or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice depending on which they preferred and staff were observed assisting patients to drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff and review of the activity programme evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. Information in lounges included the activity programme for the day and the staff allocated to provide support to patients.

Patients able to communicate their feelings indicated that they "enjoyed" living in Ladyhill. 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.

Discussion with the manager and review of records confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home.

Ten relative questionnaires were issued; none were returned.

Ten questionnaires were issued to staff; none were returned.

Any comments from patient representatives and staff in returned questionnaires received after the return date, will be shared with the registered manager for their information and action as required.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home.

Discussion with staff, a review of records and observations confirmed that the home was operating within the categories of care registered.

A review of the duty rota evidenced that the manager's and other staff hours, and the capacity in which these were worked, were recorded in accordance with standards. Discussion with patients and staff evidenced that the manager's working patterns provided opportunity to allow them to have contact with her as required.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the manager and review of records evidenced that audits were completed to ensure the quality of care and services. For example, audits were completed for administration of nutritional supplement and care records. The records of audit evidenced that any identified areas for improvement had been addressed and re audited/checked for compliance. Discussion also took place regarding how the audit process could be developed further into a formal system of governance processes. A recommendation was made.

Discussion with the manager confirmed that quality monitoring visits were completed on a monthly basis by an external person in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. However, due to refurbishment work the reports from February 2017 were not available for inspection. A requirement was made.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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

Areas for improvement

A recommendation was made to consider developing the governance processes further.

A requirement was made regarding the availability of quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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

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, Acting Manager and 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 the 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 19 (1) (a) and (2) Schedules 3 and 4 **Stated:** First time **To be completed by:** 15 June 2017.	The registered provider must ensure that records and /or information, required to be kept in the nursing home, is available for inspection. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The Registered Provied will ensure that the records and/or information required to be kept in the nursing home will be avaible for inspection. An itenarary has been developed relating to this .
Requirement 2 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** 15 June 2017.	The registered provider must ensure that copies of the report undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 are maintained in the home and available on request. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: The registered provider will ensure that the copies of the Regulation 29 Report are maintained within the home an available on request. All copies of the Regulation 29s are available for viewing in both homes. A handwritten version will be available within 2 working days following the completion of the Reg 29 to be followed up with a typed copy within 7 working days.
Recommendations	
Recommendation 1 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 30 June 2017	The registered provider should consider further development of the current governance processes in accordance with DHSSPS Care Standards for Nursing Homes. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: The Registered Provider is currently developing the current goverenace processes in accordance with DHSSPS Care Standards for Nurisng Homes. An audit system has been agreed across the organisation to reflect all required standard audit activity and this will commence July 2017. The organisation will continue with audit activity related to their ongoing improvemnets .

Please ensure this document is completed in full and returned to the web portal

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