Unannounced Care Inspection Report
5 January 2017

Tamlaght

Type of Service: Nursing Home
Address: 34 Larne Road, Carrickfergus, BT38 7DY
Tel no: 028 9336 6194
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Tamlaght took place on 5 January 2017 from 07.30 to 16.00 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection.

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	4*	8*

*The total number of requirements and recommendations includes two requirements and two recommendations which have each been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Fiona Gray, Registered Person, 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 care inspection undertaken on 9 August 2016. Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Tamlaght Private Nursing Home Limited Fiona Gray	**Registered manager:** Fiona Gray
Person in charge of the home at the time of inspection: Fiona Gray	**Date manager registered:** 5 May 2015
Categories of care: NH-PH, NH-I, RC-I, NH-LD Category NH-PH for 2 identified individuals only. A maximum of 2 residents in category RC-I with 2 additional identified individuals in this category. The home is also approved to provide care on a day basis only to 4 persons.	**Number of registered places:** 45

3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

Prior to inspection we analysed the following information:
- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report and the returned QIP
- pre inspection assessment audit

During the inspection we met with eight patients individually and others in small groups, four care staff, one registered nurse and four ancillary staff members.

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:
- validation evidence linked to the previous QIP
- six patient care records
- staff training records
- Incidents / accidents records
- duty rotas for the period 2 to 8 January 2016
- auditing documentation with regards to infection prevention and control (IPC)

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 9 August 2016

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 9 August 2016

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.	**Met**
	Action taken as confirmed during the inspection: IPC issues identified on the previous inspection had been adequately managed. However, during a review of the environment, further areas were identified which were not in compliance with best practice in IPC. See section 4.3.5 for further information.	
Requirement 2 **Ref:** Regulation 17 (1) **Stated:** First time	The registered provider must ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home.	**Partially Met**
	Action taken as confirmed during the inspection: There was evidence that two infection prevention and control audits had been conducted since the last inspection. However, given the findings within this inspection, the requirement will be stated for the second time. Please see section 4.3.5 for further information. This requirement has not been fully met and will be stated for the second time.	
Requirement 3 **Ref:** Regulation 19 (1) (a) Schedule 3 (1) (a) (b) (3) (K) **Stated:** First time	The registered person must ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.	**Not Met**
	Action taken as confirmed during the inspection: A review of patient care records in regard to wound management evidenced this requirement has not been met. See section 4.3.3 for further information. This requirement has not been met and will be stated for the second time.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 35 **Stated:** First time	It is recommended that incidents/accidents are managed and recorded in accordance with best practice and professional guidance.	**Partially Met**
	Action taken as confirmed during the inspection: Incidents/accidents had been recorded as having occurred, although, the management of the incident/accident had not been appropriately recorded. See section 4.3.2 for further information. This recommendation has not been fully met and has been stated for the second time.	
Recommendation 2 **Ref:** Standard 44 **Stated:** First time	It is recommended that patients have a means of summoning assistance, if required, within the identified area.	**Not Met**
	Action taken as confirmed during the inspection: Changes had not been made within the identified area to enable patients to summon assistance if required. This recommendation has not been met and will be stated for the second time.	
Recommendation 3 **Ref:** Standard 41 Criteria (8) **Stated:** First time	The registered person should ensure staff meetings take place on a regular basis and at a minimum quarterly. Records are kept which include: • The date of all meetings • The names of those attending • Minutes of discussions • Any actions agreed	**Met**
	Action taken as confirmed during the inspection: There was evidence that three separate staff meetings had been conducted since the last care inspection and minutes of these meetings had been recorded appropriately.	

Recommendation 4 **Ref:** Standard 12 **Stated:** First time	The registered should ensure that the menu offers a choice of two meals from which patients may select their preferred option.	**Met**
	Action taken as confirmed during the inspection: A review of the most recent menu evidenced a choice of two meals for patient selection.	

4.3 Inspection findings

4.3.1 Staffing

A review of the staffing rota for the period 2 to 8 January 2017 and discussion with the registered manager 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. One staff respondent in a questionnaire was of the opinion that staffing levels were not sufficient to meet patients' needs. This information was passed to the registered person to review.

4.3.2 Care Practices

At 07.30 hours, four patients were observed within the dining room seated in their wheelchairs at dining room tables. Breakfast did not commence until 08.15. A review of patient care records and discussion with the patients confirmed that it was their preference to rise early in the morning. A recommendation was made to review the location were patients who rise early are placed prior to the serving of breakfast.

The serving of breakfast was observed. Six patients were observed seated in wheelchairs at the dining table. Patients' feet were observed on the floor underneath the wheelchair footrests which had not been appropriately folded to the side of the wheelchair. A recommendation was made.

Breakfast in the home was well supervised and patients appeared to enjoy this mealtime. Food was served when patients were ready to eat or be assisted with their meal. Patients wore appropriate clothing protectors were necessary and staff wore aprons when serving and assisting with meals. A range of drinks were served to the patients. Staff were knowledgeable in regard to the special dietary requirements of patients. Breakfast was observed to finish at 11.20 hours. It was observed that the assisted tea trolley was available to patients at 11.00 hours and the serving of lunch commenced at 12.30 hours and 13.00 hours. It was concerning that the morning routine did not allow for sufficient 'gaps' between meals times. A recommendation was made that the registered manager reviewed the mealtimes for patients across all meals and to include how staff provide assistance, serve meals in a timely manner and ensure adequate 'gaps' between meals.

Incidents/accidents had been recorded as having occurred, although, the management of the incident/accident had not been appropriately recorded. For example, the management following a fall were the patient had/may have had a head injury did not evidence central nervous system (CNS) observation checks immediately on checking the patient and monitored for a minimum of 24 hours following the accident as per best practice guidelines. A recommendation made in the previous inspection has now been stated for a second time.

4.3.3 Care Records

Review of records pertaining to the management of wounds evidenced that registered nurses were not adhering to regional guidelines and the care planning process. For example, one patient had no wound assessment, care plan or observation chart relating to a wound that had occurred following an accident. A second patient's wound care plan did not identify a specific dressing regime and directed the wound dressing 'as per wound chart'. The wound observation chart indicated more than one wound though only included the individualised detail of one single wound. Wound dimensions had not been measured for four weeks. A gap of nine days between wound dressings was evident within the patient care records with no reference made to either the wound or wound dressings. A requirement made on the previous QIP regarding the recording of wound management, has been stated for a second time (see section 4.2).

A review of risk assessments within three patient care records evidenced deficits in malnutrition universal screening tool (MUST) and Braden assessments. All MUST assessments reviewed had been last recorded in November and not monthly as required. One patient with a MUST score indicating a high risk of weight loss had two MUST assessments completed since July 2016. A second patient had an assessment scored with no evidence that a weight had been recorded. Braden risk assessments had been recorded inconsistently. One Braden assessment had been repeated twice since July 2016. This assessment indicated that the patient was of a moderate risk of developing pressure damage, though did not inform any care plan. A second Braden assessment had been updated although was not reflective of the patient's current condition in two of the assessed areas. A requirement was made.

4.3.4 Consultation

On inspection one registered nurse, four carers and four ancillary staff members were consulted to ascertain their views of life in Tamlaght. Staff consulted confirmed that when they raised a concern, they were happy that the home's management would take their concerns seriously. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Three of the questionnaires were returned within the timescale for inclusion in the report. One respondent was not of the opinion that their concerns were taken seriously.

Some staff comments were as follows:
"It's great here."
"I love working here."
"It's ok but it can be stressful work."
"The work can be very hard."

On inspection eight patients were consulted and the patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Nine patient questionnaires were left in the home for completion. All nine patient questionnaires were returned within the timeframe. All respondents were satisfied or very satisfied with the care provided.

Some patient comments were as follows:
"I love it in here."
"They (the staff) are lovely to us."
"It's a great place here."
"I am very happy here."

No patient representatives were consulted with on the day of inspection. Seven relative questionnaires were left in the home for completion. One relative questionnaire was returned. The respondent was positive in their response.

4.3.5 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Fire exits and corridors were maintained clear from clutter and obstruction.

Issues on IPC which had been identified within the previous inspection report had been adequately managed. However, the following issues were identified which were not managed in accordance with best practice guidelines in IPC:

- inappropriate storage in identified rooms
- patients' bed heads and bed rails in disrepair
- skirting boards and architraves requiring refurbishment
- clean laundered clothing hanging above and in contact with unclean clothing in laundry
- chipped and missing tiles in sluice
- commodes stored directly beside sluicing area

The above issues were discussed with the registered person and an assurance was provided that these areas would be addressed with staff and measures taken to prevent recurrence. A requirement was made. A requirement made in the previous inspection with regards to ensuring that robust systems were in place to ensure compliance with best practice in infection prevention and control within the home has been stated for a second time.

Doors leading to the dining room, treatment room and kitchen were observed to have been wedged open during the review of the environment. This was discussed with staff who confirmed that the doors had to be maintained in an open position at certain times to allow for the passage of patients in wheelchairs, meal trolleys and medicine trolleys. This was discussed with the registered person and a recommendation was made to ensure that a magnetic lock, or a device with a similar function, was applied to the identified doors to facilitate safe and healthy working practices within the home.

Two shower chairs were observed in two shower rooms with a lap belt attached to each of them. The lap belts had been attached to the chairs with cable ties by person/s within the home and not in accordance with manufacturers' guidelines. The registered manager confirmed that shower chairs with fitted lap belts had not been ordered and the belts were removed during the inspection. A requirement was made to ensure equipment used within the home was only used for the purpose in which it was designed for by the manufacturer and not altered by any persons not qualified/authorised to do so.

4.3.6 Staff Training

Discussion with staff and the registered manager and a review of training records confirmed that the majority of staff were compliant with mandatory training requirements. However, discussion with staff also highlighted a deficit in knowledge with regards to the management of distressed reactions with patients. This was discussed with the registered manager and a recommendation was made to ensure all staff had appropriate training in the management of patients' distressed reactions reflective of their role.

Areas for improvement

Requirements have been made on the management of wound care, risk assessments and infection prevention and control. Recommendations have been made around placement of patients, mealtimes, staff training, safe use of equipment and safe working practices.

Number of requirements	2	**Number of recommendations**	6

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Fiona Gray, Registered Person, 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 nursing.team@rqia.org.uk 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 17 (1) **Stated:** Second time **To be completed by:** 5 February 2017	The registered provider must ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. **Ref: Section 4.2, 4.3.5**
	Response by registered provider detailing the actions taken: We have continued with the refurbishment of the skirting boards and architraves, replacement of cracked or missing tiles and looked again at storage. Laundry staff have changed the way they do things in order to avoid contact between clean and dirty linen. Other identified areas are under review.
Requirement 2 **Ref:** Regulation 19 (1) (a) Schedule 3 (1) (a) (b) (3) (K) **Stated:** Second time **To be completed by:** 7 January 2017	The registered person must ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **Ref: Section 4.2, 4.3.3**
	Response by registered provider detailing the actions taken: An audit tool has been designed to allow us to audit the patient records to ensure compliance with best practice.
Requirement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 7 January 2017	The registered person must ensure that MUST and Braden risk assessments are conducted as required and result in appropriate actions being taken and recorded. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Both MUST and Braden are included in the new audit tool.
Requirement 4 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 7 February 2017	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. **Ref: Section 4.2, 4.3.5**
	Response by registered provider detailing the actions taken: All the areas identified have been addressed.

Recommendations	
Recommendation 1 **Ref:** Standard 35 **Stated:** Second time **To be completed by:** 5 February 2017	It is recommended that incidents/accidents are managed and recorded in accordance with best practice and professional guidance. **Ref: Section 4.2, 4.3.2**
	Response by registered provider detailing the actions taken: Staff have been issued with a detailed protocol of the steps to be followed after a suspected or potential head injury.
Recommendation 2 **Ref:** Standard 44 **Stated:** Second time **To be completed by:** 5 February 2017	It is recommended that patients have a means of summoning assistance, if required, within the identified area. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: This is now in place.
Recommendation 3 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 7 January 2017	The registered person should review the location in which early risers are placed to prevent an elongated time for patients to be seated in wheelchairs waiting for the serving of breakfast. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Where appropriate, and desired, residents are transferred into the lounge chairs until breakfast is served.
Recommendation 4 **Ref:** Standard 47 **Stated:** First time **To be completed by:** 5 February 2017	The registered person should ensure that footrests on wheelchairs are folded away and patients' feet are securely on the floor when seated in wheelchairs unless this has been assessed and care planned as inappropriate. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Care staff have been reminded about the correct use of wheelchairs, foot plates and lap belts both when stationary and when moving.
Recommendation 5 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 5 February 2016	The registered manager should review the mealtimes for patients across all meals to include how staff provide assistance, serve meals in a timely manner and ensure adequate 'gaps' between meals. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: This is under review with us trying several different timings and looking at different use of resources to see which will optomise the experience for our residents.

Recommendation 6 **Ref:** Standard 47 **Stated:** First time **To be completed by:** 19 February 2017	The registered person should ensure a magnetic lock or similar device is applied to the identified doors in the dining, kitchen and treatment rooms to facilitate safe and healthy working practices within the home. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: This has been requested.
Recommendation 7 **Ref:** Standard 47 **Stated:** First time **To be completed by:** 7 January 2017	The registered person should ensure that equipment in the home is only used for the purpose that it was designed for and no alterations should be made to any equipment in the home unless the person is authorised and trained to do so. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: There is no equipment in the home which has been altered inappropriately and staff are fully aware that it must not happen.
Recommendation 8 **Ref:** Standard 17 Criteria (7) **Stated:** First time **To be completed by:** 1 April 2017	The registered person should ensure that staff within the home receive training pertinent to their role on distressed reactions in patients. **Ref: Section 4.3.6**
	Response by registered provider detailing the actions taken: We have sourced a provider for training in dealing with distressed reactions.

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

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