Tamlaght
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BT38 7DY

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Unannounced Care Inspection
of
Tamlaght

14 March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 14 March 2016 from 11.45 to 18.00.

The focus of this inspection was continence management which was underpinned by selected criteria from:
Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Health care and Standard 39: Staff Training and Development of the DHSSPSNI Care Standards for Nursing Homes (2015).

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Please also refer to sections 5.2 and 6.2 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Tamlaght which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 16 September 2016.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	*7

*The total number of recommendations includes three recommendations stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered person, Fiona Gray, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Tamlaght Private Nursing Home 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: RC-I, NH-I, NH-LD	**Number of Registered Places:** 45
Number of Patients Accommodated on Day of Inspection: 43	**Weekly Tariff at Time of Inspection:** £470 - £613

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the selected criteria from the following standards have been met:

Standard 4: **Individualised Care and Support, criterion 8**
Standard 6: **Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8 and 15**
Standard 21: **Health Care, criteria 6, 7 and 11**
Standard 39: **Staff Training and Development, criterion 4**

4. Methods/Process

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

- discussion with the registered manager
- discussion with patients
- discussion with patient representatives
- discussion with staff
- review of a selection of records
- observation during a tour of the premises
- evaluation and feedback.

The inspector met with 14 patients, four patient representatives, four care staff, two ancillary staff members and two registered nurses.

Prior to inspection, the following records were analysed:

- 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 returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report

The following records were examined during the inspection:

- a sample of staff duty rotas
- staff training records
- four patient care records
- selection of personal care records
- a selection of policies and procedures
- incident and accident records
- care record audits
- infection control audits
- regulation 29 monthly monitoring reports file
- guidance for staff in relation to continence care
- records of complaints.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced finance inspection dated 2 November 2015. The completed QIP was returned and approved by the finance inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection dated 16 September 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref:** Regulation 16 (2) (b) **Stated:** Third time	It is required that a procedure is established to evidence that patient's individual care plans are reviewed and evaluated on at least a monthly basis.	**Met**
	Action taken as confirmed during the inspection: A review of four patient care records evidenced the care plans within had been reviewed and evaluated on a monthly basis or more often as required.	
Requirement 1 **Ref:** Regulation 13 (7) **Stated:** Second time	The registered person must ensure that hoists, slide sheets and slings are not stored in the bathroom/shower room.	**Met**
	Action taken as confirmed during the inspection: During a tour of the premises, the bathroom / shower room was reviewed. Hoists, slide sheets and slings were no longer stored within the room.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 39.4 **Stated:** First time	The registered person should ensure that training is provided to staff, relevant to their roles in: • communicating effectively • death, dying and bereavement • palliative and end of life care.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of the training records evidenced 27 staff had completed palliative and end of life care training which incorporated communication and death, dying and bereavement.	
Recommendation 2 **Ref:** Standard 32 Criteria (1) (8) **Stated:** First time	The registered person should ensure that registered nurses develop care plans, as relevant, on patients requiring end of life care. Care plans should include patients' and/or their representatives': • individual needs and wishes • cultural, spiritual and religious preferences.	**Not Met**
	Action taken as confirmed during the inspection: A review of a patient's end of life care plan evidenced terminology used such as, 'assess wishes' and 'discuss fears, anxieties, spiritual needs and religious beliefs'. The care plan did not identify the patient's wishes, fears, anxieties, spiritual needs and religious beliefs.	
Recommendation 3 **Ref:** Standard 4 **Stated:** First time	Patients and/or their representatives should be involved in the assessment; planning and evaluation of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record. Staff should record communication between the home and patients families/representatives.	**Met**
	Action taken as confirmed during the inspection: A review of four patient care records evidenced patient and/or representative involvement via a signed care plan agreement form. Communication between the home and patients' families / representatives was also evident within the patient care records.	

Recommendation 4 **Ref:** Standard 36.2 **Stated:** First time	The policies on palliative and end of life care and death and dying should be reviewed in line with current regional guidance, such as GAIN *Palliative Care Guidelines (2013).*	**Met**
	Action taken as confirmed during the inspection: A new Palliative and End of Life Care Policy was available on inspection and made reference to the GAIN Palliative Care Guidelines (2013).	
Recommendation 5 **Ref:** Standard 32 **Stated:** First time	The registered person should ensure that a protocol for timely access to any specialist equipment or drugs is developed. A system to implement the protocol should confirm that all relevant staff have read the document with evidence of staff signature and date.	**Met**
	Action taken as confirmed during the inspection: A protocol for timely access to any specialist equipment or drugs was not available on inspection. However, staff were aware of the content of the protocol. A copy of the protocol was sent to RQIA following the inspection with an assurance that the protocol was on display at the nurses' station and the treatment room.	
Recommendation 6 **Ref:** Standard 35 Criteria (16) **Stated:** First time	Quality monitoring and audit systems in the home should evidence the action taken to address any identified shortfall and improvement with validation of outcomes by the manager.	**Not Met**
	Action taken as confirmed during the inspection: Audits reviewed did not evidence the action taken to address shortfalls or validation of outcomes by the manager. This was discussed with the registered manager and it was agreed that an action plan to address shortfalls and validation of outcomes should be recorded within the audit.	

Recommendation 7 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	
	Action taken as confirmed during the inspection: Evidence of one infection control audit being conducted was available on inspection. However, during a tour of the premises, there was evidence that compliance with infection control best practice had not been achieved. Please see section 5.4.2 for further clarification.	**Not Met**

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies on Continence Promotion; Constipation and Catheterisation were in place to guide staff regarding the management of continence.

Best practice guidance on continence care was available in the home for staff to consult from the National Institute for Health and Clinical Excellence (NICE) and the British Geriatric Society (BGS).

These included:
- Urinary Incontinence in Women (NICE)
- Continence Care in Residential and Nursing Homes (BGS)

Discussion with the registered manager and staff and a review of the training records confirmed that 19 staff had received training in continence product management.

Discussion with the manager and staff and information sent to RQIA following the inspection, confirmed there was one registered nurse trained and deemed competent in male/female urinary catheterisation. The registered person identified that other staff had received catheterisation training historically, though required update training prior to performing the task. The registered person agreed that further training on catheterisation would be sourced.

Staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Observation during the inspection and discussion with staff evidenced that there were adequate stocks of continence products available in the nursing home.

A continence link nurse had not been identified for the home. However, in discussion, the registered person stated that plans were in place to establish a continence link nurse for the home.

Is Care Effective? (Quality of Management)

Review of four patients' care records evidenced that a continence assessment was in place for each patient. This assessment clearly identified the patient's continence needs. A care plan was in place to direct the care to adequately meet the needs of the patients.

There was evidence in all four patient care records reviewed that Malnutrition Universal Screening Tool (MUST) risk assessments and Braden assessments had been reviewed consistently on a monthly basis.

Four continence care plans had been reviewed and updated on a monthly basis or more often as deemed appropriate. There was evidence within the care records of patient and/or representative involvement in the development of the care plans.

Bowel assessments had been completed in the four patient care records reviewed. However, the assessments did not consistently identify the patients' normal bowel habit. A recommendation was made. Records relating to the management of bowels were reviewed which evidenced that staff consistently made reference to the Bristol Stool Chart.

Fluid targets had not been identified consistently within the patient care records. Fluid targets should be recorded on the fluid intake charts and deficits clearly recorded in the patients' daily evaluation to include actions taken to address the shortfall. A recommendation was made.

Patients requiring assistance in managing pressure relief had appropriate repositioning charts recorded. There was a clear record of patient skin checks being carried out within these records.

Records reviewed evidenced that urinalysis was undertaken as required and patients had been referred to their GPs appropriately.

Is Care Compassionate? (Quality of Care)

On inspection, good relationships were very evident between patients and staff. Staff were noted to treat the patients with dignity and respect and responded to patients' requests promptly. Patients confirmed that they were happy in the home and that staff were kind and attentive.

Patients who could not verbally communicate appeared well presented and displayed no signs of distress. The patients appeared comfortable in their surroundings.

Areas for Improvement

It is recommended that patients' normal bowel habits, including frequency of movements and Bristol Stool Score, should be identified on admission and thereafter in bowel management records.

It is recommended that fluid targets are calculated for patients and any shortfall of the target should be recorded to include any actions taken to address the shortfall.

Number of Requirements:	**0**	**Number of Recommendations:**	**2**

5.4 Additional Areas Examined

5.4.1. Consultation with Patients, Representatives and Staff

During the inspection process, 14 patients, four patient representatives, four care staff, two ancillary staff members and two registered nurses were spoken with to ascertain their personal view of life in Tamlaght. The feedback from the patients, representatives and staff indicated that safe, effective and compassionate care was being delivered in Tamlaght.

Some patients' comments received are detailed below:
'I find the staff very nice.'
'I am happy here.'
'It's ok. The food's good.'
'It's very good.'
'It's alright here.'

Four patient representatives consulted were positive in their experience of Tamlaght and a sample of comments received are detailed below:
'I think they're great here.'
'We are very happy with the care.'
'They are very good. They do their best.'

The view from staff during conversations was that they took pride in delivering safe, effective and compassionate care to patients.

Some staff comments received are detailed below:
'I'm happy here in my job.'
'The girls are very good.'
'It's dead on. I enjoy it.'
'It's ok here.'
'It's fine.'

5.4.2. Infection Prevention and Control and the Environment

A tour of the home confirmed that rooms and communal areas were generally clean and spacious. However, a range of issues were identified within the home which were not managed in accordance with infection prevention and control guidelines:

- inappropriate storage in identified rooms
- identified chair ripped
- rusting and broken bin in use
- no covering on identified pull cords
- nail brush on sink in communal shower room
- urine bottle on sink in communal toilet
- shower gels and shampoo unlabelled in bathroom
- unlabelled topical preparation in shower room
- unclean toilet aid

The above issues were discussed with the registered person on the day of inspection. An assurance was provided by the registered person that these areas would be addressed with staff to prevent recurrence. A previous recommendation, that management systems were put in place to ensure compliance with best practice in infection prevention and control, has been stated for a second time.

5.4.3. Topical preparations

During a tour of the premises, a topical preparation was observed in a patient's bedroom. The label on the preparation did not match the named patient in the room. A recommendation was made that topical preparations are only used to treat the patient the preparation was prescribed for.

5.4.4. Duty Rota

The duty rota for week commencing 7 March 2016 was reviewed on inspection. It was observed that the hours worked by the manager did not reflect the hours worked in a managerial capacity and hours worked in a nursing capacity. The duty rota had not been verified by the registered manager or a designated representative as approved. A recommendation was made.

Areas for Improvement

It is recommended that more robust systems should be implemented to ensure compliance with infection prevention and control.

It is recommended that topical preparations should only be used on the person for whom they are prescribed.

It is recommended that the home's duty rota reflect the hours the manager works in a managerial and/or nursing capacity. The duty rota should also be approved with a manager's signature and date on completion.

Number of Requirements:	**0**	**Number of Recommendations:**	**2**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered person, Fiona Gray, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref:** Standard 32 Criteria (1) (8) **Stated:** Second time **To be Completed by:** 31 May 2016	The registered person should ensure that registered nurses develop care plans, as relevant, on patients requiring end of life care. Care plans should include patients' and/or their representatives': • individual needs and wishes • cultural, spiritual and religious preferences. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: care plans are in place for each resident stating their and/or representatives wishes for end of life care.
Recommendation 2 **Ref:** Standard 35 Criteria (16) **Stated:** Second time **To be Completed by:** 31 May 2016	I Quality monitoring and audit systems in the home should evidence the action taken to address any identified shortfall and improvement with validation of outcomes by the manager. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Monthly care plan action plan forms in place. Any shortfalls identified during monthly audits are then addressed by the named nurse and form signed before returned to nurse manager/deputy manager on completion.
Recommendation 3 **Ref:** Standard 46 Criteria (1) (2) **Stated:** Second time **To be Completed by:** 31 May 2016	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection. **Ref: Section 5.2, 5.4.2**
	Response by Registered Person(s) Detailing the Actions Taken: Monthly infection prevention and control audit in place to monitor quality and performance..and promote best practice

Recommendation 4 **Ref:** Standard 4 Criteria (1) (7) **Stated:** First time **To be Completed by:** 31 May 2016	The registered person should ensure that patient continence assessments and care plans are fully completed and include the patients' normal bowel pattern. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: continence assessments are in place and evalued monthly to identify any changes. Normal bowel habits are stated for each resident
Recommendation 5 **Ref:** Standard 4 **Stated:** First time **To be Completed by:** 31 May 2016	Fluid targets should be calculated for patients at risk and documented on fluid intake charts. Identified deficits with corresponding remedial actions should also be recorded within the patients' daily evaluation. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: each residents daily fluid intake target is recorded on a fluid chart. also recorded in daily evaluation if this target has/has not been achieved.
Recommendation 6 **Ref:** Standard 28 Criteria (1) **Stated:** First time **To be Completed by:** 30 April 2016	It is recommended that topical preparations are only administered to the person for whom they are prescribed. **Ref: Section 5.4.3**
	Response by Registered Person(s) Detailing the Actions Taken: care staff reminded that topical creams must only be administered to the person for whom they are prescribed.
Recommendation 7 **Ref:** Standard 41 **Stated: F**irst time **To be Completed by:** 31 May 2016	The registered person should ensure hours worked by the manager in a nursing or managerial capacity are reflected in the duty rota. The duty rota should be verified on completion, with a signature and date, by the nurse manager or designated representative. **Ref: Section 5.4.4**
	Response by Registered Person(s) Detailing the Actions Taken: Nurse managers hours are clearly stated on rota differentiating between managerial/nursing duties. The rota is signed and dated upon completion

Registered Manager Completing QIP	Pam McDermott Deputy manager	**Date Completed**	08/05/16
Registered Person Approving QIP	Fiona Gray	**Date Approved**	10/05/16
RQIA Inspector Assessing Response	Dermot Walsh	**Date Approved**	18/05/2016

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address