Unannounced Care Inspection Report
28 November 2016

Drummaul House

Type of Service: Nursing Home
Address: 41 New Street, Randalstown, BT41 3AF
Tel no: 02894473958
Inspector: Karen Scarlett

1.0 Summary

An unannounced inspection of Drummaul Nursing Home took place on 28 November 2016 from 09.35 until 14.50 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to inspect the recently designated, six bedded unit accommodating patients with delirium.

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	**0**	**8**

The recommendations above include one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Sarah Brady, deputy manager, 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 23 June 2016. Other than those actions detailed in the QIP there were no further actions required to be taken following 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: Hutchinson Homes Ltd	**Registered manager:** Maria Margaret Bothwell
Person in charge of the home at the time of inspection: Sarah Brady, Deputy manager	**Date manager registered:** 1 April 2005
Categories of care: RC-I, RC-MP(E), RC-PH(E), NH-I, NH-PH	**Number of registered places:** 43

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events submitted since the last inspection
- the registration status of the home
- written and verbal communication received since the last inspection
- the returned quality improvement plan (QIP) from the last inspection
- the previous care inspection report
- pre-inspection audit.

During the inspection we met with eight patients individually and with others in small groups, one registered nurse, five care staff, one ancillary staff, two visiting professionals and two resident's visitors/representative. An inspection of the premises was carried out including a selection of bedrooms, lounges, dining rooms, store rooms and bathrooms.

Questionnaires were given to the deputy manager to distribute to patients, patients' representatives and staff not on duty on the day of inspection.

The following information was examined during the inspection:

- six patient care records and a selection of daily charts
- monthly quality monitoring reports
- staff duty rota from 21 November to 4 December 2016
- a sample of incident and accident records
- a sample of complaints records
- staff training records
- staff meeting minutes
- resident meeting minutes
- a selection of audits.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 23 June 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector. This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection Dated 3 May 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39 **Stated:** First time	The registered persons should ensure that training in safe moving and handling is provided to all staff.	**Met**
	Action taken as confirmed during the inspection: A review of staff training records and discussion with staff evidenced that the majority of staff had undertaken this training and the remaining staff had dates arranged for their training. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 48 **Stated:** First time	The registered persons should ensure that fire doors are not wedged open in order to protect patients, staff and visitors in the event of a fire.	**Met**
	Action taken as confirmed during the inspection: No fire doors were observed to be wedged open on the day of inspection.	
Recommendation 3 **Ref**: Standard 23 **Stated:** First time	The registered persons should ensure that the repositioning charts are updated to reflect best practice guidelines. The charts should evidence that the patient has been effectively repositioned or document if a patient declines to be repositioned.	**Met**

	Action taken as confirmed during the inspection: The repositioning charts had been reviewed and updated since the previous care inspection and were reflective of best practice guidance. They were generally well completed to reflect the position of the patient. This recommendation has been met. It was noted that the frequency of repositioning required was not consistently completed on the charts. A recommendation has been made in this regard.	
Recommendation 4 **Ref**: Standard 16 **Stated:** First time	The registered persons should review the negative comments and observations made in relation to the provision of timely care. Patients' level of satisfaction should be assessed and any concerns addressed accordingly.	**Met**
	Action taken as confirmed during the inspection: The minutes of a residents' meeting, which took place following the previous inspection, were reviewed. Patients were reminded of how to raise concerns. No complaints were made at the meeting and no concerns were expressed in relation to timely care during the inspection. This recommendation has been met.	
Recommendation 5 **Ref**: Standard 35 **Stated:** First time	The registered person should ensure that actions identified during the monthly quality monitoring visits are carried forward for review at subsequent visits to ensure that issues have been appropriately addressed.	**Not Met**
	Action taken as confirmed during the inspection: Monthly quality monitoring visits had been completed but there was no evidence that actions identified on previous visits were carried forward to subsequent visits to ensure these issues had been addressed. This recommendation has not been met and has been stated for a second time.	

4.3 Inspection findings

4.3.1 Delirium Unit

A six bedded unit had recently been established within the home, in partnership with the local Trust to accommodate patients who may have challenging behaviours as a result of delirium. Referral criteria are in place to ensure that admissions to the home are appropriate. Intensive

support has been made available from a dedicated, multi-disciplinary, delirium team in the Trust. The registered manager and director had met with RQIA to discuss the new unit prior to opening and there had been ongoing communication as any issues have arisen. Staff had undertaken face to face training in challenging behaviours, delirium and safeguarding. The deputy manager and Trust social worker stated that although it was a new unit the staff had been coping very well and they had had some success in resolving delirium and enabling patients to return home.

In the morning the majority of patients in the unit were up and dressed and sitting in the lounge at their breakfast and others were in bed as was their preference. Patients were well presented and content. Relationships between patients and staff were friendly and staff could be observed meeting the needs of patients and offering reassurance as was required.

On discussion with staff it was noted that a key pad was in place at the entrance to the unit but that the door was open. Staff confirmed that this was only locked when an identified patient was awake and mobilising, as they displayed behaviours which were particularly challenging, mainly to staff. The current categories of care for which the home is registered would not permit a 'locked unit' and this represented a potentially restrictive practice, depriving residents of their liberty and freedom of movement. On review of the care records of patients within the unit only one had a care plan regarding restrictive practice/ deprivation of liberty. This did not include the identified patient referenced above.

On discussion with the deputy manager it was agreed that the key pad would be deactivated, the door would not be locked except in an emergency situation in which patients presented a risk to themselves or others and that this decision would be made by the nurse in charge. In addition, the deputy manager assured RQIA that deprivation of liberty care plans would be put in place for each resident who required them. This was confirmed in an email to RQIA following the inspection. A recommendation has been made that staff receive training and/or supervision in relation to restrictive practice and deprivation of liberty.

The lunch time meal in the unit was observed and it was noted that most patients were served their meal in the lounge on a side table beside their armchairs. Two patients were seated at a dining table but the table was not big enough to accommodate all six patients in the unit should they wish to take their meal at the table. A recommendation has been made.

It was further noted that one patient had been asleep since the start of the inspection and had not been woken for lunch by 13.00 hours. When asked, neither care staff nor registered nurses were able to ascertain when food of fluids had last been taken. On discussion with the deputy manager it became apparent that the patient was awake during the night on many occasions and slept on in the mornings. A member of the Trust team was observed to be working with the patient to encourage them to eat and drink. Once alerted to the situation efforts were made by the home staff to get the patient up and attend to their personal care and nutritional needs. A review of daily care records evidenced significant fluid deficits over the preceding days and there was no evidence in the documentation that appropriate action had been taken to address this. However, a doctor was visiting the home on the day of inspection and assessed the patient. A recommendation has been made that when a fluid deficit is identified that action is taken to address this. A review of the patients care plan did not evidence that the recommendations of the trust team in relation to improving the quality of the patient's sleep had been incorporated in to the care plan. Refer to section 4.3.2 for further information on findings in relation to care planning.

On discussion with staff and a visiting social worker the suitability of the placement for the identified patient was discussed. They stated that the patient was under daily review and all alternatives were being considered in order to best meet their needs.

4.3.2 Care Planning

Review of six patients' care records, from throughout the home, evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. The risk assessments had been used to inform the care planning process. It was noted that the care plans were not person-centred and were not consistently reflective of the recommendations of the multi-disciplinary team. A recommendation has been made. This was acknowledged by the deputy manager who had recently conducted a number of care record audits and identified similar issues. Further audits were planned and staff were to receive a copy of this audit and return it signed when the amendments had been made.

4.3.3 Mealtime Experience

The lunch time meal was observed in both dining rooms in the main nursing unit. A menu was on display and the meal appeared appetising. Clothing protection was in use as appropriate and timely assistance was available from staff for patients who required this. It was noted that jugs of water or juice were not made available on the tables. At a recent residents' meeting this had been requested by patients. A recommendation has been made. Two patients and one relative complained that the lunch was served cold. The relative complained that this had happened previously. This was brought to the attention of the cook and the deputy manager to address. A recommendation has been made.

4.3.4 Comments of patients, representatives and staff

As part of the inspection patients, their representatives, staff and visiting professionals were asked if care was safe, effective and compassionate and if the service was well led. Questionnaires were also issued. Two visiting professionals were spoken with and they commented positively on the quality of care provided and neither raised any concerns.

4.3.4.1 Patients' Comments

Patients spoken with were complimentary in regards to the staff and the care provided. Good relationships between staff and patients were evident and staff could were noted to be meeting patients' needs in a timely manner. No questionnaires were returned from patients. Comments from patients on inspection included:

"It's very good here. I have all my orders. I get to eat whenever I like."
"You'll find it's a hundred percent here."

4.3.4.2 Patients' Representatives Comments

Two patients' relatives were spoken with at the inspection. One relative was very satisfied with the care provided and stated that they had never had cause to complain to the management or staff. Another relative commented that the lunch was cold, as stated previously, and these concerns were shared with the deputy manager. No patients' representatives returned questionnaires.

4.3.4.3 Staff Comments

Staff spoken with were positive about working in the home. One bank member of staff commented that they thought this was the best home they had worked in. Staff confirmed that they had regular training and could approach the manager if they had concerns. No concerns were raised by staff regarding staffing levels except where there were instances of short notice sick leave. Staff also commented that they were allocated into teams and clearly knew their roles and responsibilities. Five staff returned questionnaires within the timeframe for inclusion in this report. Four respondents were satisfied that care was safe, effective and compassionate that that the service was well led. One respondent was unsatisfied. One respondent stated that they felt under pressure at times and two respondents were of the opinion that communication between staff could be improved. Concerns raised in the questionnaires were shared with the registered manager for information and action as required.

Areas for Improvement

A total of eight recommendations were made at this inspection. This includes one recommendation which has been stated for a second time.

Number of requirements	0	Number of recommendations	8

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Sarah Brady, deputy manager, 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 – no requirements were made as a result of this inspection

Recommendations	
Recommendation 1 **Ref**: Standard 35 **Stated:** Second time **To be completed by:** 31 January 2017	The registered person should ensure that actions identified during the monthly quality monitoring visits are carried forward for review at subsequent visits to ensure that issues have been appropriately addressed. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: This has been discussed with the reg 29 inspector and any recommendations will be followed up in future during their next visit.
Recommendation 2 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 31 December 2016	The registered provider should ensure that the frequency of repositioning required for each patient is recorded on the repositioning charts. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: This information has been recorded on each repositioning sheet and daily recorded audits are being carried on these sheets by a staff nurse . The required information for each patient has been condensed into a single page kept at the nurses station and is easily accessible for all staff to refer to when necessary.
Recommendation 3 **Ref**: Standard 18, criterion 10 **Stated:** First time **To be completed by:** 31 March 2017	The registered provider should ensure that staff receive training and/or supervision in relation to restrictive practice and deprivation of liberty appropriate to their role. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: This training is being carried out by trust staff from the mental health for older peoples team - dates yet to be confirmed by them.
Recommendation 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** From the date of inspection	The registered provider should ensure that when fluid deficits are identified that appropriate action to address this and these actions documented. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: Appropriate action is being taken when fluid deficits are identified and this is recorded within the patients records.

Recommendation 5 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 31 December 2016	The registered provider should ensure that care plans are person centred and reflect the advice and recommendations of relevant health and social care professionals. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: This has been discussed at recent team meetings and care plan audits are continued to moniter this.
Recommendation 6 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 31 December 2016	The registered provider should ensure that facilities are available to enable patients in the delirium unit to take their meal at the dining table if this is their preferred choice. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: A second table has been purchased so that all 6 patients within the unit can have the choice of dining at a table if they wish to do so.
Recommendation 7 **Ref**: Standard 12, criterion 17 **Stated:** First time **To be completed by:** From the date of inspection	The registered provider should ensure that a choice of drinks are available at the dining tables to ensure this is visible and accessible to patients. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Water jugs are now made available on tables in the dining room for those patients who have the ability to serve themselves during meal times as well as a selection of Juices being on the serving trolleys in both the dining rooms.
Recommendation 8 **Ref**: Standard 12 **Stated:** First time **To be completed by:** From the date of inspection	The registered provider should ensure that the mealtime experience of patients is reviewed to ensure that hot food is served hot. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: This has been discussed with both catering and care staff to ensure all future meals are served hot.

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

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