The Regulation and Quality Improvement Authority

Inspection Report

2 June 2022

Drapersfield House

Type of service: Nursing Home
Address: 10 Drapersfield Road,
Cookstown, BT80 8RS
Telephone number: 028 8676 4868

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Drapersfield Ltd **Responsible Individual:** Mrs Jill Canavan	**Registered Manager:** Mrs Margaret Kolbohm **Date registered:** 16 June 2016
Person in charge at the time of inspection: Mrs Ailish Devlin, Clinical Governance Lead	**Number of registered places:** 45 There shall be a maximum of 1 named patient in category NH-MP(E) and there shall be a maximum of 1 named resident receiving residential care in category RC-I.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 38
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 45 people. Bedrooms and living areas are located over three floors with access to communal lounges, dining areas and gardens.	

2.0 Inspection summary

An unannounced inspection took place on 2 June 2022, from 10.15am to 5.30pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Areas for improvement were identified during the inspection as discussed throughout this report and quality improvement plan (QIP) in Section 6.0. Two areas for improvement have been

stated for a second time in relation to repositioning records and the recording of recommended dietary/fluid type within recording charts.

Patients told us that they felt well looked after. Patients who were less able to communicate their views were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report.

The findings of this report will provide the management team with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included "I am getting brilliant care here. The staff here are marvellous", "I feel very safe here", "Happy here" and "Well cared for".

Staff said that management were very approachable, teamwork was great and that they felt well supported in their role. One staff member said: "(I) can go to management with anything", "Good place to work" and "Really enjoy working here". There was no feedback from the staff online survey.

Six questionnaires were returned, three from patients and three from relatives. The respondents were either satisfied or very satisfied with the overall service provision. Comments included: "I would recommend this care home to others. Great caring, compassion and kindness", "I am more than pleased with the care ……. receives", "I am very well cared for and I am very happy and content", "All care is excellent", "Treated so very well" and " I am happy with my care".

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 8 April 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 21 (1) (a) (b) **Stated:** First time	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files prior to commencing employment.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of staff recruitment and selection files evidenced that this area for improvement had been met.	
Area for improvement 2 **Ref:** Regulation 20 (1) (c) (ii) **Stated:** First time	The registered person shall ensure a robust system is in place to ensure that relevant staff are registered with an appropriate professional regulatory body.	**Met**
	Action taken as confirmed during the inspection: Review of relevant governance records evidenced that this area for improvement had been met.	
Area for improvement 3 **Ref:** Regulation 16 (2) (b) **Stated:** First time	The registered person shall ensure that care records are maintained to direct the delivery of care. With specific reference: • where a patient has a relevant medical condition a care plan is implemented • patients at risk of dehydration have a care plan in place detailing the recommended	**Met**

	daily fluid target with the action to be taken, and at what stage, if the recommended target is not met.	
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with management evidenced that this area for improvement had been met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 29 **Stated:** Second time	The registered person shall ensure that all handwritten entries on medication administration records involve two trained staff to check that the information is accurate.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of medication administration records evidenced that this area for improvement had been met.	
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that where a patient has been assessed as requiring repositioning, the care plan accurately reflects the frequency of repositioning within the patient's recording charts.	**Partially met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with management evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that supplementary recording charts contain the following information: • the date of entry • relevant information regarding patient recommended dietary/fluid type • where abbreviations are utilised a code is provided to signify what they represent.	**Partially met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with management evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics including moving and handling, fire safety and adult safeguarding. Staff confirmed that they were provided with relevant training both online and face to face to enable them to carry out their roles and responsibilities effectively.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC).

Review of a sample of employee recruitment records evidenced that systems were in place to ensure that patients are protected.

Staff said they felt supported in their roles and that there was good team work with effective communication between staff and management. Staff also said that, whilst they were kept busy, the number of staff on duty was generally satisfactory to meet the needs of the patients.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the Manager was not on duty.

The inspector reviewed five staff competency and capability assessments for the nurse in charge in the absence of the Manager and found these to be completed. The Clinical Governance Lead confirmed that there was a system in place to review these assessments on a yearly basis.

A record of staff supervision and appraisals was maintained by management with staff names and the date that the supervision/appraisal had taken place. The Clinical Governance Lead discussed plans to increase the number of supervisions/appraisals which had been delayed due to the COVID-19 pandemic.

Patients said that they felt well looked after and that staff were attentive. One patient commented “the staff are very good here” and another patient referred to the staff as “very friendly.”

5.2.2 Care Delivery and Record Keeping

There was clear evidence of a relaxed, pleasant and friendly atmosphere between patients and staff. The inspector also observed where staff facilitated patients’ favourite music or television programme for those who were on bed rest.

Patients who were less able to mobilise require special attention to their skin care. Whilst most care records relating to repositioning were maintained, a number of recorded entries exceeded the recommended frequency of repositioning. Care records for one patient contained conflicting information regarding the frequency of repositioning and there was no recommended frequency

within the recording chart for a further patient. This was discussed in detail with management and an area for improvement has been stated for a second time.

The use of hoist slings specific to when a patient is seated was discussed with the Clinical Governance Lead and the potential to impact patients' skin integrity; following the inspection written confirmation was received from the Clinical Governance Lead that the use of hoist slings had been reviewed and relevant action had been taken.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. During the inspection a number of patients were seated within the dining rooms whilst others were either seated within the lounge or their bedroom. Discussion with staff and a number of patients evidenced that this was their personal choice.

Patients who choose to have their lunch in their bedroom or lounge had trays delivered to them and whilst the food was covered on transport it was noted that the desserts came from the kitchen uncovered. This was discussed with management who agreed to have desserts covered going forward.

There was a choice of meals offered and patients said they very much enjoyed the food provided in the home. Staff knew which patients preferred a smaller portion and demonstrated their knowledge of individual patient's likes and dislikes.

There was conflicting information within two patient's care plans, nutritional assessment and supplementary recording charts regarding their dietary recommendations. This was discussed with the Clinical Governance Lead and an area for improvement has been stated for a second time.

Whilst discussion with staff evidenced that they were providing the correct diet as recommended by the Speech and Language Therapist (SALT), two members of staff provided inaccurate information regarding an identified patient's fluid type. Details were discussed with the Clinical Governance Lead who agreed to review staff training needs where necessary. Following the inspection the Clinical Governance Lead confirmed in writing that relevant action had been taken to address this.

Review of three patients' care records evidenced that whilst the majority of care plans and risk assessments were reviewed regularly, a number were overdue. Details were discussed with the Clinical Governance Lead who acknowledged that these records should have been updated and agreed to have them reviewed. Following the inspection the Clinical Governance Lead confirmed in writing that relevant action had been taken to address this.

Review of a sample of care records specific to the management of daily fluid intake evidenced that the total volume of fluids consumed over a 24 hour period had not been totalled within the chart or recorded within patients' daily progress notes. It was further noted that the care plan did not contain the action to take and at what stage if the fluid target is not met. The importance of registered nurses having oversight of patients' daily fluid intake was discussed with the Clinical Governance Lead and an area for improvement was identified.

Whilst most care records were securely stored, supplementary care records were easily accessible within areas of the home. This was discussed with the Clinical Governance Lead who secured the records during the inspection and agreed to review the current storage arrangements to ensure that all records are held confidentially going forward.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was fresh smelling, neat and tidy and patients' bedrooms were found to be personalised with items of memorabilia and special interests. Outdoor spaces and gardens were well maintained with areas for patients to sit. The Clinical Governance Lead advised that refurbishment work was ongoing to both the internal and external of the home to ensure that it is maintained.

Whilst most corridors and fire exits were clear of clutter and obstruction an identified sluice room door was wedged open; a bedroom door was propped open with a chair and there was evidence that a further bedroom door had been wedged open. This type of practice was discussed with the Clinical Governance Lead and an area for improvement was identified.

Observation of the environment highlighted some areas in which cleaning items were not securely stored; the importance of ensuring that all areas of the home are hazard free was discussed with management and an area for improvement was identified.

The Clinical Governance Lead told us that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases and that any outbreak of infection was reported to the Public Health Agency (PHA).

Visiting and care partner arrangements were managed in line with the Department of Health and infection prevention and control (IPC) guidance.

There were a number of practices which were not in keeping with IPC best practice. For example; hand hygiene between patients at meal times; several staff members were observed wearing their face mask incorrectly and inappropriate storage of patient equipment in bedrooms, communal bathrooms and a lounge. The above details were discussed with management and an area for improvement was identified.

5.2.4 Quality of Life for Patients

Observation of life in the home and discussion with staff and patients established that staff engaged well with patients individually or in groups. One patient said; "Staff are very good" and "(I'm) happy here."

During the inspection a number of patients participated in chair exercise in the morning and a game of bingo in the afternoon with the activity coordinator. Other patients were observed engaged in their own activities such as; watching TV, resting or chatting to staff. Patients appeared to be content and settled in their surroundings and in their interactions with staff.

Patients commented positively about the food provided within the home with comments such as; "The food is good and plenty of choices", "If I don't like something on the menu they always make me something different" and "The food is very good here."

Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

There has been no change to management arrangements for the home since the last inspection. The Clinical Governance Lead said they felt well supported by the Manager and the Responsible Individual.

Review of accidents/incidents records confirmed that a notification was required to be submitted retrospectively to RQIA. Details were discussed with the Clinical Governance Lead and the relevant notification was submitted during the inspection.

A number of audits were completed on a monthly basis by the management team to ensure the safe and effective delivery of care. For example, care records, environment, IPC and hand hygiene. Where deficits were identified the audit process included an action plan but did not include the person responsible for completing the action, a time frame for completion or a follow up to ensure the necessary improvements had been made. This was discussed in detail with the Clinical Governance Lead and an area for improvement was identified.

The Clinical Governance Lead confirmed that the home was visited each month by the Responsible Individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were not available during the inspection. Following the inspection the Responsible Individual forwarded the relevant reports and confirmed in writing that reports would be made available within the home going forward.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	3	4*

* The total number of areas for improvement includes two standards that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Ailish Devlin, Clinical Governance Lead, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27 (4) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall take adequate precautions against the risk of fire to ensure the safety and wellbeing of patients in the home. Specific reference to ensuring: • that fire doors are not wedged/propped open. Ref: 5.2.3
	Response by registered person detailing the actions taken: Raised at staff metting and supervisions carried out. All doors assessed and Black boxes installed, were required.
Area for improvement 2 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered persons must ensure that all areas of the home to which patients have access are free from hazards to their safety. Ref: 5.2.3
	Response by registered person detailing the actions taken: Raised at staff meeting and supervisions carried out. Staff informed to read COSHH policy and where to locate it, staff advised to ensure all chemicals when not in use are locked away.
Area for improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance. Ref: 5.2.3
	Response by registered person detailing the actions taken: Raised at staff meetings and supervisions carried out. Daily walkabouts to ensure compliance.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	

Area for improvement 1 **Ref:** Standard 23 **Stated:** Second time **To be completed by:** 2 July 2022	The registered person shall ensure that where a patient has been assessed as requiring repositioning, the care plan accurately reflects the frequency of repositioning within the patient's recording charts. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: All careplans reviewed and all information is correct in both careplan and repositioning charts. Supervisions and staff meeting carried out to address, carefiles reviewed and audited.
Area for improvement 2 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 2 July 2022	The registered person shall ensure that supplementary recording charts contain the following information: • relevant information regarding patient recommended dietary/fluid type. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: All charts, reviewed and all information accurate and correct. Addressed at staff meeting and supervisions carried out, ongoing review.
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 16 June 2022	The registered person shall ensure that fluid intake management is clearly documented in individualised care plans and recording charts. This should include: • the patients recommended daily fluid intake target • the action to take and at what stage if the fluid target is not met • the total fluid intake over 24 hours is recorded within the daily fluid intake chart • there is daily oversight by registered nurses of patients total fluid intake over 24 hours. Ref: 5.2.2
	Response by registered person detailing the actions taken: All charts reviewed and monitored to ensure compliance. Raised at staff meeting and supervision carried out.
Area for improvement 4 **Ref:** Standard 35 **Stated:** First time **To be completed by:**	The registered person shall ensure that the full audit process is completed where an action plan has been implemented to include a time frame, the person responsible for addressing the deficit and a follow up. Ref: 5.2.5

2 July 2022	**Response by registered person detailing the actions taken:** Action plan devised to include a time frame have now been implemented.

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