Unannounced Inspection Report
17 November 2020

Chester

Type of Service: Nursing Home
Address: 27-29 Chester Avenue, Whitehead, BT38 9QQ
Tel No: 028 9335 3060
Inspectors: Mandy Ellis and Rachel Lloyd

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 43 persons.

3.0 Service details

Organisation/Registered Provider: Chester Homes Ltd **Responsible Individual:** Colin Nimmon	**Registered Manager and date registered:** Frank Mudie – 11 March 2020
Person in charge at the time of inspection: Babin George, Deputy Manager (08.00 – 14.00) Alexandru Moldoveano, staff nurse (14.00 – 20.00)	**Number of registered places:** 43 A maximum of 10 persons in category NH-PH. The home is also approved to provide care on a day basis to three persons. There shall be a maximum of two named residents receiving residential care in category RC-DE and one named resident receiving residential care in category RC-I.
Categories of care: Nursing Home (NH) DE – Dementia PH – Physical disability other than sensory impairment	**Number of patients accommodated in the nursing home on the day of this inspection:** 33

4.0 Inspection summary

An unannounced inspection was undertaken by a care and a pharmacist inspector on 17 November 2020 from 09.40 to 17.00 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

The inspection assessed progress with any areas for improvement identified at or since the last care and medicines management inspections and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The following areas were examined during the inspection:

- staffing arrangements
- Personal Protective Equipment (PPE)
- Infection Prevention and Control (IPC)
- environment
- care delivery
- governance and management arrangements
- medicines management.

The findings of this report will provide Chester with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Frank Mudie, manager and Angela Dorrian, regional 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.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care and medicines management inspections
- the returned QIPs from the previous inspections
- the previous inspection reports

During the inspection the care inspector met with four patients and nine staff. Ten questionnaires were left in the home to obtain feedback from patients and patients' representatives. A poster was displayed for staff, inviting them to provide feedback to RQIA online. The inspector provided the manager with 'Tell Us' cards which were then placed in a prominent position to allow patients and their relatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service. No responses to the staff survey were returned within the indicated timeframe.

The following records were examined:

- the duty rota from 9 November to 29 November 2020
- the home's registration certificate
- four patients' care records
- four patients' supplementary care charts in regard to repositioning
- two staff recruitment files
- complaints records
- incident and accident records
- a sample of monthly monitoring reports

A sample of the following records, regarding medicines management, was examined:

- personal medication records
- medicine administration
- medicine receipt and disposal
- controlled drugs
- care plans related to medicines management

- governance and audit
- staff training and competency
- medicine storage temperatures

Areas for improvement identified at the last care and medicines management inspections were reviewed and assessment of compliance recorded as met.

6.0 The inspection

6.1 Review of areas for improvement from previous inspections

The most recent inspection of the home was an unannounced care inspection undertaken on 21 November 2019. The most recent medicines management inspection was undertaken on 5 February 2019.

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that patient care plan records and care plan evaluations are completed in a comprehensive, accurate and contemporaneous manner in accordance with legislative and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: Four patient care plans were reviewed and were completed and evaluated accurately and in a contemporaneous manner.	
Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 29 **Stated:** Second time	The registered person shall ensure that personal medication records are closely monitored to ensure these are kept up to date at all times.	**Met**
	Action taken as confirmed during the inspection: The records examined were found to be accurate and up to date. Monitoring of these records was included in audit procedures and the small number of discrepancies that had been identified had been addressed.	

Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that medication administration records are fully and accurately maintained as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The records examined were found to be accurate and up to date. Monitoring of these records was included in audit procedures and the small number of discrepancies that had been identified had been addressed. Where handwritten additions were made to printed medication administration records (MARs); these were usually verified by two nurses/members of staff and it was evident this was the expected practice. It was agreed that this would take place on every occasion.	

6.2 Inspection findings

6.2.1 Staffing arrangements

On the day of the inspection we observed that staffing levels were satisfactory and patients' needs were being met in a prompt and timely manner. Staff did not express any concerns regarding staffing levels.

A review of the staff duty rota from 9 November to 29 November 2020 evidenced that the planned staffing levels were adhered to. Staff were able to identify the person in charge of the home in the absence of the manager. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.
We identified that on several occasions the full name of staff members working was not used; this was particularly evident when agency staff were utilised to cover shifts. An area for improvement was identified.

Staff spoken with commented positively about working in the home; comments included:

- "I like my job."
- "It is very rewarding here, but can also be challenging"
- "I like working with patients who have dementia."

6.2.2 Personal Protective Equipment (PPE)

Signage had been put up at the entrance to the home to reflect the current guidance on COVID-19. The manager told us that the home had a sufficient supply of PPE. PPE stations were found to be well stocked throughout the home.

Vinyl gloves were observed in PPE stations and in use for patient care; this was discussed with the regional manager for action as vinyl gloves are not recommended and are less effective in the clinical setting than other latex type gloves. The regional manager gave assurances that the

use of vinyl gloves will be reserved for duties that do not involve direct patient care. This will be followed up at a future inspection.

The walk around the home identified a lack of danicentres (wall mounted PPE dispensers) in two specific areas of the home, this was discussed with the manager who agreed to review and purchase additional danicentres as required.

6.2.3 Infection Prevention and Control (IPC) and the environment

We reviewed the home's environment; undertaking observations of a sample of bedrooms, bathrooms, lounges, dining rooms, sluice rooms and storage areas. Some minor environmental issues raised on inspection were discussed with the manager. Correspondence received the morning after the inspection confirmed the appropriate actions had been taken to resolve the identified deficits.

We found corridors and fire exits to be clear and unobstructed and the home was clean, tidy and fresh smelling throughout.

The patients' bedrooms which were viewed appeared clean, warm and had been personalised with items that were meaningful to individual patients.

Patients had a twice daily temperature check; a record of this was maintained. Staff had a temperature check prior to commencing their shift. On the day of inspection the home was in the process of swabbing all staff members as part on the ongoing routine Covid- 19 staff screening programme.

6.2.4 Care delivery

Patients looked well cared for and were seen to be content and settled in their surroundings and in their interactions with staff. Staff were seen to treat patients with respect and to talk to them in a friendly and pleasant manner. Patients spoken with commented positively about the care they received; they told us:

- "All the staff are very good."
- "I am well looked after."

The manager shared a recent compliment the home received from a patient's relative; "Just a few words to pass on our most grateful thanks for the excellence of care my father received from the team at Chester."

We observed the serving of the lunch time meal. We saw that staff attended to the patients' needs in a prompt, caring manner and that staff wore the appropriate PPE. The tables were set and condiments were available. Patients were offered a selection of drinks. The food served looked and smelt appetising.

Review of four patients' care records evidenced individualised comprehensive care plans were in place to direct the care required and reflected the assessed needs of patients. Risk assessments reviewed were up to date and appropriate to the patients' needs.

Two wound care records were reviewed. Both records evidenced a wound care plan, body map, photograph of the wound and evidence of wound dressing as prescribed.

Supplementary care records were reviewed in relation to patient repositioning. Four repositioning charts were reviewed. A review of the repositioning records did not evidence the consistent delivery of pressure relieving care, in keeping with the patients repositioning care plan. The documentation in several repositioning charts omitted to state the frequency of the repositioning prescribed and the type of mattress in use. An area for improvement was identified.

6.2.5 Governance and management arrangements

Following review of a sample of governance audits, it was evident that the manager maintained a good level of oversight in the home. Audits reviewed included falls, weight loss, wound care, restrictive practices, hand hygiene and environmental audits. These audits included the development of action plans to address identified deficits.

A review of records evidenced that the monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. A review of accident and incident records evidenced that systems were in place to ensure notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Two staff recruitment files were reviewed; these both evidenced that the appropriate pre-employment checks had been completed prior to the staff member commencing employment.

There was a system in place to monitor the registration status of nursing and care staff with their appropriate regulatory body on a regular basis. The records reviewed were up to date.

There was a system in place to monitor staff compliance with mandatory training and to indicate what training was due.

The minutes of staff meetings were reviewed, the meetings occurred monthly or more often as required. A record of the staff who attended and the agenda items was maintained.

6.2.6 Medicines management findings

Personal medication records and associated care plans

Patients in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with local GPs and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the records when they were written and updated to provide a double check that they were accurate.

Hospital discharge letters were retained in the home so that any entry on the personal medication record could be verified. Personal medication records were verified using prescriptions prior to the start of each medication cycle, before the prescriptions were forwarded to the community pharmacy for dispensing.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for three patients. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available. Records of administration were clearly recorded. The reason for and outcome of administration were recorded.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

We reviewed the management of thickening agents for two patients. Speech and language assessment reports and care plans were in place. Records of prescribing were in place and records of administration were maintained.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered as directed/when required. Care plans directing the required care were in place.

Medicine storage and record keeping

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner. The records inspected showed that with one exception, medicines were available for administration when patients required them. An order had already been placed for the one out of stock medicine. The deputy manager advised this was for a recently admitted patient and agreed to follow this up immediately.

The treatment room was observed to be locked when we arrived. Medicines in use were stored in three trolleys which were observed to be securely locked to prevent unauthorised access.

The trolleys were tidy and organised so that medicines belonging to each patent could be easily located.

Satisfactory recordings were observed for the refrigerator and room temperatures.

We reviewed the disposal arrangements for medicines. Discontinued medicines were disposed of via the community pharmacy, which holds a waste transfer license, for disposal and records maintained. There was a large amount of medicines waste awaiting collection, which had been requested; the deputy manager agreed to follow this up immediately.

Administration of medicines

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on printed MARs. A sample of these records was reviewed. The records were found to have been fully and accurately completed. Records were filed once completed.

One patient regularly refuses the administration of two medicines. Nurses were already aware that any ongoing refusal needs to be discussed with the prescriber for guidance. It was agreed that this would take place following the inspection.
Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of Schedule 2 and 3 controlled drugs were recorded in a controlled drug record book. Monitoring was also carried out on controlled drugs in Schedule 4, Part (1) e.g. diazepam. This is good practice.

Management and staff audit medicine administration on a regular basis within the home. The date of opening was recorded on medicines so that they could be easily audited. This is good practice. The audits completed at the inspection indicated that medicines were administered as prescribed.

Management of medicines on admission/re-admission to the home

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one care setting to another.

We reviewed the management of medicines on admission for two patients. The patients' personal medication records had been verified and signed by two members of staff. Medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

Medicine related incidents

Occasionally medicines incidents occur in homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. Staff were familiar with the type of incidents that should be reported.

The medicine related incidents reported to RQIA since the last medicines management inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

Medicines management training

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported.

Staff in the home receive a structured induction which included medicines management when this forms part of their role. Competency assessments were completed annually; records were available for inspection.

Areas of good practice

Areas of good practice were identified in relation to staffing, treating patients with respect and kindness, individualised comprehensive care plans, the management of medicines and governance arrangements.

Areas for improvement

Areas requiring improvement were identified in relation to the staff duty rota and patient repositioning.

	Regulations	Standards
Total number of areas for improvement	0	2

6.3 Conclusion

On the day of the inspection patients were observed to be well cared for, content and settled in the home. Staff treated them with kindness and compassion; staff were timely in responding to their individual needs.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Frank Mudie, manager and Angela Dorrian, regional manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the duty rota clearly evidences the full name of all staff working in the home. Ref: 6.2.1
	Response by registered person detailing the actions taken: All staff have been informed that when booking agency staff that the full name of the agency staff member is completed and that the name is entered into the correct area of the rota comensurate with the correct designation of the staff member. The rota has also been changed to ensure correct designation and full names of all staff working are recorded.
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in regard to those patients who are assessed as requiring assistance with being repositioned: • Patients' repositioning needs must be consistently met in keeping with their prescribed care and best practice standards. • Supplementary repositioning records must be completed in an accurate, comprehensive and contemporaneous manner at all times. Ref: 6.2.4
	Response by registered person detailing the actions taken: The repositioning charts have been changed in order that their start and finish time is midnight. This allows night staff to change the chart for the next day and ensure staff have the time to document the repositioning frequency, as per the resident's care plan and An audit will be completed on a monthly basis to ensure good compliance and accurate information is recorded and to deal with any deficits accordingly.

Please ensure this document is completed in full and returned via the Web Portal

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