Unannounced Care Inspection Report
26 and 27 June 2019

Kintullagh Care Home

Type of Service: Nursing Home (NH)
Address: 36, Westbourne Ave, Carniny Road, Ballymena, BT43 5LW
Tel No: 028 2565 4444
Inspectors: James Laverty and Briege Ferris

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 which is registered to provide nursing care for up to 61 persons.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Limited **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager and date registered:** Mrs Julie-Ann Jamieson Registration pending
Person in charge at the time of inspection: Day 1: See section 6.3 for further comment. Mrs Julie-Ann Jamieson arrived into the building following our arrival. Day 2: Mrs Julie-Ann Jamieson	**Number of registered places:** 61 comprising: 57 – NH-I and PH 1 – NH-LD 3 – RC-I There shall be a maximum of 1 named patient in Category NH-LD. There shall be a maximum of 3 named residents receiving residential care in category RC-I.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. LD– Learning disability. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 53 (on both days of the inspection)

4.0 Inspection summary

An unannounced inspection took place on 26 June 2019 from 10.05 to 16.21, and 27 June 2019 from 09.30 to 14.30.

This inspection was undertaken by the care inspector. Following this, an announced finance inspection also took place on 3 July 2019 from 10:00 to 12:00 hours.

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 Care Standards for Nursing Homes, 2015.

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

Evidence of good practice was found in relation to: staff training, monitoring the professional registration of staff, staff communication and collaboration with the multiprofessional team. Further areas of good practice were also noted in regard to: staff interactions with patients, complaints management and the arrangements to safeguard patients' monies and valuables.

Areas requiring improvement were identified in relation to: the environment, compliance with Control of Substances Hazardous to Health (COSHH) regulations, the administration of medicines, staffing arrangements and accident/incident analysis. Further areas requiring improvement were also noted in regard to: the use of bedrails, the provision of activities, monthly monitoring reports and the annual quality report.

The findings of this report will provide the home 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	5	7

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Julie-Ann Jamieson, 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.

4.2 Action/enforcement taken following the most recent inspection dated 14 January 2019

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 14 January 2019. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received, for example serious adverse incidents. During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

RQIA involves service users and members of the public as volunteer lay assessors. A lay assessor is a member of the public who will bring their own experience, fresh insight and a public focus to our inspections. A lay assessor was present during this inspection and their comments are included within this report.

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined and/or discussed during the inspection:

- staff training records for the period 2019/20
- accident and incident records
- six patients' care records including relevant supplementary wound / nutritional care records
- a selection of governance audits
- complaints records
- adult safeguarding records
- notifiable incidents to RQIA
- staff selection and recruitment records
- RQIA registration certificate
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a sample of patients' individual written agreements
- a sample of deposit receipts for monies received on behalf of patients
- a sample of (chiropody) treatment records
- a sample of comfort fund records
- evidence of the reconciliation of monies and valuables held on behalf of patients
- a sample of patients' property records

Areas for improvement identified at the last finance and premises inspections were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of outstanding areas for improvement from previous inspection(s)

There were no areas for improvement identified as a result of the last care or medicines management inspections.

Areas of improvement identified at the previous finance inspection have been reviewed. Of the total number of areas for improvement all were validated as met.

Five areas for improvement identified at the previous premises inspection on 21 June 2016 have been reviewed. All five areas identified have been met.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Upon arrival to the home we were greeted by a member of the nursing team. While we were assured that staffing levels were in keeping with the staff roster on both days of inspection. However, feedback from staff said that there was no designated nurse in charge of the building in the absence of the manager. It is essential that in the manager's absence, there is effective oversight of patient care throughout the building at all times. An area for improvement was made. The manager told us that she intends to review the competency and capability assessments for nurses who are in charge of the home in her absence; the manager also stated that she wants these assessments to provide a greater focus on aspects of leadership for nurses. This was welcomed.

Staffing levels were discussed with the manager and various staff. The manager stated that managing staff sickness has been challenging. The manager provided assurances that a robust system was in place for managing periods of staff sickness. The need to ensure that staffing levels are maintained at a level to ensure that safe and effective care is delivered was agreed.

Staff told us they received regular mandatory training and felt that their mandatory training provided them with the skills and knowledge to effectively care for patients. The manager also told us that a new 'in-house' trainer for the Runwood Group was in post and assisting with training staff.

Staff spoke positively about the support they receive from the manager, however supervision and appraisal records were not available during the inspection. We were therefore unable to assure ourselves that staff were receiving regular supervision and appraisal. An area for improvement was made.

A review of governance records provided assurance that all notifiable incidents had been reported to the Regulation and Quality Improvement Authority (RQIA) as required. It was further noted that there were effective arrangements for monitoring and reviewing the registration status of nursing staff with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC).

We observed the interior of the home and this included a range of areas such as patients' bedrooms, communal lounges, storage areas and dining rooms. It was noted that some areas were not always locked as necessary, namely, two treatment rooms, the laundry area and one identified storage room. An area for improvement was made. While the environment was generally clean and tidy throughout, some shortfalls in relation to infection prevention and control practices were observed, including: used laundry bags sitting alongside unused linen, the underside of some equipment ineffectively cleaned, staff not always wearing aprons at appropriate times and some clinical waste bins in poor repair. An area for improvement was made.

Discussion with the manager and review of records confirmed that accident/incidents within the home were reviewed on a monthly basis. However, this review did not produce a clear analysis of any trends/patterns which would help to inform ongoing quality assurance by the manager. An area for improvement was made. It was also noted that this shortfall was not noted within monthly monitoring reports which are referred to in section 6.6 of this report.

We observed that a lounge door was wedged open using a chair and had no form of self-closure device. This was discussed with the manager who stated that new self-closure devices had been purchased for several areas throughout the home. It was confirmed with the manager following the inspection that all required self-closure devices were now fitted.

The way in which Control of Substances Harmful to Health regulations are adhered to throughout the home was considered. It was noted that in four areas, improvement was needed. The identified substances were secured by the manager before the conclusion of the inspection and an area for improvement was made.

It is important that patients are effectively assisted at all times with the administration of medicines. While this was observed during most of the inspection, it was noted that some medications had been left unattended on one occasion with a patient who required assistance. This was immediately brought to the attention of nursing staff who attended to the patient. An area for improvement was made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training and monitoring the professional registration of staff.

Areas for improvement

Areas for improvement were highlighted in relation to the environment, COSHH, the administration of medicines, staffing arrangements and accident/incident analysis.

	Regulations	Standards
Total number of areas for improvement	4	3

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

Staff told the inspectors that there was effective communication throughout each shift which allowed them to discuss and review the ongoing needs of patients.

Staff told us that if they had any concerns, they could raise these with their line manager and/or the manager. The manager stated that there is a daily meeting at 11.00 hours when she meets with various Heads of departments in order to discuss care provision and service delivery to patients.

A review of patients' care records evidenced that nursing staff regularly engaged with members of the multi-professional team; this included regular contact with professionals such as GPs, tissue viability nurses (TVN), dieticians and speech and language therapists (SALT).

Care records which were viewed demonstrated that staff regularly communicated with patients' families or representatives as they used/reviewed a range of risk assessments to help inform the care being provided.

The care records for one patient who recently experienced a fall evidenced that a thorough, detailed and person centred risk assessment and action plan was in place. An accident book and post falls documentation had been completed in an accurate and timely manner. The incident had also been referenced within a daily handover report given to the manager. This is commended.

Care records for two patients who required ongoing wound care were reviewed. Relevant care plans for both patients were noted to be detailed, accurate and up to date. A review of supplementary wound care records for both patients also evidenced that staff were dressing the wound as prescribed. It was noted however that some supplementary wound care records were of poor photocopied quality and not consistently completed at every dressing change. This was discussed with the manager and it was agreed that all supplementary records should be legible and that a consistent approach be maintained as to where wound care is documented. This will be reviewed at a future care inspection.

The care records for one patient who required bed rails were examined. While a care plan was in place which referenced the patient's preferred times for getting into and out of bed, there was no care plan in place for the use of bed rails. A bed rail assessment was in place which confirmed the need for the use of bedrails but was incomplete. There was also no evidence of appropriate written consent having been obtained and/or discussed. An area for improvement was made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff communication and collaboration with the multiprofessional team.

Areas for improvement

An area for improvement was highlighted in relation to the use of bedrails.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Throughout the inspection, staff interactions with patients were observed to be compassionate and timely. Patients were very positive in their comments regarding the staffs' ability to deliver care and respond to their needs and/or requests for assistance. Feedback received from a number of patients during the inspection included the following comments:

- "Julie-Ann has been great."
- "The staff are all very nice."
- "I'm here today to prove the good nursing I have received here."

Staff demonstrated a good knowledge of patients' wishes, and preferences as identified within the patients' care plan. Staff told us of the requirements regarding patient information and confidentiality.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Staff said that they considered the manager to be supportive and approachable and they felt confident that they could raise concerns if they arose.

We observed the serving of breakfast on the first day of the inspection. It was noted that while some patients preferred to be served breakfast in their bedrooms, several patients were seated in a lounge on the first floor. Staff served breakfast from a trolley that was wheeled into this lounge/dining area which resulted in limited space for one patient who was eating their breakfast. It was further noted that staff did not provide timely assistance to one patient who required assistance with eating their meal. An area for improvement was made.

We discussed the dining experience of patient with the manager. The manager stated that a dining experience audit had been completed in April 2019 in order to quality assure this aspect of service delivery. However, the findings of the audit were yet to be analysed and used to inform ongoing improvement. The manager did confirm that some patients had expressed dissatisfaction with the variety of the evening menu and a lack of home baking. In addition, one patient told us "My only complaint is the food; the same thing over and over again." In response to recent verbal feedback from patients, the manager stated that the cook had introduced a revised evening meal menu and intended discussing menu options at a residents' meeting scheduled for 4 July 2019. The manager assured us that she would prioritise analysis of the recent dining audit and implement any identified improvements required. This will be reviewed at a future care inspection. The majority of patients spoken to on the day of inspection were praiseworthy of the meals provided.

The provision of activities and addressing the social needs of patients was considered. The manager advised that the job title of the activity therapist was now 'Wellbeing lead'. It was noted that the Wellbeing lead was on leave during our inspection; however, there was ineffective arrangements in place to manage this absence so that a structured timetable of activity provision to patients would not be organised. An area for improvement was made.

Feedback from the manager and review of records confirmed that relatives' meetings occurred regularly. The manager stated that she intended introducing varied times for these meetings to help facilitate greater engagement and dialogue with families.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff interactions with patients.

Areas for improvement

Areas for improvement were highlighted in relation to the dining experience and the provision of activities.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

There was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. For example, the manager's hours, and the capacity in which these were worked, were clearly recorded.

Staff and patients told us that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. We discussed the current application to RQIA for registration of the manager and it was agreed that outstanding documents would be forwarded to RQIA as soon as possible.

Staff felt the manger offered good leadership. They confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. One staff member told us "Teamwork is really good in the home."

Selection and recruitment records were examined and we were assured that all the necessary pre-employment checks had been carried out.

We looked at monthly monitoring reports and identified shortfalls relating to governance within the home, for instance, the lack of effective accident/incident analysis. The monthly monitoring report viewed did not clearly evidence that the action plan had been reviewed and addressed by the manager. The manager stated that some aspects of this action plan had been addressed although this was not recorded. An area for improvement was made. The need for effective managerial oversight and governance within the home was discussed with the manager and the need to maintain such an approach was stressed.

It was also noted that the home's 2018/19 annual quality report was not available. The manager stated that it had been completed but yet to be circulated to patients/relatives/staff. An area for improvement was made.

Whilst staff meetings were regularly scheduled, improvements were required in relation to recording who chaired the meetings, what the meeting agenda was and who recorded the minutes. This was discussed with the manager who agreed to implement these areas for improvement with immediate effect.

Management of service users' monies

A sample of patients' finance files were reviewed which confirmed that either a signed written agreement was in place between each patient and the home, or there was clear evidence to identify the efforts the home had made to secure a signature on written agreements with patients. This area for improvement which was identified at the previous inspection was therefore validated as met.

Discussion with the home administrator and a review of a sample of records identified that the home had a mechanism in place to ensure that patients or their representatives were given written notice of any changes to their individual written agreements and that these changes were agreed in writing with the patient or their representative. This area for improvement which was identified at the previous inspection was therefore validated as met.

A review of a sample of cash deposit receipts identified that these were routinely signed by two people, namely the person handing over cash and the person receiving cash. This area for improvement which was identified at the previous inspection was therefore validated as met.

A review of a sample of chiropody treatment records identified that records were being maintained in line with the standard. Discussion with the home administrator established that the home did not arrange hairdressing services; each patient or their representative made their own personal arrangements in this regard. This area for improvement which was identified at the previous inspection was therefore validated as met.

Written policies and procedures were discussed with the home administrator who provided evidence that a written policy and procedure addressing the administration of the comfort fund was in place and was dated within three years of the current inspection date. This area for improvement which was identified at the previous inspection was therefore validated as met.

A review of a sample of comfort fund records identified that receipts were available to evidence how the comfort fund monies were being spent for the benefit of patients in the home. This area for improvement which was identified at the previous inspection was therefore validated as met.

A review of the safe contents record identified that reconciliations signed and dated by two people were being carried out and recorded. This area for improvement which was identified at the previous inspection was therefore validated as met.

A review of a sample of patients' property records identified that patients' property records were being reconciled on at least a quarterly basis. This area for improvement which was identified at the previous inspection was therefore validated as met.

It was very good to note that as detailed above, each of the eight areas for improvement identified at the previous inspection were all validated as met.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to recruitment of staff, complaints management and the arrangements to safeguard patients' monies and valuables.

Areas for improvement

Areas for improvement were highlighted in relation to monthly monitoring reports and the annual quality report.

	Regulations	Standards
Total number of areas for improvement	1	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Julie-Ann Jamieson, 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 Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all chemicals are securely stored in keeping with COSHH legislation to ensure that patients are protected from hazards to their health at all times. Ref: 6.3
	Response by registered person detailing the actions taken: Staff meeting and supervision held to discuss the importance of ensuring such chemicals are kept within locked storage areas. Each unit has the availability of a locked storage area for products. Daily walk rounds made by home manager and deputy manager to oversea areas are made. COSHH training on 2 separate occassions made available for all staff to ensure understanding of responsibilities and legislation to protect all residents.
Area for improvement 2 **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 managed to minimise the risk and spread of infection. Ref: 6.3
	Response by registered person detailing the actions taken: Discussed at staff meeting and supervision held to discuss. Daily walk rounds by head housekeeper and also home manager/deputy manager to ensure appropriate infection control measures are adhered to. Infection control audit completed monthly and staff advised of outcomes and actions required. Record available for staff to complete following decontamination of any type of equipment.
Area for improvement 3 **Ref:** Regulation 14 (2) (a)(c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all parts of the home to which patients have access are free from hazards to their safety and that all unnecessary risks to their health and safety are eliminated as far as is reasonably practicable. This relates specifically to those areas identified in this report. Ref: 6.3
	Response by registered person detailing the actions taken: Discussed at staff meeting and supervision held to discuss areas required to remain locked to maintain residents safety.

Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that medicines are administered to patients in a safe manner at all times. This relates to medicines not being left unattended with patients requiring assistance with their administration. Ref: 6.3
	Response by registered person detailing the actions taken: Care plans and risk assessments reviewed re administration of medicines. Supervision and HR process followed as required.
Area for improvement 5 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the monthly monitoring report is completed in a thorough, robust and accurate manner at all times. Ref: 6.6.
	Response by registered person detailing the actions taken: Monthly monitoring report completed thoroughly.
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 there is a designated nurse in charge of the home in the absence of the manager at all times. Ref: 6.3
	Response by registered person detailing the actions taken: In the absence of manager, the person in charge is identified in the off duty by an asterix. It is also made available in the entrance hall for visitors
Area for improvement 2 **Ref**: Standard 35 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that accidents/incidents are effectively monitored and analysed on a monthly basis in order to quality assure patient care and service delivery. Ref: 6.3
	Response by registered person detailing the actions taken: Alongside audit of falls, it is now analysed for recurrance and timings of incidents. This is discussed with staff so that appropriate actions can be taken with MDT.

Area for improvement 3 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 22 August 2019	The registered person shall ensure that there is a robust system in place which ensures/demonstrates that staff receive individual, formal supervision/appraisal in keeping with best practice standards. Ref: 6.3
	Response by registered person detailing the actions taken: Supervision and appraisal matrix forwarded to inspector following insepction. All received and up to date.
Area for improvement 4 **Ref**: Standard 18 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in relation to the use of bedrails: • a comprehensive and person centred care plan should be in place and reviewed in a timely manner • an appropriate risk assessment should be in place, thoroughly completed and reviewed by appropriate staff in a timely manner • appropriate consent and/or a best interest discussion should be evidenced within the patient's care record Ref: 6.4
	Response by registered person detailing the actions taken: Care plan reviewed following insepction and updated for particular resident identified. All risk assessments and care plans reviewed monthly as part of resident of the day process. Consent obtained were possible from relatives. Care regularly discussed with relatives and also at care reviews which take place annually.
Area for improvement 5 **Ref**: Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the dining experience of patients is in keeping with best practice standards at all times. This includes, but is not limited to: • ensuring that patients are assisted in a timely manner with their meals, as needed • ensuring that there is sufficient space in the dining area for all patients to enjoy their dining experience Ref: 6.5
	Response by registered person detailing the actions taken: Meal times being trialled at 2 seperate timings to ensure a timely manner is given for those who require assistance. In smaller areas, residents have agreed to attend another area for their meals and also to build relationships with others.

Area for improvement 6 **Ref**: Standard 35 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that a robust and effective system is implemented and monitored which ensures that activity provision to patients is maintained in the absence of the Wellbeing lead/activity staff. Ref: 6.5
	Response by registered person detailing the actions taken: Runwood homes now operate a tools down programme were all staff participate in activities with residents at 2.30pm daily.
Area for improvement 7 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 1 August 2019	The registered person shall ensure that the 2018/19 annual quality report is made available to patients and all relevant stakeholders. Ref: 6.6
	Response by registered person detailing the actions taken: Report forwarded to inspector post inspection. Report now available for anyone who wishes to view.

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

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