The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
16 February 2017

Antrim Care Home

Type of Service: Nursing Home
Address: 88 Milltown Road, Antrim, BT41 2JJ
Tel no: 028 94 428717
Inspector: Aveen Donnelly

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Antrim Care Home took place on 16 February 2017 from 09.15 to 16.15 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

On the day of inspection patients, relatives and staff spoken with commented positively in regard to the care in the home. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Although there was evidence that some action had been taken to improve the effectiveness of the care, three requirements and two recommendations made as a result of the previous care inspection have been stated for the second time. One requirement and two recommendations were made as a result of this inspection.

The term 'patients' is used to describe those living in Antrim Care Home which provides both nursing and residential care.

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	4	5

The total number of requirements and recommendations above includes three requirements and two recommendations that have been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Noby Jacob, 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 finance inspection undertaken on 22 December 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of 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 Janet Montgomery	Registered manager: Sharon Smyth
Person in charge of the home at the time of inspection: Noby Jacob, Deputy manager	**Date manager registered:** 10 June 2016
Categories of care: RC-I, NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 53

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with four patients, three care staff, two registered nurses, one activities coordinator, one patients' representatives and two visiting professionals.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- accident and incident records
- audits in relation to care records
- complaints received since the previous care inspection
- records pertaining to NMC and NISCC registration checks.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 22 December 2016

The most recent inspection of the home was an unannounced finance inspection. There were no issues required to be followed up during this inspection and any action taken by the registered person/s, as recorded in the QIP will be validated at the next finance inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 1 September 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 20 (1) (c) (ii) **Stated:** First time	The registered persons should ensure that a robust system is implemented, to ensure that registered nurses' registration with the Nursing and Midwifery Council (NMC) is checked on a regular basis. **Action taken as confirmed during the inspection**: Discussion with the deputy manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff with the NMC were appropriately managed.	**Met**
Requirement 2 **Ref:** Regulation 15 (2) (b) **Stated:** First time	The registered persons must ensure that risk assessments are completed for all patients and that the assessment of the patient's need is kept under review and revised on a regular basis. **Action taken as confirmed during the inspection**: A review of records confirmed that risk assessments were either not in place or were not consistently reviewed on a regular basis. Refer to section 4.3.2 for further detail. This requirement was not met and has been stated for the second time.	**Not Met**

Requirement 3 **Ref:** Regulation 16 (1) **Stated:** First time	The registered persons must ensure that comprehensive written care plans are prepared by registered nurses, in consultation with the patient and/or their representative.	**Not Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that care plans were not reflective of the patients' current care needs. Refer to section 4.3.2 for further detail. This requirement was not met and has been stated for the second time.	
Requirement 4 **Ref:** Regulation 24 (1) **Stated:** First time	The registered persons must ensure that a complaints procedure is established for receiving, managing and responding to concerns raised by patients and or their representatives.	**Not Met**
	Action taken as confirmed during the inspection: Although there was evidence that appropriate action had been taken in response to concerns raised, the complaints record was not fully completed, to evidence the complainants' level of satisfaction with the home's response. Where responses had been emailed to complainants, these were not available for inspection, therefore we were unable to verify if the complaint had been managed in line with regulation. A review of the complaints record also evidenced that not all complaints were recorded.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 22.6 **Stated:** Second time	The falls risk assessment should be reviewed in response in changes to the residents' condition and the care plan amended accordingly.	**Not Met**
	Action taken as confirmed during the inspection: Risk assessments for falls had not been updated after a patient had fallen. This recommendation was not met and has been stated for the second time.	

Recommendation 2 **Ref**: Standard 41 **Stated:** First time	The registered persons should review the time scheduled, at all changes of shifts, for handover reports to be given on resident care and other areas of accountability. This review should address ways of ensuring that care staff, are fully informed of changes in patients' care needs.	**Met**
	Action taken as confirmed during the inspection: Discussion with care staff confirmed that they were consistently included in the shift handover reports.	
Recommendation 3 **Ref**: Standard 35.4 **Stated:** First time	A system of robust auditing should be implemented, to ensure that care records meet regulatory and professional standards. Traceability of the identified records and follow up on identified areas should be evident.	**Partially Met**
	Action taken as confirmed during the inspection: Although there was evidence that the care records were being audited on a regular basis, the audits reviewed were not sufficiently robust to identify the shortfalls identified during this inspection. This recommendation was not fully met and has been stated for the second time.	

4.3 Inspection findings

4.3.1 Staffing arrangements

The deputy manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 6 February 2017 evidenced that the planned staffing levels were generally adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.3.2 Care practices and care records

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with four patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound. A review of the patient care records evidenced that the dressing had been changed according to the care plan and the review of repositioning records evidenced that patients were repositioned according to their care plans.

As discussed in section 4.2, the review of patient care records evidenced some deficits in the completion of risk assessments. The majority of patients had a range of validated risk assessments completed as part of the admission process; however, these were not consistently updated. The home had introduced an electronic system for assessing, planning and evaluating patients' care needs shortly before the previous care inspection. Discussion with the deputy manager evidenced that the care record audits had identified that the evaluation dates of a number of risk assessments required to be amended on the electronic system; however, the audits reviewed had not identified the shortfalls identified during this inspection. The electronic system also did not have a pain assessment template. A requirement made in relation to the completion of risk assessments has been stated for the second time.

The review of the care records also identified that care plans were not consistently reflective of patients' current care needs. For example, although there was evidence that the staff had been appropriately managing a patient's care in relation to refusing care and treatment, a care plan had not been developed to reflect this. A care plan had also not been developed to outline what the patient's rehabilitative needs were and the level of assistance required with personal care needs or mobility. Care plan evaluations also included statements such as 'care plan ongoing'. A requirement that was previously made in relation to the development of care plans has been stated for the second time. A recommendation has also been made that care plan evaluations contain meaningful statements, which reflect the patients' current care needs.

A review of one patient's fluid intake records evidenced that although the patient's fluid intake was being recorded, there was no evidence of oversight by the registered nurses. The registered nurse consulted with explained that the identified patient's condition had been deteriorating over the previous few months and that the patient had been referred to their general practitioner regarding their palliative care needs. However, the review of the patient's care record did not evidence that the patient's risk of dehydration was being managed appropriately. There was no care plan in place in relation to the patient's fluid intake and the care plan on the patient's end of life care needs was not accurate. It was evident that the template on the electronic system had not been modified in relation to the needs of the patient. A requirement has been made in this regard.

Areas for improvement

A recommendation has also been made that care plan evaluations contain meaningful statements, which reflect the patients' current care needs.

A requirement has been made that patients' total fluid intake are recorded in the daily progress notes, to evidence validation by registered nurses and to identify any action taken in response to identified deficits.

Number of requirements	1	Number of recommendations	1

4.3.3 Consultation

During the inspection, we met with four patients, three care staff, two registered nurses, one activities coordinator, one patients' representatives and two visiting professionals. Some comments received are detailed below:

Patients' representatives

"'It is dead on here, we have no concerns."

Patients
"I am treated fairly well."
"It is all very good here."
"I could not complain at all."

One patient consulted with stated that they were unaware of the complaints procedure. Although discussion with the registered nurse confirmed that any concerns or complaints were documented within the patients care records and communicated to the registered manager to address, the complaints procedure was not available to patients and/or their representatives. A recommendation has been made in this regard.

Staff

"It is very good here, the interaction between staff and patients is excellent."
"The care is very good, everyone gets a choice, if the patients want to have a lie in, they can."
"It is very good."
"It is not too bad, it is alright."
"All is fine here."
"The care is fine here."

Other visiting professionals

"We have no concerns, all is good and the staff are very helpful."
"No concerns at all."

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. No questionnaires were returned within the within the timeframe for inclusion in this report.

Areas for improvement

A recommendation has been made that a copy of the complaints procedure is provided on admission to every patient and to any person acting on their behalf, and this is available in a range of formats where required.

Number of requirements	0	Number of recommendations	1

4.3.4 Management and governance arrangements

Discussion with the deputy manager and staff evidenced that there was a clear organisational structure within the home. All those consulted with knew who the registered manager was and stated that they were available at any time if the need arose. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Although there was evidence that some action had been taken to improve the effectiveness of the care from the previous care inspection, it was concerning that three requirements and two recommendations have been stated for the second time. Refer to section 4.2 and 4.3.2 for further detail. The deputy manager was unsure regarding the level of training staff had received in relation to the electronic records system; however it was evident that the staff required further training in this area, to ensure that the risk assessments were completed on a regular basis and that the care plans were reflective of the individual patient care needs. A recommendation has been made in this regard.

Areas for improvement

A recommendation has been made that registered nursing staff are provided with training on the electronic records system, to ensure that risk assessments and care plans are completed on a regular basis. Evidence of the training, in whatever format provided, must be retained in the home.

Number of requirements	0	Number of recommendations	1

4.3.5 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Noby Jacob, 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	
Requirement 1 **Ref**: Regulation 15 (2) (b) **Stated:** Second time **To be completed by:** 16 April 2017	The registered persons must ensure that risk assessments are completed for all patients and that the assessment of the patient's need is kept under review and revised on a regular basis. **Ref: Section 4.2 and 4.3.2** **Response by registered provider detailing the actions taken:** While the majority of risk assessments are regularly reviewed, we will ensure all are to the same standard
Requirement 2 **Ref:** Regulation 16 (1) **Stated:** Second time **To be completed by:** 16 April 2017	The registered persons must ensure that comprehensive written care plans are prepared by registered nurses, in consultation with the patient and/or their representative. **Ref: Section 4.2 and 4.3.2** **Response by registered provider detailing the actions taken:** While the majority of care plans are comprehensive, we will ensure all are to the same standard
Requirement 3 **Ref:** Regulation 24 (1) **Stated:** Second time **To be completed by:** 16 April 2017	The registered persons must ensure that a complaints procedure is established for receiving, managing and responding to concerns raised by patients and or their representatives. **Ref: Section 4.2** **Response by registered provider detailing the actions taken:** All staff will be trained in the complaints procedure to ensure that any concerns are delat with appropriately
Requirement 4 **Ref:** Regulation 13 (1) (a) **Stated**: First time **To be completed by:** 16 April 2017	The registered persons must ensure that patients' total fluid intake are recorded in the daily progress notes, to evidence validation by registered nurses and to identify any action taken in response to identified deficits. **Ref: Section 4.3.2** **Response by registered provider detailing the actions taken:** This action will be put into practice by all Registered nurses for those residents who are at risk of dehydration

Recommendations	
Recommendation 1 **Ref**: Standard 22.6 **Stated:** Second time **To be completed by:** 16 April 2017	The falls risk assessment should be reviewed in response in changes to the residents' condition and the care plan amended accordingly. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: There will be ongoing monitoring of this to ensure that all staff update risk assessments and care plan in a timely fashion
Recommendation 2 **Ref**: Standard 35.4 **Stated:** Second time **To be completed by:** 16 April 2017	A system of robust auditing should be implemented, to ensure that care records meet regulatory and professional standards. Traceability of the identified records and follow up on identified areas should be evident. **Ref: Section 4.2 and 4.3.4**
	Response by registered provider detailing the actions taken: The audit process has been reviewed and will ensure there is evidence of follow up actions
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 16 April 2017	The registered persons should ensure that care plan evaluations completed by registered nurses contain meaningful statements, which reflect the patients' current care needs. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: This will be monitored through the audit process
Recommendation 4 **Ref**: Standard 16.3 **Stated:** First time **To be completed by:** 16 April 2017	The registered persons should ensure that a copy of the complaints procedure is provided on admission to every patient and to any person acting on their behalf, and this is available in a range of formats where required. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: The complaints procedure will be provided to all residents as well as their family to ensure that all concerns are dealt with appropriately
Recommendation 5 **Ref**: Standard 39.4 **Stated:** First time **To be completed by:** 16 April 2017	The registered persons must ensure that registered nursing staff are provided with training on the electronic records system, to ensure that risk assessments and care plans are completed on a regular basis. Evidence of the training, in whatever format provided, must be retained in the home. **Ref: Section 4.3.2 and 4.3.4**
	Response by registered provider detailing the actions taken: Further training will be provided to all staff on care planning and ensuring the electronic recording system is accurate

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