Unannounced Care Inspection Report
1 September 2016

Antrim Care Home

Type of Service: Nursing Home
Address: 88 Milltown Road, Antrim, BT41 2JJ
Tel No: 02894428717
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Antrim Care Home took place on 1 September 2016 from 09.20 to 16.00 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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the home was clean and well maintained. Areas for improvement were identified in the frequency with which registered nurses' registrations are checked with the Nursing and Midwifery Council (NMC); and in relation to the completion of falls risk assessments, in response to each incident. One requirement has been made; and one recommendation has been stated for the second time.

Is care effective?

The systems and processes in place, to ensure that care delivery was effective, were reviewed. A review of care records confirmed that a range of risk assessments and care plans were completed on admission and informed the care planning process. We examined the systems in place to promote effective communication between staff, patients and relatives. Areas for improvement were identified in relation to the completion of risk assessments and care plans; and in relation to communication between staff at shift change. Two requirements and one recommendation have been made.

Is care compassionate?

Consultation with patients and their representatives evidenced that patients were treated with dignity and respect and a number of positive comments received have been included in the report. There was evidence that patients were encouraged with their meals and assistance provided, as required. There was a range of activities available, for patients to choose from. Comments were received from staff, both verbally and on the returned questionnaires, in relation to the staffing levels and on the poor communication between registered nurses and care staff. These matters were brought to the attention of the registered manager, to address. There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

The systems and processes, in place to ensure that the home was well led, were reviewed. There was a clear organisational structure evidenced within the home and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. There were systems were in place to monitor and report on the quality of nursing and other services provided. Weaknesses were identified in the management of complaints and in the care records auditing process. One requirement and one recommendation have been made.

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	*3

The total number of requirements and recommendations above includes one recommendation that has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered 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 care inspection undertaken on 11 February 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. Refer to section 4.6 for further detail.

2.0 Service details

Registered organisation/registered person: Hutchinson Homes Jane Montgomery	**Registered manager:** Sharon Smyth
Person in charge of the home at the time of inspection: Sharon Smyth	**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, four care staff, three registered nurses and three patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- staff training records for 2015/2016
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 February 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned, approved by the care inspector and will be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 22 February 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 22.6 **Stated:** First 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: A review of patient care records evidenced that although the falls risk assessments and care plans were in place, these were not updated in response to patients' falls.	
Recommendation 2 **Ref**: Standard 34.4 **Stated:** First time	The Statement of Purpose and Service User Guide should be reviewed.	**Met**
	Action taken as confirmed during the inspection: The statement of purpose and service user guide had been updated to reflect the change in the ownership of the home.	

4.3 Is care safe?

The registered 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 22 August 2016 evidenced that the planned staffing levels were not adhered to on two days. The registered manager stated that this was due to short notice absenteeism and explained that she provided support to the staff on one of these days. Staff consulted with raised concerns regarding a high level of absenteeism in the home. This was discussed with the registered manager and we were assured that this was being monitored by her. Although, there was no impact on patient care

observed during the inspection, weaknesses were identified in regards to the care records and communication between grades of staff. Refer to section 4.4 for further detail.

Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was not always well maintained in the home and that appropriate information was not consistently communicated in the shift handover meetings. Refer to section 4.4 for further detail.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and there was evidence that further training had been planned. A review of staff training records confirmed that staff completed modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. Advice was given in relation to developing a training matrix, which would provide clear information, to enable the registered manager to have better oversight of when training updates/refresher training were due.

Observation of the delivery of care evidenced that training had been embedded into practice.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervisions and annual appraisals.

There were safe systems in place for the recruitment and selection of staff. A review of two personnel files evidenced that these were reviewed by the registered manager and checked for possible issues. A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their PIN numbers were checked with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that their registrations were valid. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with Access NI and a record was maintained of the Access NI reference number and the date received.

A review of the records evidenced that the NMC register had not been checked on a regular basis. Although all registered nurses' registrations were confirmed on the day of the inspection, a review of the records confirmed that two registered nurses had renewed their registrations during the period in between the checks. This meant that the system of checks was not sufficiently robust. This was discussed with the registered manager. A requirement has been made in this regard.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adults safeguarding. There had not been any reported safeguarding incidents since the previous care inspection. Discussion with the registered manager confirmed that she was

knowledgeable regarding the regional safeguarding protocols and the home's policies and procedures and was aware of how to report and record any safeguarding incidents.

Validated risk assessments were completed as part of the admission process and informed the care planning process. However, a review of the care records evidenced that these were not consistently reviewed on a regular basis. Refer to section 4.4 for further detail.

A review of the accident and incident records confirmed that although care management, patients' representatives and RQIA had been notified appropriately, the falls risk assessments and care plans were not consistently completed following each incident. As discussed in section 4.2, a recommendation that was made in this regard, has been stated for the second time.

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

A requirement has been made 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.

Number of requirements	1	**Number of recommendations**	0

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and informed the care planning process. However, as discussed in section 4.3 these were not consistently updated on a regular basis. Although RQIA acknowledges that the home had recently introduced electronic care records and that the registered nurses were in the process of transferring the patient information onto this system, the review of the care records evidenced that the care records had not been reviewed in some time. For example, two patients, who were prescribed transdermal opioid patches to manage their pain, did not have validated pain assessments updated since February 2016. This was discussed with the registered manager. A requirement has been made in this regard.

The review identified that care plans had not been reviewed on a regular basis. This was evident in four care records. Care plans had also not been developed for patients who were prescribed antibiotics for acute infections. This was discussed with the registered manager. A requirement has been made in this regard.

The care records adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or

dieticians. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

Discussion with staff confirmed that registered nursing staff attended a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. This information was then to be shared, in a shorter format, with the care staff. Two care staff spoken with stated that this not the case and that communication between the registered nursing staff and carers was not effective. One carer provided written comment on the returned questionnaire, that the care staff 'cannot get onto the computer, to see if the patients' needs have been changed'. A recommendation has been made in this regard.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Discussion with the registered manager and review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. The most recent patients' and relatives' meeting was held on 28 April 2016. Minutes of the meetings held were reviewed and confirmed attendance and the detail of the issues discussed. Although, patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management, inspection findings evidenced that these concerns were not consistently recorded. Refer to section 4.6 for further detail.

Areas for improvement

A requirement has been made 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.

A requirement has been made that comprehensive written care plans are prepared by registered nurses, in consultation with the patient and/or their representative.

A recommendation has been made that the time scheduled, for handover reports is reviewed to ensure that all staff are fully informed of changes in patients' care needs.

Number of requirements	2	**Number of recommendations**	1

4.5 Is care compassionate?

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. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal in two dining rooms. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set in advance of patients being seated. The lunch served in both units appeared very appetising and patients spoken with stated that it was always very nice

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. A list of planned activities was displayed on a notice board that included rhythm and movement; manicure and pamper sessions; hairdressing and foot-spas; and skittles. A 'bake-off' had also been planned to take place in another of the provider's homes and the registered manager explained that the patients would be given the opportunity to attend this. Religious Hairdressing services were provided regularly and there was evidence that arrangements were in place to meet the patients' religious and spiritual needs within the home.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff and relatives, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

During the inspection, we met with four patients, four care staff, three registered nurses and three patients' representatives. We also issued ten questionnaires to staff and relatives respectively; five questionnaires were issued to patients. At the time of writing this report 10 staff, four patients and five relatives had retuned their questionnaires. Some comments received are detailed below:

Staff

"The care is alright".
"Communication can be bad with the nurses, sometimes it is hard to understand their English".
"No concerns about the way the patients are being treated".
"It is a brilliant home, with a great bunch of girls to work with".

With one exception, all respondents indicated that the home provided 'excellent' or 'good' care under the four areas or domains. Two staff members provided written comment regarding the lack of a handover report at the beginning of each shift. Refer to section 4.4 for further detail.

Patients

"I couldn't say a word, it couldn't be better".
"It is just fabulous here".
"Everything is good here".

All respondents indicated that they found the home provided 'excellent' or 'good' care under the four areas or domains. No written comment was received.

Patients' representatives

"'Everything is good, we are very pleased".
"No concerns about the care".
"We are very happy".

All respondents indicated that they found the home provided 'excellent' or 'good' care under the four areas or domains. One written comment received include 'sometimes there are crossed wires in terms of relaying information between staff, but nothing to cause any real difficulties'.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Discussion with the registered manager and 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.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis and that plans were in place to standardise the policies throughout the group of homes.

Although patients and their representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately, discussion with the staff and a review of the home's complaints record evidenced that complaints were not managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern

Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Care staff readily described to the inspector, detail regarding two complaints which relatives had made to the nurse in charge of the home. When raised with the registered manager, she was unaware of these complaints. A formal complaint was also received by the registered manager, on the day of the inspection, in relation to the care of a patient who was no longer residing in the home. Through discussion, it was evident that that the registered manager was aware of dissatisfaction with the care of this patient and explained that discussions held at relevant meetings would have been recorded in the patient's care record. It was concerning that the registered manager and registered nursing staff did not recognise these matters as complaints and record them as such. A requirement has been made in this regard.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- accidents
- care records
- wound audits
- medicines management

The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. However, given that two requirements were made in regards to the completion of risk assessments and care plans, we were not assured of the care records auditing process. This was discussed with the registered manager. A recommendation has been made in this regard.

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.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. The monthly monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. Discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

The registered manager was advised that the monthly monitoring report should be received by her within a meaningful timeframe, to enable her to follow up on any identified actions in a timely manner.

Areas for improvement

A requirement has been made that a complaints procedure is established for receiving, managing and responding to concerns raised by patients and or their representatives.

A recommendation has been made that a system of robust auditing is implemented, to ensure that care records meet regulatory and professional standards. Traceability of the identified records and follow up on identified areas should also be evident.

Number of requirements	1	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the registered 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 20 (1) (c) (ii) **Stated:** First time **To be completed by:** 01 December 2016	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. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The policy for ensuring Nurses registration is updated and monitored on a monthly basis by the Nurse Manager
Requirement 2 **Ref:** Regulation 15 (2) (b) **Stated:** First time **To be completed by:** 01 December 2016	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 4.4**
	Response by registered provider detailing the actions taken: All nursing records have now been transferred to an electronic system which alerts staff on a daily basis if a rsik assessment is due for updating. The risk assessment are also audited on a monthly basis
Requirement 3 **Ref:** Regulation 16 (1) **Stated:** First time **To be completed by:** 01 December 2016	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: Sections 4.4**
	Response by registered provider detailing the actions taken: All nursing care plans are drawn up where possible with the patients input or next of kin if applicable
Requirement 4 **Ref:** Regulation 24 (1) **Stated:** First time **To be completed by:** 01 December 2016	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 4.6**
	Response by registered provider detailing the actions taken: The complaints procedure had been revised and all complaints are recorded in a designated book available for inspection
Recommendations	
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. **Ref: Section 4.2**

To be completed by: 01 December 2016	**Response by registered provider detailing the actions taken:** The falls risk assessment is reviwed after each fall and the care plan ammended if possible. This is also monitored through monthly audits of falls.
Recommendation 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 01 December 2016	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. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: The staff handover process has been reviewed and all shifts now commence 15 minutes earlier to allow a non-interupted and comprehensive handover
Recommendation 3 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 01 December 2016	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 4.6**
	Response by registered provider detailing the actions taken: An audit process has been implemented by the home manager and includes care plans, Risk assessments, falls, accidents, incidents, wounds and complaints

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews