The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
20 April 2017

Whitehead Nursing Home

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Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Whitehead Nursing Home took place on 20 April 2017 from 10:20 to 16:30 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, staff training and development and the environment. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The nurse in charge and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

Concerns were identified in the delivery of safe care, specifically in relation to fire safety practices and infection prevention and control. Compliance with the requirement and recommendation made will achieve improvements within this domain.

Is care effective?

Review of patient care records evidenced that care plans were reviewed on a regular basis. We reviewed the management of pressure area care, nutrition and falls risk. Care records contained details of the reposition programme and a contemporaneous record was maintained to evidence the delivery of care. Care records also reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians.

Supplementary care charts such as repositioning, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Staff were commended for the level of sustained improvement in contemporaneous record keeping since the previous care inspection in April 2016.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

There were no areas for improvement identified within this domain.

Is care compassionate?

We arrived in the home at 10:20 hours and were greeted by staff who were helpful and attentive. Patients were enjoying a late breakfast of a morning cup of tea/coffee in the dining room or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

Discussion with patients and review of the activity programme evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. 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. Discussion with patients confirmed that living in Whitehead Nursing Home was a positive experience.

There were no areas for improvement identified in this domain.

Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

Unannounced quality monitoring visits were completed on a monthly basis by the regional manager on behalf of the provider. Copies of the quality monitoring visits were available in the home.

Discussion with staff evidenced that there was a clear organisational structure within the home. In discussion, patients and representatives/relatives were aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

There were no areas for improvement identified within this domain.

The term 'patient' is used to describe those living in Whitehead Nursing 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	1	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with the nurse in charge, Barbara Wilson, and Ms Angela Dorrian, regional manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an announced premises inspection undertaken on 16 February 2017. 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: Whitehead Nursing Home Ltd/ Mr Colin Nimmon	**Registered manager:** Mrs Cara Parker
Person in charge of the home at the time of inspection: Registered Nurse Barbara Wilson	**Date manager registered:** 16 January 2015
Categories of care: NH-LD(E), NH-I, NH-PH, RC-DE,RC-I, RC-PH(E), RC-MP(E) A maximum of 12 residential places including 4 identified residents in category RC-DE. One identified patient in category NH-LD(E). The home is also approved to provide care on a day basis for 2 persons only.	**Number of registered places:** 41

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events 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 plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with 16 patients individually and with others in small groups; two registered nurses, three care staff, one member of domestic staff and one relative.

Questionnaires were also left in the home to obtain feedback from patients, relatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left.

The following information was examined during the inspection:

- duty rota for nursing and care staff from 3 April to 30 April 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC)and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment file
- three patient care records
- three patient care charts including fluid intake charts and reposition charts
- consultation with patient, relatives and staff
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly monitoring reports undertaken in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 16 February 2017

The most recent inspection of the home was an announced premises inspection. There were no requirements or recommendations made as a result of this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 27 April 2016.

Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 35.9 **Stated:** First time	The registered person should ensure that any notifiable accident or incident occurring in the nursing home is reported to RQIA in line with legislative requirements and RQIA procedural guidance. Refer to RQIA's guidance entitled; 'Statutory Notification of Incidents and Deaths: Guidance for Registered Providers and Managers of Regulated Services, July 2015' available on the web site www.rqia.org.uk	**Met**

	Action taken as confirmed during the inspection: Review of accident/incident records from 1 January 2017 and review of notified events to RQIA confirmed that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time	The registered provider should ensure that the detailed and contemporaneous recording of reposition records.	**Met**
	Action taken as confirmed during the inspection: Review of three patient records and discussion with staff confirmed that this recommendation had been met.	

4.3 Is care safe?

The nurse in charge confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 1 to 30 April 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Staff said that on occasions staffing levels were affected by short notice leave. However staff confirmed that this only happened occasionally. We also sought staff opinion on staffing via questionnaires; two were returned following the inspection. One respondent answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?" The second staff member answered 'no' to this question and recorded, "Sometimes we are short staffed and it puts pressure on the rest of staff on duty."

Patients spoken with during the inspection commented positively regarding the staff and the care delivered. Patients were satisfied that when they required assistance staff attended to them in timely manner. Observations evidenced that staff attended to patients needs in a timely and caring manner.

One relative spoken with commented that they had no concerns and "all was okay". We sought other relatives' opinion on staffing via questionnaires; five completed questionnaires were returned. Four respondents indicated that staff had enough time to care for their relatives and one recorded, "very hard to have enough staff to take everyone to the toilet when required".

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained; and that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that the registered manager had an effective process in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2016/17. Records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Mandatory training compliance was monitored by the registered manager and was also reviewed by senior management as part of the monthly quality monitoring process. Additional training was also available to staff to ensure they were able to meet the assessed needs of patients.

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

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the regional manager, confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedures into practice. A safeguarding champion had been identified and that training had been delivered.

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process and that these assessment informed the care planning process.

Review of accidents/incidents records from 1 January 2017 and notifications forwarded to RQIA confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts.

Patients spoken with were complimentary in respect of the home's environment. However, a metal ladder was found obstructing the first floor landing of the staircase, adjacent to the dining room side of the building; and a number of items, such as paint pots and ceiling tiles were stored under the same stair case on the ground floor. Details were discussed with the nurse in charge and the regional manager who agreed to have the ladders and items removed immediately. A requirement was made in relation to fire safety practices.

Sluice rooms and bathroom/toilets were observed to be clutter free and well organised. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home. However, some PPE and incontinence products were observed to be stored in bathrooms were there was a toilet; and one shower chair was observed to be rusted and in need of cleaning. Details were discussed with the nurse in charge and a recommendation was made.

Areas for improvement

A requirement was made that fire safety practices are adhered to at all times and that compliance monitoring is in place. Any deficits identified must be reported to the person in charge of the home, at the time, and addressed immediately.

A recommendation was made that infection prevention and control measures are reviewed in relation to storage and the cleaning of patient equipment. Any identified deficits in practice should be addressed.

Number of requirements	1	Number of recommendations	1

4.4 Is care effective?

Review of three patient care records evidenced that care plans were in place to direct the care required. Discussion took place regarding the updating of care plans following changes to recommendations made by other healthcare professionals such as, the speech and language therapist (SALT) or the tissue viability nurse (TVN). Nursing staff spoken with were aware of professional requirements to review and update care plans as the needs of patient changed.

We reviewed the management of pressure area care, nutrition and falls risk. Care records contained details of the reposition programme and a contemporaneous record was maintained to evidence the delivery of care. Care records also reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians.

Supplementary care charts such as repositioning, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Staff were commended for the level of sustained improvement in contemporaneous record keeping since the previous care inspection in April 2016.

The nursing staff confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient’s condition and any changes noted.

Staff spoken with confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed.

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 the registered manager or the regional manager.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patient spoken with expressed their confidence in raising concerns with the home’s staff and management. Patients were aware of who the nursing and care staff were and knew the registered manager and referred to her as Cara.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

We arrived in the home at 10:20 hours and were greeted by staff who were helpful and attentive. Patients were enjoying a late breakfast of a morning cup of tea/coffee in the dining room or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice depending of which they preferred and staff were observed assisting patient to drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Discussion with patients and review of the activity programme evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. 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. Discussion with patients confirmed that living in Whitehead Nursing Home was a positive experience.

All of the patients spoke highly of the staff and the registered manager. It was evident that patients knew staff and the registered manager well. Patients and staff confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. One relative spoken with confirmed that they had no concerns.

Discussion with the regional manager and review of records confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home.

Ten relative questionnaires were issued; five were returned within the timescale for inclusion in this report. Relatives were very satisfied or satisfied with the care provided across the four domains. One relative commented regarding staffing levels; details can be viewed in section 4.3.

In addition one relative wrote a letter to RQIA and confirmed they were happy for the contents to be shared with the home. The letter was very complimentary regarding all staff and how the care they provided made a difference for the patient and the relative. For example, "…I now

can come home and not have to worry anymore, knowing that …is being well cared for." The details of the letter were relayed to the registered manager by telephone on 28 April 2017.

Ten questionnaires were issued to staff; two were returned prior to the issue of this report. The staff members were very satisfied or satisfied with the care provided across the four domains. One staff member raised a concern regarding staffing levels as detailed in section 4.3.

Eight questionnaires were issued to patients; none were returned prior to the issue of this report.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

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?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Review of records evidenced that monthly audits were completed to ensure the quality of care and services was maintained. For example, audits were completed for mandatory training attendance, accidents/incidents, complaints and care records. The records of audit evidenced that any identified areas for improvement had been addressed and checked for compliance. Audit outcomes informed the monthly quality monitoring process undertaken by the regional manager on behalf of the provider.

Review of records evidenced that quality monitoring visits were completed on a monthly basis. Recommendations were made within the report to address any areas for improvement. Copies of the quality monitoring visits were available in the home. It was good to note that the monitoring visit had identified that additional monitoring of patients' daily fluid intake was required and an action plan was in place to ensure this was addressed.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with staff evidenced that there was a clear organisational structure within the home. In discussion, patients and representatives/relatives were aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

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 the nurse in charge, Barbara Wilson, and Ms Angela Dorrian, regional manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that 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 via web portal 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 27 (4) **Stated:** First time **To be completed by:** Immediate action required.	The registered provider must ensure that fire safety practices are adhered to at all times and that compliance monitoring is in place. Any deficits identified must be reported to the person in charge of the home at the time and addressed immediately. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Fire safety practices are already in place however the ladders and other items stored under the stair case are removed and in a secure area as per the Fire Regulations.
Recommendations	
Recommendation 1 **Ref**: Standard 46 **Stated:** First time **To be completed by:** 31 May 2017	The registered provider should review infection prevention and control measures in relation to storage and the cleaning of patient equipment. Any identified deficits in practice should be addressed. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Infection prevention and control measures have been reviewed and the storage of the trolley containing patient equipment is now being stored in an appropriate area.

Please ensure this document is completed in full and returned via web portal

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