Unannounced Care Inspection Report
31 August 2016

Ballyclare Nursing Home

Type of Service: Nursing Home
Address: 107a Doagh Road, Ballyclare, BT39 9ES
Tel No: 028 9334 0310
Inspector: Bridget Dougan

1.0 Summary

An unannounced inspection of Ballyclare Nursing Home took place on 31 August 2016 from 10.30 to 16.30 hours.

The inspection sought to assess progress with issues raised during and since the previous 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 environment of the home was warm, well decorated, fresh smelling and clean throughout. Whilst recruitment records were generally well maintained, weaknesses were identified with regard to the management of pre-employment checks.

There was evidence of competent and safe delivery of care on the day of inspection. Staff confirmed that there were good communication and support systems in the home, including; staff appraisal and supervision systems, staff meetings and staff were required to attend a 'handover meeting' when commencing duty.

Weaknesses were identified in the management of staff training records, falls audits and monitoring the registration status of nursing and care staff.

Two requirements and two recommendations have been made.

Is care effective?

Care records generally reflected the assessed needs of patients, were kept under review and where appropriate adhered to recommendations prescribed by other healthcare professionals.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate.

Each staff member understood their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Patients' representatives expressed their confidence in raising concerns with the home's staff/management.

There were no requirements or recommendations made.

Is care compassionate?

Staff interactions with patients were generally observed to be compassionate, caring and timely. The care records of one patient did not reflect their refusal of assistance with some personal care. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

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.

The feedback received from patients was very complimentary regarding the care they received and life in the home. Relatives were also praiseworthy of the quality of care and services provided.

Two recommendations have been made in respect of patients' personal care needs and further training for staff on the management of challenging behaviour.

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

Discussion with the registered manager and staff; and a review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. However, some weaknesses were identified with regard to the management of the audits of care records and accidents/incidents.

Complaints were managed in accordance with legislation. Notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

One recommendation has been made.

The term 'patients' is used to describe those living Ballyclare 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	2	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Harriet Dunsmore, 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 medicines management inspection undertaken on 29 June 2016. Other than those actions detailed in the previous QIP there were no further actions required. 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/Mrs Janet Montgomery	**Registered manager:** Ms Harriet Dunsmore
Person in charge of the home at the time of inspection: Ms Harriet Dunsmore	**Date manager registered:** 1 April 2005
Categories of care: RC-I, RC-MP(E), RC-PH(E), NH-I	**Number of registered places:** 34

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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 we met with 25 patients, two relatives, three registered nurses, five care staff, one cook and one domestic staff.

Questionnaires for patients (three), relatives (10) and staff (10) to complete and return were left for the registered manager to distribute. Three patients, eight relatives and eight staff completed and returned questionnaires within the required time frame.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- accident and incident records
- notifiable events records
- sample of audits
- complaints and compliments records
- nurse competency and capability assessments
- minutes of staff meetings
- minutes of patient/relatives meetings
- monthly monitoring report
- annual quality report.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 29 June 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection

4.2 Review of requirements and recommendations from the last care inspection dated 20 August 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 4 **Stated:** First time **To be Completed by:** 1 October 2015	The registered manager should ensure that assessments and care plans are in place for the management of pain for patients who are in receipt of regular analgesia.	**Met**
	Action taken as confirmed during the inspection: We reviewed the care records of three patients who were in receipt of regular analgesia. Assessments and care plans were in place for the management of pain for these patients.	

Recommendation 2 **Ref:** Standard 32.3 **Stated:** First time **To be Completed by:** 1 October 2015	The registered manager should ensure that a palliative care link nurse has been identified for the home.	**Met**
	Action taken as confirmed during the inspection: A palliative care link nurse had been identified for the home.	

4.3 Is care safe?

The registered manager 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 rotas for the weeks commencing 8, 15, 22 and 29 August 2016 evidenced that the planned staffing levels were adhered to.

Discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing levels.

The registered manager informed us that there were systems in place for the safe recruitment and selection of staff, and staff consulted confirmed that they had only commenced employment once all the relevant checks had been completed. Three staff personnel files were viewed and we were able to evidence that all the relevant pre-employment checks had been completed for two members of staff. A reference from one staff member's previous employer had not been maintained on file. This was discussed with the registered manager and confirmation was received following the inspection that the reference had been obtained for the member of staff. A requirement has been made with regard to recruitment practices.

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. Staff were mentored by an experienced member of staff during their induction. Records for three staff members were reviewed and found to be completed in full and dated and signed appropriately.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Electronic records indicated that the majority of staff had completed mandatory training to date. We were only able to evidence that a record had been kept of the signatures of staff attending safeguarding vulnerable adults training in March 2016. A recommendation has been made.

Staff clearly demonstrated the knowledge, skills and experience necessary to fulfil their role, function and responsibility.

A planner was in place to ensure all staff received supervision and appraisal and there was evidence that supervision and appraisal meetings had taken place with approximately fifty per cent of staff to date in 2016.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. A review of documentation confirmed that any potential safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were also notified appropriately.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were not sufficiently robust. We were informed that the registration status of a nurse had recently lapsed and the member of staff had been removed from the duty rotas until their registration had been renewed. A requirement has been made in this regard.

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Discussion with the registered manager confirmed that a range of audits was conducted on a regular basis (refer to section 4.6 for further detail). A sample of falls audits was reviewed. Whilst these audits had been completed monthly, we were unable to evidence that the information had been analysed to identify patterns and trends. There was no clear action plan in place to address any deficits identified. A recommendation has been made.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident. Trust representatives, patients' representatives and RQIA were notified appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction and equipment was appropriately stored.

Areas for improvement

Two requirements have been made in respect of recruitment practices and the arrangements for monitoring the registration status of nursing and care staff. Two recommendations have been made in respect of the management of staff training records, and falls audits.

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

4.4 Is care effective?

Care records, which were maintained on an electronic system. Care records generally reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. The care records of one patient did not reflect their refusal of assistance with their personal care. This is discussed further and a recommendation has been made in section 4.5.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements.

Review of three patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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

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 staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff also confirmed that regular staff meetings were held, that they could contribute to the agenda and the meeting and minutes were available. The review of the minutes of staff meetings evidenced the registered manager had held general staff meetings and subsequent meetings with the individual groups of staff for example; catering staff and housekeeping, when required. Staff confirmed they found the level of communication from the registered manager to be very good and clarified what was expected of them.

Patients and their representatives expressed their confidence in raising concerns with the home's staff/management.

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?

Staff interactions with patients were observed to be compassionate, caring and timely. The majority of patients were observed to have good standards of personal hygiene and all appeared content and relaxed in their environment. The personal care needs of one patient however had not been met in a timely manner. This was discussed with the registered manager and we were informed that the patient had refused assistance with personal hygiene. This had not been documented in the patients care records. A recommendation has been made in this regard.

Observation of the lunch time meal confirmed that patients were given a choice in regards to, food and fluid choices and the level of help and support requested. Staff were observed to offer patients reassurance and assistance appropriately. The daily menu was displayed in the dining rooms and offered patients a choice of two meals for lunch and dinner. A choice was also available for those on therapeutic diets. Patients all appeared to enjoy their lunch.

Discussions with staff confirmed that they had a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients spoken with were complimentary regarding the care they received and life in the home. Those 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.

A patient told us how he really enjoyed gardening and showed us around the enclosed garden and patio area with raised beds where vegetables and strawberries were growing. The registered manager informed us of plans to get a greenhouse for those patients who wished to garden over the winter time. Another patient was engaged in painting on canvas and told us how the staff had assisted him to pursue his hobby. Various arts and crafts produced by patients were on display throughout the home. An activity therapist was employed by the home; however they were not on duty at the time of this inspection.

A musician provided live entertainment in the lounge in the afternoon and the majority of patients attended. Patients told us that they enjoyed listening to the music and reminiscing. Live entertainment was provided on a regular basis as part of the activities programme.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives on the quality of the service provided. We were informed that regular patient/representative meetings were held. The minutes of a patient/relatives meeting held in April 2016 were available in the home and there was evidence of actions taken to address any issues identified. A survey of patient/representatives views on the quality of care and services provided was conducted annually and the 2015 report was available for review and indicated a high level of satisfaction in all areas.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. Three patients, eight patient's representatives and eight staff completed questionnaires. Some comments are detailed below.

Patients

- "Staff are all very good and kind."
- "I enjoy the food."
- "I can't think of anything that needs improved."

Staff

- "We all work well as a team."
- "Matron is very approachable if you have a problem."
- "I feel staff would benefit from further training in the management of challenging behaviour."

This comment was discussed with the registered manager and a recommendation has been made.

Patients' representatives

- "This is an excellent home; the staff are all very good and kind."
- "We are very pleased with the level of care provided, it is excellent."

Areas for improvement

Two recommendations were made in respect of the personal care needs of patients and staff training.

Number of requirements	0	Number of recommendations	2

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 were knowledgeable in regards to their roles and responsibilities. Staff also confirmed that there were good working relationships and staff stated that the registered manager was responsive to any concerns raised.

The certificate of registration issued by RQIA was displayed in the home.

A certificate of public liability insurance was current and displayed.

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

Review of the home's complaints record and discussion with the registered manager evidenced 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. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

There was evidence that a range of audits had been completed on a monthly basis, including care records, accidents/incidents, medication management and infection prevention and control. Whilst the medication management and infection prevention and control audits had been well completed, the audits of accidents/incidents and care records lacked clarity with regard to outcomes and action plans. A recommendation has been made accordingly.

Discussion with the registered manager and review of records for May, June and July 2016 evidenced that Regulation 29 monthly quality monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. 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.

Areas for improvement

One recommendation has been made in respect of the management of audits.

Number of requirements	0	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 Harriet Dunsmore, 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 21 (1) (b) **Stated:** First time **To be completed by:** 14 September 2016	The registered provider must ensure, before making an offer of employment, two written references, linked to the requirements of the job are obtained, one of which is from the applicant's present or most recent employer. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** There had been one reference outstanding this has now been forwarded to and we will ensure that we will obtain two references prior to employment in future.
Requirement 2 **Ref:** Regulation 20 (c) (ii) **Stated:** First time **To be completed by:** 14 September 2016	The registered provider must ensure the arrangements for monitoring the registration status of nursing and care staff is appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** A new system is in place to ensure that appropiate checks are carried out regarding registration status.
Recommendations	
Recommendation 1 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure a record is kept in the home of all training, including induction and professional development activities completed by staff. The record should include the names and signatures of those attending the training event. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** We will ensure that rebost records are maintained of all staff for inspection
Recommendation 2 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that a robust system of auditing care records and accidents/incidents is maintained. Audits should include action plans to address any deficits identified. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** The system for auditing has been reviewed and new systems are in place to address the issures

Recommendation 3 **Ref:** Standard 6.14 **Stated:** First time **To be completed by:** 07 September 2016	The registered provider should ensure that patients' personal care and grooming needs are regularly assessed and met. This includes (but is not limited to) patients hair and nails. Where patients refuse assistance with their personal care, this should be documented in their care records. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: We will ensure that the care plan always details when a resident refuses care and will continue to endeavour to give the best personal care and grooming needs of all the residents and ensure their needs are regularly assessed.
Recommendation 4 **Ref:** Standard 39.4 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that further training is provided for staff in the management of challenging behaviour. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: Challenging behaviour has been organised for 19th October`15 which will be held in our Nursing Home.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

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