Unannounced Care Inspection Report
6 February 2017

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 06 February 2017 from 10.30 to 14.30 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.

The focus of the inspection was meals, mealtimes and nutrition.

Is care safe?

There was evidence of competent and safe delivery of care on the day of inspection. Whilst patients and relatives expressed no concerns regarding staffing levels, six staff indicated some dissatisfaction with staffing levels, in particular relating to sickness absence. A recommendation has been made in this regard. A recommendation has also been made in respect of staff training in the management of feeding techniques for patients with swallowing difficulties. The home was found to be warm, well decorated, fresh smelling and clean throughout.

Is care effective?

Whilst a range of validated risk assessments were completed as part of the admission process, they had not been reviewed and updated on a regular basis for all patients. There was evidence that the care plans of two patients had not been reviewed and updated in response to the changing needs of the patients. Three recommendations have been made in respect of the management of care records. Systems for auditing care records should be further developed to address the deficits identified during this inspection. A recommendation has been stated for the second time. It is recommended that registered nurses receive training in relation to care planning and the nursing process.

There was evidence of regular meetings with the different staff groups; however, there was no evidence of meetings with catering assistants. A recommendation has been made in this regard.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients were given a choice in regards to food and fluid choices and the level of help and support requested. A choice was also available for those on therapeutic diets.

Where patients required assistance with meals, staff were observed to offer patients reassurance and assistance in a discreet, unhurried and sensitive manner. Patients spoken with were complimentary regarding the care they received and life in the home.

There were no requirements or recommendations made.

Is the service well led?

Systems were in place to monitor and report on the quality of nursing and other services provided. Complaints, incidents and accidents were managed in accordance with legislation.

There were no requirements or recommendations made.

Throughout the report the term “patients” is used to describe those living in Ballyclare Nursing Home which also provides 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	0	8*

* The recommendations above include one which has been stated for a second time.

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 care inspection undertaken on 31 August 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/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 A maximum of 8 Residential beds.	**Number of registered places:** 34

3.0 Methods/processes

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 we met with 20 patients, two registered nurses, four care staff, two catering and one domestic staff.

Six questionnaires were also issued to patients, staff, and relatives. Refer to section 4.5.

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
- complaints and compliments records
- sample of audits
- policy on meals and mealtimes.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 31 August 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and was validated at this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 31 August 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 21 (1) (b) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Review of three staff personnel records evidenced that this requirement had been met.	
Requirement 2 **Ref:** Regulation 20 (c) (ii) **Stated:** First time	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).	**Met**
	Action taken as confirmed during the inspection: Records as outlined above were available at the time of inspection and were maintained to a satisfactory standard.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 39 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Records were maintained of all training, including induction and professional development activities completed by staff. The record included the names and signatures of those attending the event	
Recommendation 2 **Ref:** Standard 35.6 **Stated:** First time	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.	**Partially Met**
	Action taken as confirmed during the inspection: An audit tool had been developed for accidents/incidents; audits had been completed monthly and action plans were in place to address any deficits identified. However care records had not been audited on a regular basis. The registered manager informed us that they were using the printout from the electronic care records system to identify gaps in care records. There was evidence of one printout dated 01 February 2017. This system was not robust and failed to identify deficits in care records. This recommendation has been partially met and has been stated for the second time.	
Recommendation 3 **Ref:** Standard 6.14 **Stated:** First time	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.	**Met**

	Action taken as confirmed during the inspection: Care records evidenced patients personal care needs had been assessed and met. Where patients refused assistance with their personal care, this had been documented in their care records. No issues with patients' personal care were identified at the time of this inspection.	
Recommendation 4 **Ref:** Standard 39.4 **Stated:** First time	The registered provider should ensure that further training is provided for staff in the management of challenging behaviour.	**Met**
	Action taken as confirmed during the inspection: Training in the management of challenging behaviour had been provided on 19 October 2016. This training was attended by the majority of care and nursing staff.	

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 roster for weeks commencing 30 January and 06 February 2017 evidenced that the planned staffing levels were adhered to. On the day of the inspection one care assistant had reported sick however cover had subsequently been obtained. The registered manager informed us that there had been a high level of sickness absence over the winter months; however they had generally been able to cover this with agency staff or their own staff working additional shifts. Feedback from questionnaires and discussion with patients, relatives and staff evidenced that patients and relatives had no concerns regarding staffing provision within the home. Six staff, however expressed some dissatisfaction with staffing levels, in particular relating to sickness absence. This was brought to the registered manager's attention and a recommendation has been made in this regard.

Review of the training records evidenced that food hygiene training had been provided for all relevant staff in 2016. Staff informed us that they would appreciate an update in the management of feeding techniques for patients who have swallowing difficulties and a recommendation has been made accordingly.

Staff consulted with and observation of care delivery and interactions with patients, clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice.

A policy was in place on "meals and mealtimes" dated 2014. We were informed that this policy was being reviewed at the time of the inspection. A system was in place to ensure all relevant staff had read and understood the policy

Up to date nutritional guidelines were available and used by staff on a daily basis.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms 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 recommendations have been made in respect of the contingency arrangements in place for managing staff sickness and the provision of training in the management of patients with swallowing difficulties.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

Review of three patients' care records evidenced that the care records of one patient had been maintained to a satisfactory standard. Whilst a range of validated risk assessments were completed as part of the admission process, they had not been reviewed and updated on a regular basis within the other two care records reviewed. Nutritional, falls and pressure ulcer (Braden) risk assessments had not been reviewed monthly or more frequently in response to the changing needs of the patients. A recommendation has been made in this regard.

There was evidence that the care plans for two patients had not been reviewed and updated in response to the changing needs of the patients. The nutritional care plan for one patient did not reflect that a referral had recently been made to the dietician for weight loss. The patient's weight had been recorded in a supplementary paper record and had not been transferred to the main care records which were held electronically.

The care records of a second patient receiving treatment and care for wounds and/or pressure damage were reviewed. The review of wound assessment charts and associated documentation evidenced that, whilst the dressing regimes had been adhered to, they were not recorded in line with best practice guidelines. A recommendation has been made in this regard. A care plan had not been developed for the management of the patients wounds. Nurses were evidently using the treatment plan developed by the tissue viability nurse as a substitute for a nursing care plan.

A recommendation has been made that care plans are developed to meet the assessed health needs of patients and are kept under review and updated in response to the changing needs of the patients.

It is recommended that registered nurses receive training in relation to care planning and the nursing process. Records of training should be retained.

Systems for auditing care records should be further developed to address the deficits identified during this inspection. A recommendation in this regard has been stated for the second time. Refer to section 4.2.

The majority of staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Two staff members indicated some dissatisfaction with lack

of staff meetings. Refer to section 4.5. Discussion with the registered manager and review of a sample of the records of staff meetings evidenced that regular meetings had been held with different staff groups. Whilst there was evidence of meetings with the cooks from the different homes within the group, there was no evidence of meetings with catering assistants. One recommendation has been made in this regard.

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

Areas for improvement

Six recommendations have been made in respect of the management of care records, audits of care records, training and staff meetings.

Number of requirements	0	**Number of recommendations**	6

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

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. The majority of patients chose to come to the dining room where the tables were nicely presented with cutlery, crockery and a choice of condiments. Those patients who choose to remain in their bedroom were served their meals on trays set with condiments; the meals were covered prior to leaving the kitchen. A record was maintained for all patients to reflect their food and fluid intake at each mealtime. A discussion with catering staff demonstrated that they were knowledgeable regarding the patients dietary needs. This included; patients who required modified diets; diabetic diets and food fortification. The daily menu was displayed in the dining room and offered patients a choice of two meals for lunch and dinner. All the meals looked and smelt attractive and appealing and patients appeared to enjoy their lunch.

Where patients required assistance with meals, staff were observed to offer patients reassurance and assistance in a discreet, unhurried and sensitive manner.

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.

As part of the inspection process, we issued questionnaires to staff, patients and patients' representatives. Nine staff, two relatives and one patient completed and returned questionnaires within the required time frame. Some comments are detailed below.

Staff

- "there are too many sick staff at the moment. Managers try to cover as best they can, but sometimes they can't get anyone to cover shifts."
- "we don't have regular meetings."
- "I enjoy my job."
- "this is a good place to work."
- "I feel there are not enough staff to meet the needs of the patients."

The comments made by the staff members were discussed with the registered manager for follow up. Two recommendations have been made in respect of staffing levels and staff meetings. Refer to sections 4.3 and 4.4.

Patients and relatives indicated that they were either "very satisfied" and/or "satisfied" that the care was safe, effective and compassionate and the home was well led. No additional written comments were received.

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 were knowledgeable in regards to their roles and responsibilities.

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

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.

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 Ms 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 - None

Recommendations

Recommendation 1 **Ref**: Standard 35.6 **Stated:** Second time **To be completed by:** 06 March 2017	The registered provider should ensure that a robust system of auditing care records is maintained. Audits should include action plans to address any deficits identified. **Ref: Sections 4.2 and 4.4**
	Response by registered provider detailing the actions taken: A robust auditing system is in place to ensure care records are always appropriately maintained
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 28 February 2017	The registered provider should ensure that risk assessments are kept under review and updated in response to the changing needs of patients. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Trained staff are regularly reviewing and updating risk assessments to ensure residents needs and changing needs are met. This is checked and maintained through audit
Recommendation 3 **Ref**: Standard 4.7 **Stated:** First time **To be completed by:** 06 March 2017	The registered provider should ensure that care plans have been developed to meet the assessed health needs of patients and are kept under review and updated in response to the changing needs of patients. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Trained staff are planning care according to residents assessed health needs and are regularly reviewing and updating care plans to ensure residents needs and changing needs are met. This is checked and maintained through audit
Recommendation 4 **Ref**: Standard 41.1 **Stated:** First time **To be completed by:** 06 March 2017	The registered provider should review the contingency arrangements in place for managing staff sickness so that the number and ratio of staff on duty at all times meet the care needs of patients. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: New care assistant staff have recently been recruited to meet the needs of residents at all times

Recommendation 5 **Ref**: Standard 39.8 **Stated:** First time **To be completed by:** 30 April 2017	The registered provider should ensure that registered nurses receive training in relation to care planning and the nursing process. Records of training should be retained. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Training in care planning and the nursing process for all trained staff has been arranged
Recommendation 6 **Ref**: Standard 12.9 **Stated:** First time **To be completed by:** 30 April 2017	The registered provider should ensure that all relevant staff receives updated training in the management of feeding techniques for patients who have swallowing difficulties. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Training in swallowing difficulties has taken place on 15/03/17
Recommendation 7 **Ref**: Standard 41.8 **Stated:** First time **To be completed by:** 31 March 2017	The registered provider should ensure that staff meetings take place on a regular basis and at a minimum quarterly, with all staff groups, including catering assistants. Records of all staff meetings should be maintained. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Regular staff meetings have been commenced for all staff groups, with records appropriately maintained
Recommendation 8 **Ref**: Standard 23.2 **Stated:** First time **To be completed by:** 31 March 2017	The registered provider should ensure that where a patient is assessed as at risk of pressure damage, a documented pressure damage prevention and treatment programme is drawn up and agreed with relevant professionals and entered into the patients care plan. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: All of this area has been reviewed and pressure damage prevention and treatment programmes are now recorded in residents' care plans

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