Unannounced Care Inspection Report
27 September 2017

Hamilton Private Nursing Home

Type of Service: Nursing Home (NH)
Address: The Plantain, 168 Ballycorr Road, Ballyclare, BT39 9DF
Tel No: 02893341396
Inspector: Karen Scarlett

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 36 persons.

3.0 Service details

Organisation/Registered Provider: Heather Hamilton **Responsible Individual:** Heather Hamilton	**Registered Manager:** Lucinda Dawn Hamilton
Person in charge at the time of inspection: Lucinda Dawn Hamilton	**Date manager registered:** 5 June 2008
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment Residential Care (RC) I – Old age not falling within any other category MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 36 comprising: A maximum of 3 residents in categories RC-I, RC-MP(E) or RC-PH(E) with 1 additional identified resident in category RC-I. Category NH-PH for 2 identified patients only.

4.0 Inspection summary

An unannounced inspection took place on 27 September 2017 from 09.50 to 15.00 hours.

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.

The term ‘patients’ is used to describe those living in Hamilton Private Nursing Home, which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to the standard of the home’s environment and its cleanliness. Staffing levels were well managed and staff reported feeling well supported by the manager and working well as a team. There was evidence of good practice in personalised care delivery particularly in the management of food and fluids and activities provision. Governance systems were in place to ensure that the service was well led.

Areas requiring improvement under the standards were identified in relation to recruitment, recording and review of wound care and post falls management. One area for improvement under regulation regarding notifiable events was stated for a second time.

Patients said that they were happy and content living in Hamilton Private Nursing Home and no concerns were raised.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	***1**	**3**

*The total number of areas for improvement include one under regulation which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Lucy Hamilton, 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.

4.2 Action/enforcement taken following the most recent inspection dated 15 September 2017

The most recent inspection of the home was an announced premises inspection undertaken on 15 September 2017. The report has been issued to the registered provider and there were no further actions required to be taken following this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing .
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with six patients individually and with others in groups, 12 staff, one visiting professional and two patients' visitors/representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff, relatives and patients were left for distribution by the registered manager.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- duty rota for all staff from 18 to 31 October 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- staff meeting minutes
- incident and accident records
- three staff recruitment and induction files
- three patient care records
- six patient care charts including food and fluid intake charts and wound charts
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability insurance
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 15 September 2017

The most recent inspection of the home was an announced premises inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 8 March 2017

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 30

Stated: First time</td><td>The registered persons must ensure that all notifiable events are reported to RQIA in accordance with regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Incident and accident records were reviewed from the date of the last care inspection to the present. Seven head injuries had not been reported to RQIA and one had not been reported until 6 days following the incident. This was discussed with the registered manager to clarify what events were notifiable to RQIA. This area for improvement has not been met and has been stated for a second time.</td></tr>
<tr><th colspan="2">Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 4

Stated: First time</td><td>The registered persons should ensure that where lap straps are in use on wheelchairs that a care plan is developed for their use in accordance with best practice guidelines and in consultation with the patient and/or their representatives.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The care plan of one patient who uses a lap strap on their wheelchair was reviewed. This was found to be maintained in accordance with best practice and it was evidenced that the patient’s representatives had been consulted. This area for improvement has been met.</td></tr>
</table>

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 rota from 18 to 31 October 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients and their representatives evidenced that there were no concerns regarding staffing levels.

A training session was being held on the afternoon of the inspection enabling day and night staff to be consulted. They confirmed that, whilst they were busy, staffing levels met the assessed needs of the patients. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff recruitment information was available for inspection and records were generally maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Three records of recently recruited staff were reviewed and there was evidence that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained. Some deficits were identified in regards to obtaining applicants' full employment history and the exploration of any gaps in employment, for example, through retention of interview notes. An area for improvement has been identified under the standards.

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. The induction file was reviewed and there was evidence that staff received a full induction upon starting employment. The induction record of a newly appointed registered nurse had been signed off by the registered manager. Induction of two newly appointed ancillary staff was currently underway and the manager stated that the records were with the staff concerned and were not available for inspection. This will continue to be monitored at future inspections.

Review of the training matrix/schedule for 2016/17 indicated that training was being undertaken. Topics included but were not limited to manual handling, infection control, first aid, falls, health and safety, fire safety and Control of Substances Hazardous to Health (COSHH). However, it was difficult to ascertain how many staff had been trained in each topic as no overall record of training was in place to enable the registered manager to maintain oversight of this. The benefits of this were discussed with the registered manager who confirmed that this work was in progress. The registered manager also agreed to collate these figures and forward them to RQIA following the inspection. These were received via email on 28 September 2017 and evidenced that the majority of staff had attended the required training.

Staff spoken with confirmed that they had regular training and they clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. A safeguarding champion had been appointed in accordance with the current regional policy and procedure. The manager stated that there had been no recent safeguarding incidents but any concern would be managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of three 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.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last inspection confirmed that head injuries had not been appropriately notified. An area for improvement under regulation had been identified at the last care inspection and has now been stated for a second time. Refer to section 6.2 for further information. It was further noted that entries of observations done following confirmed or suspected head injuries were occasionally recorded on the incident and accident records. This did not consistently include neurological observations. Observation records for one patient following a recent suspected head injury were requested but could not be located. In discussion with the registered manager and one registered nurse it was evident that there was no clear guidance for staff on when and how often to perform neurological observations following a fall in which a head injury could reasonably be suspected. It should be noted that in the case of one patient in which a head injury was confirmed that prompt and appropriate action had been taken and medical attention sought. An area for improvement under the standards was identified to ensure that staff had clear and consistent guidance on post falls management/neurological observations in accordance with best practice.

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. Patients, their representatives and staff spoken with were complimentary in respect of the home's environment. Infection prevention and control measures were adhered to and equipment was appropriately stored.

One corridor leading to a fire exit was found to be obstructed with laundry skips and a free standing fire extinguisher unit. This was brought to the attention of the registered manager and home manager, Patrick Hamilton. Immediate action was taken to ensure this was cleared. Fire training records evidenced that staff had received training in June 2017 and the importance of keeping exits clear had been part of this training. The home manager, who takes responsibility for fire safety, agreed to reinforce this with staff as soon as possible. The registered manager stated that she would source an alternative and safe location for the laundry skips going forward. All other fire exits and corridors were observed to be clear of clutter and obstruction.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the home's environment, staffing levels and management of safeguarding.

Areas for improvement

Areas for improvement under the standards were identified in relation to staff recruitment and post falls management.

	Regulations	Standards
Total number of areas for improvement	**0**	**2**

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three 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.

Care records accurately 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.

Three wound care records were reviewed. No formal care plan was in place for these patients. This was discussed with the registered nurses on duty who stated that they tended to record wound care on the open wound assessment charts and wrote in the diary when the next dressing was due. A review of the open wound charts identified gaps in the recording of wound dressings, ranging from 5 to 26 days. Wounds had been assessed but there was no consistency in how often the wounds were to be assessed by the registered nurses. The registered nurses were obviously knowledgeable regarding each patient's wound and reported that these were all improving and healing. On discussion with the registered manager it was agreed that a holistic wound care plan should be put in place when patients develop a wound in order to ensure that holistic care was being delivered. There was currently no agreed protocol to guide staff on the frequency of wound assessment and to ensure that every dressing was appropriately documented. An area for improvement under the standards was identified.

A review of food and fluid intake records evidenced that these were maintained in accordance with best practice guidance, care standards and legislation. Care assistants were observed to be reporting patient fluid intakes to the senior care assistants after the morning tea round so that any concerns could be raised in a timely manner. Care staff confirmed that this occurred at planned intervals throughout their shift. This was good practice and was commended.

Review of 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. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

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.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), SLT, dietician and TVN. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained.

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.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care planning and team working. In particular the system in which staff reviewed patients' fluid intake at planned intervals throughout their shift was commended.

Areas for improvement

An area for improvement under the standards was identified in relation to recording and review of wound care.

	Regulations	Standards
Total number of areas for improvement	**0**	**1**

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

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

very well presented and staff were noted to be placing rollers in patient's hair following her shower that morning. Activities staff were noted to be helping patients to participate in personalised activities and a harvest service was held in the afternoon which patients were noted to be enjoying. Staff were observed hoisting a patient into an arm chair and this was done with dignity and the patient's feet placed on a comfortable stool. Staff were also observed to be offering a choice of food and fluids at meal and snack times. A wide variety of juices, tea and coffee were on offer at break time and patients were offered appropriate assistance.

Those patients spoken with were very positive about the staff and the care they received. No patients raised any concerns. One patient returned a questionnaire and indicated that they were very satisfied that care was safe, effective, compassionate and well led. 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.

Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. There was evidence that suggestions for improvement had been considered and used to improve the quality of care delivered. Satisfaction questionnaires were being prepared for distribution next month.

One visiting professional had no concerns and expressed their confidence in the home and the staff.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Two relatives expressed satisfaction with the care, with one commenting; 'it's like a hotel'. One relative returned a questionnaire and indicated that they were very satisfied with the care.

Staff spoken with were all happy working in the home and felt that the needs of patients were being met. Seven staff returned questionnaires and all indicated that they were either very satisfied or satisfied that care was safe, effective, compassionate and well led. Two staff in returned questionnaires indicated dissatisfaction in the well led domain and commented that the manager was not approachable and nor responsive to their suggestions. This was contrary to the findings on inspection in which staff stated that the registered manager was very approachable and anything they needed was actioned for them. Staff spoken with stated that they were well supported and were happy working in the home.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to personalised care delivery, availability of food and fluids and activities provision.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	**0**	**0**

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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. In discussion, patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern. As previously noted in Section 6.6 all except two staff in the returned questionnaires, commented very positively in regards to the registered manager and felt well supported.

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 staff, patients and their representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team.

The registration certificate and certificate of public liability insurance were up to date and displayed appropriately. Discussion with the registered manager and review of records evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and review of the home's complaints record 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. The outcome of complaints had been recorded and the registered manager had responded very effectively to all of the complaints raised.

Patients and their representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was.

As previously stated the registered manager had not notified RQIA of a number of head injuries since the last care inspection. Notifiable events were discussed with the registered manager. Please refer to section 6.2 for further information.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to care records, infection prevention and control, environment, medications, incidents/accidents and pressure ulcers. A schedule for auditing was in place and was being adhered to. Results of

audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been embedded into practice.

Discussion with the registered manager and review of records evidenced that Regulation 29 (or 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. Copies of the reports were available for patients, their representatives, staff and trust representatives.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the approachability and responsiveness of the registered manager and the governance arrangements.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	**0**	**0**

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Lucy Hamilton, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 30 **Stated:** Second time **To be completed by:** Immediately from date of inspection	The registered persons must ensure that all notifiable events are reported to RQIA in accordance with regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. **Ref: Section 6.2** **Response by registered person detailing the actions taken:** All staff nurses within HPNH have been made aware that all head injuries or suspected head injuries are notifiable events.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 27 October 2017	The registered person shall ensure that a record of an applicant's employment history is sought and any gaps in employment are identified, explored and reasons documented. **Ref: Section 6.4** **Response by registered person detailing the actions taken:** The application form has been updated to include more room for this information. Please find attached our updated application form.
Area for improvement 2 **Ref**: Standard 4, criterion 8 **Stated:** First time **To be completed by:** Immediately from date of inspection	The registered provider should ensure that following a suspected or confirmed head injury that neurological observations are carried out in accordance with best practice guidelines, documented and responded to appropriately. The registered provider should ensure that a local protocol is developed to guide staff. **Ref: Section 6.4** **Response by registered person detailing the actions taken:** This has been fully addressed. Please find attached a copy of our Post Falls protocol, CNS observations policy from policies and procedures. HPNH Neurological Observation Chart, Post Falls Assessment Tool and Post Fall Body Map.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 27 October 2017	The registered person shall ensure that the wound care needs of patients are set out in an individualised care plan and the frequency of wound re-assessment is specified in the care plan. Contemporaneous notes of the wound care delivered should be consistently maintained. **Ref: Section 6.5** **Response by registered person detailing the actions taken:** All current residents with wounds now have a care plan and this clearly states that wound assessment using the open wound

	assessment chart is to be done weekly as per guidance from the NHSCT. All staff nurses have been made aware that the Open wound assessment chart must be maintained weekly unless there is a deterioration in the wound and then the frequency of assessment will be increased to every dressing change.

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

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

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

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