

Unannounced Care Inspection Report 8 March 2017



Hamilton Private Nursing Home

Type of Service: Nursing Home

Address: The Plantain, 168 Ballycorr Road, Ballyclare, BT39 9DF

Tel no: 028 93 341396

Inspector: Karen Scarlett

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Hamilton Private Nursing Home took place on 8 March 2017 from 11.25 hours to 14.25 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 home was found to be clean, warm and comfortable. 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. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection confirmed that a head injury requiring attendance at hospital was not appropriately notified to RQIA. A requirement was made. A recommendation was also made in regards care planning for the use of lapstraps on wheelchairs.

Is care effective?

A review of care records evidenced that risk assessments and care plans were in place to address the needs of patients and that these were kept under regular review. Systems were in place to promote good communication amongst the care team and with other health professionals. Significant progress had been made in relation to the completion of supplementary care charts and this was commended. No areas for improvement were identified.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Systems were in place to obtain feedback on the care and services provided. Observation of the mealtime confirmed that this was an enjoyable experience for the patients and assistance was offered as required. There was evidence of varied activities provision. Comments from patients, representatives and staff were positive and no concerns were raised. No areas for improvement were identified.

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. 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. A system of regular auditing had been established and any deficits identified had been addressed. There was evidence of good working relationships amongst staff. No areas for improvement were identified.

The term 'patients' is used to describe those living in Hamilton Private 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 Lucinda Hamilton, registered manager and Patrick Hamilton, home 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 care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 12 September 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: Heather Hamilton	Registered manager: Lucinda Dawn Hamilton
Person in charge of the home at the time of inspection: Lucinda Dawn Hamilton	Date manager registered: 5 June 2008
Categories of care: NH-I, NH-PH, RC-I, RC-MP(E), RC-PH(E) 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	Number of registered places: 36

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the last inspection
- the registration status of the home
- written and verbal communication received since the last inspection
- the returned quality improvement plan (QIP) from the last inspection
- the previous care inspection report
- pre-inspection audit

The inspector met with seven residents and with others in small groups, six care staff, one registered nurse, one ancillary staff and one resident's visitors/representative.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector. Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty on the day of inspection.

The following information was examined during the inspection:

- Duty rota from 6 to 12 March 2017
- Incident and accident records since the previous care inspection
- Complaints records
- Four patient care records and a selection of supplementary records
- A selection of audits
- Staff training records in relation to adult safeguarding
- Service user satisfaction survey

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 September 2016

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

4.2 Review of requirements and recommendations from the last care inspection dated 12 September 2016

Last care inspection statutory requirements		Validation of compliance
<p>Requirement 1</p> <p>Ref: Regulation 12 (1) (a) & (b)</p> <p>Stated: <u>Third and final time</u></p>	<p>The registered person shall provide treatment to patients which meets their individual needs and reflects current best practice. This is particularly in relation to:</p> <ul style="list-style-type: none"> ensuring that the repositioning schedule is adhered to and records of same are up to date 	<p>Met</p>
	<p>Action taken as confirmed during the inspection:</p> <p>A selection of repositioning charts were reviewed and these were consistently well completed by day and night staff. The frequency of repositioning was specified and regular skin checks were completed and recorded. The records provided a detailed account of the care provided. This represented significant progress since the previous care inspection. In addition, the registered nurses met with care staff on three occasions during both the day and night shifts to ensure that records were completed and to give staff the opportunity to pass on any concerns in regards to the patients' skin. This was commended. This requirement has been met.</p>	
<p>Requirement 2</p> <p>Ref: Regulation 15 (2)</p> <p>Stated: <u>Third and final time</u></p>	<p>The registered person must ensure that the assessment of patient's needs is kept under review, particularly in relation to:</p> <ul style="list-style-type: none"> ensuring that fluid balance charts are recorded and totalled accurately and appropriate actions taken as required 	<p>Met</p>
	<p>Action taken as confirmed during the inspection:</p> <p>There were no patients on a fluid balance chart. However, fluid intake was captured on the food chart and the total fluid intakes were accurately recorded. An output chart was also maintained which recorded urinary output and bowel movements. Staff spoken with were knowledgeable of the process and the needs of patients. This requirement has been met.</p>	

<p>Requirement 3</p> <p>Ref: Regulation 16 (1) and (2) (b)</p> <p>Stated: First time</p>	<p>The registered provider must ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patient's needs in respect of his health and welfare are to be met. This patient's plan must be kept under review. This is particularly in relation to patients' palliative and end of life care needs.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The care record of one patient in receipt of end of life care was reviewed. The care plan had been developed to meet the needs of the patient and was found to be comprehensive in addressing their symptoms. There was evidence of the involvement of the patient and their family as well as the multi-disciplinary team. This requirement has been met.</p>		
<p>Last care inspection recommendations</p>		<p>Validation of compliance</p>
<p>Recommendation 1</p> <p>Ref: Standard 46, criteria 2 and 3</p> <p>Stated: Second time</p>	<p>Regular infection prevention and control audits should be carried out and documented and any deficits actioned appropriately.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>There was evidence of a schedule for monthly infection prevention and control audit and these were consistently completed. There were records of any deficits identified and the action taken to address these. This recommendation has been met.</p>		
<p>Recommendation 2</p> <p>Ref: Standard 25, 11</p> <p>Stated: <u>Third and final time</u></p>	<p>Care records should be regularly audited to ensure they are consistent with the home's policies and procedures and appropriate actions taken to enhance the quality of care.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>There was evidence of a quarterly schedule for care record audits and these were consistently completed. There was evidence of deficits identified and a communication was sent to each named nurse to address these. Once the actions were completed these were signed off by the named nurse and re-checked by the registered manager. This recommendation has been met.</p>		

<p>Recommendation 3</p> <p>Ref: Standard 19</p> <p>Stated: Second time</p>	<p>The regional guidelines for breaking bad news should be made available for staff to reference as required.</p> <p>Action taken as confirmed during the inspection: These guidelines were available for staff in a resource file. This recommendation has been met.</p>	Met
<p>Recommendation 4</p> <p>Ref: Standard 12</p> <p>Stated: Second time</p>	<p>The mealtime experience of patients should be reviewed to ensure that hot food is served hot.</p> <p>Action taken as confirmed during the inspection: The lunchtime meal service was observed and food was served hot and was appropriately covered on leaving the kitchen. This recommendation has been met.</p>	Met
<p>Recommendation 5</p> <p>Ref: Standard 13, criterion 11</p> <p>Stated: First time</p>	<p>The registered provider should ensure that all staff have adult safeguarding training appropriate to their role.</p> <p>Action taken as confirmed during the inspection: A review of staff training records evidenced that the majority of staff had completed adult safeguarding training in September and October 2016 and that further dates were planned. Discussions with the care staff confirmed that they were knowledgeable concerning adult safeguarding matters and the mechanisms for reporting this.</p> <p>The registered manager and home manager had each completed higher level training in adult safeguarding and were aware of the new policy and procedure. The home manager had been nominated as the adult safeguarding champion for the home. This recommendation has been met.</p>	Met

<p>Recommendation 6</p> <p>Ref: Standard 41, criterion 7</p> <p>Stated: First time</p>	<p>The registered persons should ensure that, in the absence of the registered manager, a capable and competent registered nurse is allocated as the nurse in charge.</p>	<p style="text-align: center;">Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The duty rota was reviewed and clearly indicated which nurse was in charge of each shift. This recommendation has been met.</p>		
<p>Recommendation 7</p> <p>Ref: Standard 18</p> <p>Stated: First time</p>	<p>The registered persons should ensure that where potentially restrictive devices or practices are considered for use that this is considered in accordance with standard 18 of the Care Standards for Nursing Homes, 2015.</p>	<p style="text-align: center;">Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>Since the previous care inspection a consent/discussion form had been developed and was completed for patients requiring any form of restrictive practice. This recommendation has been met.</p>		

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 rota for week commencing 6 March 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

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 clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice.

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.

Review of four 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. Since the previous care inspection consent/discussion forms had been developed in relation to the use of restrictive practices such as, alarm mats and bed rails. A recommendation in this regard was met. It was noted that one patient was sitting in a wheelchair with lap strap on for long periods in the lounge. Discussion with the registered nurse, registered manager and care staff confirmed that this was the patient's preference. A review of the patient's records found that this was not specified in the care plan. The risks were discussed with the registered manager and a recommendation was made.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection confirmed that a head injury requiring attendance at hospital was not appropriately notified to RQIA. A requirement was made.

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

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

A requirement was made that all notifiable events are reported to RQIA in accordance with regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

A recommendation was made 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.

Number of requirements	1	Number of recommendations	1
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4.4 Is care effective?

Review of four 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.

Supplementary care charts, including repositioning and food and fluid intake records, evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Two requirements made in this regard had been met.

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 the registered manager.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Since the previous inspection a new system was introduced whereby registered nurses met formally with the care assistants on three occasions throughout both the day and night shifts in relation to the completion of charts and to report any concerns with patients. Care assistants spoken with were familiar with this system and found it beneficial. Records of these meetings were maintained. This was commended.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff and management. Patients and representatives knew the registered manager.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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 were noted to be patient and kind in their interaction with patients and were taking time to talk with patients and giving them time to walk to the bathroom. 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.

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

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. A recent service user survey completed in September 2016 was reviewed. This demonstrated a high level of satisfaction with the care and services provided. Concerns had been raised regarding choice at meal times and action had been taken to address these. Patients spoken with confirmed that they were offered choice at mealtimes.

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

Consultation with patients individually, and with others in smaller groups, confirmed that they were happy in the home. Patients were complimentary regarding staff and the food provided. They commented on the good standard of cleanliness in the home and the quality of the laundry service.

An activities assistant was noted to be assisting patients in the lounge to make jewellery. The patients were noted to be very engaged and were chatting happily together. In the afternoon a sing-a-long was held which many of the patients enjoyed.

The lunchtime service was observed and it was noted to be a relaxed and enjoyable time for patients. Tables were well set with napkins, flowers and appropriate condiments. A choice of drinks was available. The food looked and smelt appetising and patients looked to be enjoying their meals. Full and timely assistance was given to patients with encouragement being offered as required. Efforts were made to ensure the dignity of patients was maintained throughout.

Ten questionnaires each were left with the registered manager for distribution to staff not on duty and for relatives and patients. Six patients, three relative and nine staff returned questionnaires. All respondents indicated that they were either very satisfied or satisfied that the care provided was safe, effective, compassionate and well led.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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 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.

The registration certificate was up to date and displayed appropriately. Discussion with the registered manager 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.

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 medications, wound management, care records, infection prevention and control and environment. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. The home also maintained a safety cross in relation to pressure ulcer incidence and these were consistently well maintained.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. One relative stated in their questionnaire that the manager was very approachable and that they were always made very welcome in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Lucinda Hamilton, registered manager and Patrick Hamilton, home 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 [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

<p>Requirement 1</p> <p>Ref: Regulation 30</p> <p>Stated: First time</p> <p>To be completed by: Ongoing from date of inspection</p>	<p>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.</p> <p>Ref: Section 4.3</p>
	<p>Response by registered provider detailing the actions taken: All staff nurses have been made aware of this and have updated themselves on what needs to be reported in accordance with regulation 30.</p>

Recommendations

<p>Recommendation 1</p> <p>Ref: Standard 4</p> <p>Stated: First time</p> <p>To be completed by: 9 April 2017</p>	<p>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.</p> <p>Ref: Section 4.3</p>
	<p>Response by registered provider detailing the actions taken: This has been fully addressed and the care plan now reflects the informed decision this resident has made and that the same has been discussed with their NOK or representative.</p>



The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9051 7500

Fax 028 9051 7501

Email info@rqia.org.uk

Web www.rqia.org.uk

 @RQIANews