Unannounced Care Inspection Report
19 June 2017

Avila

Type of Service: Nursing Home (NH)
Address: 32 Convent Hill, Bessbrook, Newry, BT35 7AW
Tel No: 02830838969
Inspector: Donna Rogan

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 for up to 39 persons.

3.0 Service details

Organisation/Registered Provider: Kilmorey Care Ltd **Responsible Individual:** Mrs Peggy O'Neill	**Registered Manager:** Mrs Maria Lucille Holt
Person in charge at the time of inspection: Maria Lucille Holt	**Date manager registered:** 17 July 2013
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years. I – Old age not falling within any other category. PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years. A maximum of 1 patient shall be accommodated within category NH-LD/LD(E).	**Number of registered places:** 39

4.0 Inspection summary

An unannounced inspection took place on 19 June 2017 from 10.30 to 17.45 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 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 recruitment procedures, notifications of incidents; staff training; delivery of compassionate care; adult safeguarding, monitoring staffs' registration status with the appropriate bodies; the management of mealtimes and engagement with patient and patient representatives.

Patients said that they were very satisfied with care and services provided and described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

There were no areas for improvement identified in all four domains reviewed.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Lucy Holt, registered manager and Peggy O'Neill, registered person as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 25 January 2017. There were no further actions required to be taken following the most recent inspection, no areas for improvement were identified.

5.0 How we inspect

Prior to inspection we analysed the following information:

- notifiable events submitted 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 quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection the inspector met with 17 patients, five care staff, two registered nurses and six patients' 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 and relatives and eight for patients were left for distribution.

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

The following records were examined during the inspection:

- staffing arrangements in the home
- one staff recruitment and selection record
- staff induction, supervision and appraisal records
- staff training records for 2016/2017
- accident and incident records
- patient register
- annual quality report
- compliments records
- RQIA registration certificate
- certificate of public liability
- audits in relation to care records and falls

- records relating to adult safeguarding
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- four patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- minutes of staff' and relatives' meetings held since the previous care inspection
- a selection of policies and procedures
- complaints received since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- the system for managing urgent communications, safety alerts and notices.

There was one area for improvement identified at the last care inspection.

The findings of the inspection were provided to Lucy Holt, registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 25 January 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 14 October 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 44 **Stated:** First time	The registered provider should consider bringing forward the painting of the corridors on the first floor and ensure that the identified shower room is not used as a store.	**Met**
	Action taken as confirmed during the inspection: The corridors on the first floor have been repainted. The identified shower room was not in use as a store.	

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 stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. The planned staffing levels were based on the patients' dependency levels. The registered manager explained that this was reviewed on a regular basis and that the staffing levels could be adjusted as required. A review of the staffing rota for the week commencing 12 June 2017 to 25 June 2017, evidenced that the planned staffing levels were generally adhered to. Observation of the delivery of care evidenced that patients' needs were consistently met by the number and skill mix of staff on duty.

A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 21, schedule 2. Where nurses and carers were employed, their registrations were checked with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought and received, prior to the staff member starting employment. The registered manager had obtained all of the information required, to demonstrate that prospective employees were suitable to work with vulnerable adults, for example, employment histories were clearly recorded on the application form and any gaps were explored prior to employment starting. There was no agency usage of staff in the home.

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. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. Discussion with the registered manager and staff confirmed that staff from other homes within the organisation, also received an induction to the home.

All the staff spoken with expressed that they felt well supported in relation to their practice. Discussion with the registered manager and a review of records confirmed, that the all the registered nurse' competency and capability assessments had been updated as required.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on fire safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. Overall compliance with training was monitored by the manager and this information informed the responsible persons' monthly quality monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

A 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).

Staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. The staff understood what abuse was and how they should report any concerns that they had. All staff were aware of how to access the relevant contact details; and the whistleblowing policy was available to staff.

Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice; a safeguarding champion had been identified. Discussion and a review of records also evidenced that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures.

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. A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident; care management and patients' representatives were notified appropriately. Information on accidents and incidents informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Where patients required bedrails, to maintain their safety whilst in bed, there was evidence that risk assessments had been completed; and that regular safety checks had been carried out, when the patients were in bed.

A number of patients had pressure relieving mattresses on their beds, to prevent skin breakdown. Discussion with staff evidenced that they were aware of the correct mattress setting, and beds were observed to be set to the required setting, this ensured that they were being effectively used.

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. All of the areas reviewed were found to be clean, tidy, well decorated and warm throughout. The corridor to the first floor had been repainted.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas of good practice

There were areas of good practice identified in relation to staff induction, training and development; adult safeguarding arrangements; and risk management processes.

Areas for improvement

There were no areas for improvement identified in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

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 plans had been personalised to meet the individual needs of the patients and had been reviewed monthly.

Supplementary care records in regards to bowel management and repositioning were reviewed. Bowel management had been recorded well on all three patient care records reviewed. An individual toileting chart had been developed on assessed patients and was diligently recorded.

Repositioning records were reviewed. Two of the patients' care records reviewed required repositioning following individualised assessments. A care plan which included the repositioning regime was in place. The frequency of repositioning was documented on repositioning charts. There were no gaps observed within the repositioning charts and they were maintained in accordance with the patient's care plan.

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.

Staff demonstrated an awareness of the importance 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.

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. Discussion with the registered manager and a review of minutes of staff meetings confirmed that since the last inspection there had been staff meetings conducted on 24 January 2017 and 20 March 2017.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and language therapist (SALT), dietician and Tissue Viability Nurse specialists (TVN). Discussion with registered nurses 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.

Where patients were prescribed antibiotic therapy for the treatment of acute infections, care plans had been developed in relation to this.

There was also good practice identified in relation to the management of diabetes. The signs and symptoms of hypoglycaemia and hyperglycaemia were included in the care plan; and the protocol for managing fluctuations in blood sugars was maintained in the medication chart. There was evidence that blood glucose monitoring was undertaken, in keeping with the prescribed insulin regimen.

A review of wound care records evidenced that wound care was managed in line with best practice. A review of the daily progress notes of one patient evidenced that the dressing had been changed according to the care plan. Wound care records were supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.

Patients who had been identified as being at risk of losing weight had their weights monitored regularly. This ensured that any weight loss was identified and appropriate action taken in a timely manner. The patients' weights were audited by the registered manager on a monthly basis. Patients who were identified as requiring a modified diet, had the relevant risk assessments completed. Care plans in place were reflective of the recommendations of SALT and care plans were kept under review.

Relatives' and residents meetings were held formally; the last relatives/residents meeting was held on 9 March 2017 and was well attended. Minutes were retained and displayed for those who could not attend.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to risk assessment and care planning; bowel management; communication between members of the multi-disciplinary team and the homes' staff; shift handovers; staffs' knowledge of their roles and responsibilities and contact with relatives/representatives; wound care management; diabetes care; modified diets and the oversight of weight loss.

Areas for improvement

There were no areas of improvement identified in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

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. Consultation with 17 patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Staff were observed chatting with patients when assisting them. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. 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.

Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their choice of attire. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

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

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

The serving of lunch was observed in the main dining room on the ground floor. Patients were seated around tables which had been appropriately laid for the meal. Food was served from the kitchen when patients were ready to eat or to be assisted with their meals. Food appeared nutritious and appetising. The mealtime was well supervised. Staff were observed to encourage patients with their meals and patients were observed to be assisted in an unhurried manner. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors where required. Condiments were available on tables and a range of drinks were offered to the patients. Appropriate music was played in the background. Patients appeared to enjoy the mealtime experience.

The provision of activities was reviewed. A programme of activities for week commencing 19 June 2017 was displayed.

Two registered nurses, five carers and two ancillary staff members were consulted to ascertain their views of life in Avila.

Some staff comments were as follows:

"It's a lovely home. Hard work but we are like a wee team."
"I'm happy here. I really enjoy the work."
"I think there is a great atmosphere in the home; good team spirit."
"I love my job."
"We are well trained; I don't think there could be anywhere else that I would like to work."

Ten staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Four of the questionnaires were returned within the timescale for inclusion in the report.

Comments were as follows:

"Very satisfied that care is compassionate".
"Very satisfied with everything."
"Very good home manager."
"Any concerns or issues are handled very well."

Seventeen patients were consulted with.

Some patient comments were as follows:

"I like it here; I have no concerns".
"I have no complaints; the staff are very good".
"I like the food; it is very homely".
"I come and go as I please; staff, keep me right"
"I am happy enough, it's not home, but it is as close to it as it can be".

Eight patient questionnaires were left in the home for completion. Four of the patient questionnaires were returned with the following comments:

"Satisfied that the care is safe."
"Although I am physically disabled, I often feel treated as if I am blessed."
"I am satisfied that the home is well led."
"The care is good."

Six patient representatives were consulted during the inspection. All representatives were very positive on the care provided in the home. Ten relative questionnaires were left in the home for completion. Four of the relative questionnaires were returned. Comments made by relatives during the inspection and in the returned questionnaires made the following comments:

"I find staff approachable."
"At times there are not enough staff to do toileting after lunch, and patients are left waiting."
"Patients and family meeting held at home and me and my sister attended."
"Very satisfied that the care is compassionate."
"Lucy and her team of staff are great."
"Very satisfied."
"I could not complain about a thing."
"I think my …. is safe and very well looked after."
"Staff keep me informed."

The care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met. At the time of the inspection no one was receiving end of life care.

The registered manager explained that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. An annual quality report had been undertaken in 2016, in keeping with regulation 17 of the Nursing Homes Regulations (Northern Ireland) 2005.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for 'the attentiveness and professionalism of the staff' and the 'consistent, compassionate care' given to a patient, who had been receiving end of life care.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to privacy, dignity and respect afforded to patients; staff interaction with patients; the mealtime experience; consultation with relatives; the management of DNAR; activities and the spiritual arrangements for patients.

Areas for improvement

There were no areas for improvement identified in this domain.

	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.

Staff spoken with confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. All those consulted with described the registered manager in positive terms; comments included "very approachable" and that they "were very good at involving staff in things." Staff described how they felt confident that the registered manager would respond positively to any concerns/suggestions raised. One staff member provided written comment in the returned questionnaires, describing how the registered manager "was approachable in every way."

Discussion with the registered manager and observation of patients evidenced that the home was operating within its' registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

There was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities.

Consultation 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 Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients 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.

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 in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails.

There were good examples found, where the auditing processes were being utilised appropriately; this related in particular to the wounds audits, which were completed on a weekly basis. Accidents and incidents were also analysed on a monthly basis. Accidents/incidents in the home informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.
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. These included medication and equipment alerts; the Chief Nursing Officer (CNO) alerts, regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that monthly quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement; discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas of good practice

There were examples of good practice identified in relation to the management of complaints; auditing; management structure and good working relationships were evident within the home.

Areas for improvement

There were no areas for improvement identified in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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