Unannounced Care Inspection Report
8 December 2016

Hockley Private Nursing Home

Type of service: Nursing Home
Address: 11 Drumilly Road, Armagh BT61 8RG
Tel No: 028 3887 0365
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Hockley Private Nursing Home took place on 8 December 2016 from 10.15 to 15.15 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.

The term 'patients' is used to describe those living in Hockley Private Nursing Home which provides both nursing and residential care.

This inspection was underpinned by underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	*2	*2

The total number of requirements and recommendations above includes two requirements and one recommendation that have been stated for a second time. One recommendation has been carried forward for validation at the next care inspection.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Jane Sagayno, Nursing Sister, 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 finance inspection undertaken on 27 October 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.

2.0 Service details

Registered organisation/registered person:	**Registered manager:**
Elim Trust Corporation Pastor Edwin Michael	Mrs Marion Gertrude Wilson

Person in charge of the home at the time of inspection: Mrs Marion Wilson, Registered ,Manager Mrs Jane Sagayno, Nursing Sister	**Date manager registered:** 1 April 2005
Categories of care: RC-I, NH-I 56 Nursing; 4 Residential. There shall be a maximum of 32 patients accommodated in the Mews Wing and a maximum of 28 patients accommodated within the Lodge Wing.	**Number of registered places:** 60

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 plan (QIP) from the previous care inspection
- the previous care inspection report
- pre-assessment inspection audit

During the inspection, care delivery/care practices were observed and review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff and a request was made that these would be returned within an identified timescale for inclusion within the report. We also met with seven patients individually and the majority of others in smaller groups, two care staff, five registered nurses, the laundress, the maintenance man , an activity co-ordinator and a number of catering staff. No patient representatives were spoken with at this inspection.

The following information was reviewed during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records and supplementary records
- staff training records
- accident and incident records
- a sample of quality audits

4.0 The inspection

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

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance inspector. This QIP will be validated by the finance inspector at the next finance inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 1 June 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (1) (a) **Stated:** First time	The registered person must ensure that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met. This refers particularly to the management of patients who are at risk of dehydration and malnutrition and require their total fluid intake to be monitored and prescribed nutritional supplements should be recorded on the fluid chart accordingly.	**Met**
	Action taken as confirmed during the inspection: A review of a care records and supplementary charts for an identified patient who was at risk of dehydration and malnutrition was conducted. The review evidenced that the Malnutrition Nutritional Universal Risk (MUST) assessment had been updated regularly and at minimum monthly intervals. The care plan accurately reflected the findings of the assessment undertaken and interventions included were appropriate in regards to the patient's identified needs. A sample review of food and fluid intake charts evidenced that these were recorded to a satisfactory standard. Recorded entries included all food and fluids offered and refused. Supplements administered in accordance with the prescription were also recorded on the charts reviewed. Fluid intakes were totalled over a 24 hour period and this information was also recorded in the patient's daily progress notes. Appropriate actions had been taken when fluid and/or food intake was inadequate. These included referrals to the general practitioner and/or dietician. This requirement has been met.	

Requirement 2 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time	The registered provider must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This relates specifically to the management of wound management and pressure care to include; the "repositioning needs" of patients and care is recorded in keeping with best practice guidelines.	
	Action taken as confirmed during the inspection: A review of care records for patients with wounds and /or pressure care needs were conducted. The care records reviewed in regards to wound management evidenced that a care plan was in place and had been reviewed and updated in accordance with any changes in the condition of the wounds. The care plan included the treatment actions required and was reflective of recommendations made by other health care professionals for example; podiatry and/or tissue viability. A review of wound assessment charts evidenced that these had been completed in accordance with best practice guidelines. Care plan evaluations were completed and included meaningful evaluations in regards to the progress and /or improvements noted. A repositioning schedule was not required and the care plan reflected the rationale for same. Two care records were reviewed in relation to pressure management care. Risk assessments had been completed for both patients and the level of risk was identified. The first care record evidenced that a care plan was in place for pressure care management although this did not include a repositioning schedule. The registered nurse on duty advised that the patient required 'two hourly' repositioning. A review sample of repositioning records evidenced that these records were maintained to a satisfactory standard during the "day duty" shift however significant gaps were identified from 6pm onwards with gaps up to and including 14 hours on one occasion. There was no negative impact noted and the patient's pressure areas were intact. Staff advised that the patient would have been repositioned however the records had not been maintained accordingly. The identified patient was observed during the inspection and appeared comfortable. Given that the patient's pressure	**Partially met**

	areas were intact and the information provided by staff, RQIA were satisfied that this was most likely to be an error in record keeping, rather than care not being delivered. The care plan was updated during the inspection to include the repositioning schedule as advised by staff. The second care record and repositioning charts evidenced that a risk assessment had been completed and the care plan accurately reflected the assessment outcome. The repositioning schedule was identified within the care plan and a sample review of repositioning records evidenced that positional changes had been carried out accordingly and information recorded was in line with best practice guidelines. This requirement has not fully been met due to the shortfalls identified in relation to repositioning records and therefore has been stated for a second time.	
Requirement 3 **Ref:** Regulation 17 (1) **Stated:** First time	The registered provider must implement a robust system to review the quality of nursing and other services provided by the home. **Action taken as confirmed during the inspection**: Since the last inspection, some progress had been made and audits had been developed and implemented in a number of areas. These included; infection prevention and control; accident and incidents; nutrition; wound care; continence and care plan audits. However, a sample review of audit records evidenced that these were not completed robustly; some audits did not identify the areas for improvement and when areas for improvement had been identified there was limited evidence in the audit records that the areas for improvement had been re-audited to check compliance. The completion of the audit cycle as a means to ensure quality improvement was discussed with the nursing sister. This requirement has not been fully met and has been stated for a second time.	**Partially met**

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 4 Criteria (1) (7) **Stated:** Second time	It is recommended that continence assessments and care plans are completed comprehensively to include all aspects of continence management.	**Met**
	Action taken as confirmed during the inspection: A review of three care records evidenced that continence assessments were completed comprehensively and included detailed information in relation to both urinary and bowel management. The care plans reviewed accurately reflected the outcomes of the completed continence assessments. This recommendation has been met.	
Recommendation 2 **Ref:** Standard 37 Criteria 4 **Stated:** Second time	It is recommended that the information recorded in the bowel record is entered into the electronic records to ensure that patients' care records are accurate and up to date.	**Met**
	Action taken as confirmed during the inspection: A review of bowel management records for two identified patients evidenced that information was recorded within the electronic records. This information was also recorded by registered nurses in the daily progress notes. The review of this information confirmed that patients' needs in regards to bowel care were being managed and appropriate actions had been taken. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 4 **Stated:** Second time	It is recommended that care plans are in accordance with the regime of care prescribed and are reviewed and updated according to ongoing re-assessment and appropriate to the patients individual needs.	**Met**
	Action taken as confirmed during the inspection: A review of care records pertaining to the management of wounds and/or pressure damage evidenced that this recommendation had been met. There was evidenced that care plans accurately reflected recommendations made by the tissue viability nurse (TVN) and/or podiatrist. Assessments and care plans had been updated in accordance with any changes in the patient's condition and treatment plans. This recommendation has been met.	

Recommendation 4 **Ref**: Standard 4 Criteria 9 **Stated:** First time	It is recommended in accordance with NMC guidelines, contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each resident.	**Partially met**
	Action taken as confirmed during the inspection: A review of nursing records evidenced that in the majority contemporaneous nursing records were kept of all nursing interventions, activities and procedures carried out in relation to each resident with the exception of "repositioning records" for one identified patient as previously discussed. The registered nurse advised that this patient had been repositioned however records had not been maintained accordingly. Therefore this recommendation was not fully validated and has been stated for a second time. This recommendation was not fully met and has been stated for a second time.	
Recommendation 5 **Ref**: Standard 19.4 **Stated:** First time	It is recommended that registered nurses are provided with training, as appropriate on the nursing process. Evidence of the training provided, should be retained in the home.	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager, registered nurses and a review of training records evidenced that two registered nurses had completed training at the Royal College of Nursing (RCN). Arrangements were in place for this learning to be shared with fellow colleagues. A review of care records evidenced that improvements had been made and indicated that the learning had been embedded into practice. This recommendation has been met.	

Recommendation 6 **Ref**: Standard 23 **Stated:** First time	It is recommended that the current template for recording patients "repositioning care" is reviewed to ensure that it provides detailed information in regards to the "condition of the skin" when checked.	**Met**
	Action taken as confirmed during the inspection: A sample review of "repositioning records and information" evidenced that staff were reporting on the condition of the patient's skin at each positional change. There was written evidence that appropriate actions had been taken as deemed necessary. This recommendation has been met.	
Recommendation 7 **Ref**: Standard 7 **Stated:** First time	It is recommended that patients and relatives meetings are organised and records are kept to include; list of attendees, the agenda, details of discussion and any agreed actions.	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager and a review of information confirmed that patients and relatives meetings had been held on the 15 June 2016 and 4 October 2016. A review of the minutes included; the agenda; list of attendees; details of discussion and agreed actions. This recommendation has been met.	
Recommendation 8 **Ref**: Standard 35.7 **Stated:** First time	It is recommended that the content of the report prepared in accordance with Regulation 29 of the Nursing Homes Regulations Northern Ireland (2005) should be reviewed and developed to monitor and report on the delivery of nursing and other services provided and the robustness of the homes governance arrangements.	**To be validated at the next care inspection**
	Action taken as confirmed during the inspection: A discussion with the registered manager confirmed that arrangements were in place for an independent healthcare consultant to carry out the monthly monitoring visits and reports in accordance with Regulation 29 of the Nursing Homes Regulations Northern Ireland (2005). The first visit was to be undertaken in December 2016. In light of this information, a decision was made not to review this recommendation in its entirety and it therefore has been carried forward to the next care inspection.	

4.3 Inspection Findings

4.3.1 Consultation

During the inspection we met with seven patients, two care staff, five registered nurses, the laundress, the maintenance man, an activity co-ordinator and a number of catering staff. No patient representatives were spoken with at this inspection.

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Six staff and four relatives returned their questionnaires, within the timeframe for inclusion in this report. No questionnaires were returned by patients.

Staff

All responses received indicated that staff were either 'very satisfied' and/or 'satisfied' across all four domains.

Additional comments included:
"I think the home is well led with nurse manager and nursing sisters working well to ensure a well-run home."
"Very happy I have worked in the home for over 20 years and have no issues."

Patients

As previously discussed no questionnaires were returned in the identified time frame. However, discussions with patients individually and in smaller groups during the inspection indicated their level of satisfaction with care and living in Hockley.

Some comments included:
"No complaints get everything I need."
"Spoilt looked after too well."
"Nurses and staff are great."

No concerns were raised.

Patients' representatives

No relatives were spoken with during the inspection process although four questionnaires returned indicated that respondents were 'very satisfied' with care in the home.

Some additional comments included:
"The staff are all very approachable and endeavour to make sure everyone is well looked after and are happy in their surroundings."
"We feel the home is very well run and attention to detail is obviously high on the agenda. The manager is freely available at any time and is always glad to talk about mum or just to chat in general. I could not think of any improvement I would like or is needed."

4.3.2 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, and communal areas. In general, the areas reviewed were found to be warm, clean and reasonably tidy. The home was decorated throughout for the Christmas celebrations. At the last inspection, items were observed being stored in a link corridor between Hockley Mews and Hockley Lodge. Whilst some improvement had been made, some items continued to be kept in this area. A discussion with the maintenance man provided an explanation for this practice and agreed that alternative arrangements would be made in this regard.

4.3.3 Mealtime experience

The serving of the lunchtime meal was observed in the Hockley Mews Unit and was noted to be well managed. Patients were observed having their meal in their preferred location for example; their bedroom, lounge and/or dining room. Tables were set with condiments and patients were provided with clothing protectors. Staff were also observed wearing appropriate aprons when serving and /or assisting patients with their meals. Meals transported on trays were presented to a satisfactory standard. The food smelt and looked appetising. Staff were knowledgeable of the patient's nutritional and dietary requirements and provided appropriate assistance and encouragement. Staff were observed offering patients choice and were kind and respectful in their interactions. Patients advised the food was tasty and appeared to enjoy the dining experience. In the main dining room the menu was not displayed. The registered manager advised that the menu was displayed in other areas of the home and whilst this information was available the registered manager agreed to have the menu displayed in an appropriate format in the dining rooms.

4.3.4 Storage of information

During the inspection a computer screen displaying patient information was observed when staff was not present. This matter was brought to the attention of the registered manager who responded immediately. The registered manager advised that signs had been displayed recently reminding staff to close the screen monitors to ensure patient confidentiality. These signs were observed by the inspector and the registered manager provided assurances that this matter would be closely monitored and actions would be taken as necessary. This will be monitored at subsequent care inspections.

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 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 the 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 taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 12 (1) (a) (b) **Stated:** Second time **To be completed by:** 31 March 2017	The registered provider must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This relates specifically to the management of wound management and pressure care to include; the "repositioning needs" of patients and care is recorded in keeping with best practice guidelines. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Registered Nurses and Care Assistants have been reminded of the paramount importance of recording the interventions made in the care of their patients. An audit of the system showed that record keeping has improved. The records will continue to be subject to audit.
Requirement 2 **Ref**: Regulation 17 (1) **Stated:** Second time **To be completed by:** 31 March 2017	The registered provider must implement a robust system to review the quality of nursing and other services provided by the home. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: The audit process is being re-evaluated to include follow-up so as an improvement in the quality of care delivered can be evidenced.
Recommendations	
Recommendation 1 **Ref**: Standard 4 Criteria 9 **Stated:** Second time **To be completed by:** 31 March 2017	It is recommended in accordance with NMC guidelines, contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each resident. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Registered Nurses have been reminded of their accountability in maintaining the accuracy of the record of all nursing interventions concerning the care of patients, whether carried out by them personally or, by a care assistant.

Recommendation 2 **Ref**: Standard 35.7 **Stated:** First Time **To be completed by:** 11 July 2016	**Carried forward until the next care inspection** It is recommended that the content of the report prepared in accordance with Regulation 29 of the Nursing Homes Regulations Northern Ireland (2005) should be reviewed and developed to monitor and report on the delivery of nursing and other services provided and the robustness of the homes governance arrangements. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: With regard to Regulation 29, a visit was made on 28/12/16, by an independent healthcare consultant. A report has been received. This monitoring process will continue on a monthly basis.

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