Hockley Private Nursing Home
RQIA ID: 1471
11 Drumilly Road
Armagh
BT61 8RG

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Unannounced Care Inspection
of
Hockley Private Nursing Home

11 February 2016

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 82205 2544 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 11 February 2016 from 11.00 to 17.00 hours.

The focus of this inspection was continence management which was underpinned by selected criteria from:

Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Health care and Standard 39: Staff Training and Development.

On the day of the inspection, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 20 August 2015.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent actions record regarding the management of weight loss was issued to Marion Wilson, the Registered Manager at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home.

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	3	4

The details of the Quality Improvement Plan (QIP) within this report were discussed with management representatives at Hockley Private Nursing Home as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Elim Trust Corporation/Pastor Edwin Michael	**Registered Manager:** Mrs Marion Gertrude Wilson
Person in Charge of the Home at the Time of Inspection: Mrs Margaret Thornbury, Nursing Sister Mrs Marion Wilson, Registered Manager	**Date Manager Registered:** 01 April 2005
Categories of Care: RC-I, NH-I	**Number of Registered Places:** 60
Number of Patients Accommodated on Day of Inspection: 48	**Weekly Tariff at Time of Inspection:** £470.00 - £593.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards have been met:

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the selected criteria from the following standards have been met:

Standard 4: Individualised Care and Support, criteria 8
Standard 6: Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8 and 15
Standard 21: Health Care, criteria 6, 7 and 11
Standard 39: Staff Training and Development, criteria 4.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the registered manager
- discussion with the nursing sisters
- discussion with staff on duty during the inspection
- review of care records
- observation during a tour of the premises
- evaluation and feedback.

Prior to inspection the following records were analysed:

- inspection report and quality improvement plan (QIP) from the previous care inspection dated 20 August 2015
- incident reports submitted in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection focus
- complaints record
- three patient care records
- staff training records.

5.0 The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Hockley Private Nursing Home was an unannounced care inspection dated 20 August 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 20 August 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref:** Regulation 13 (7) **Stated:** First time	The registered manager/registered person(s) must ensure that all issues identified in section 5.5.2 of the report pertaining to infection prevention and control and findings from the audit completed post inspection are addressed to minimise the risk of infection and spread of infection between patients and staff.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that audits had been completed following the last care inspection. A review of information evidenced that audits had been completed 29 September and 11 October 2015 in relation to the areas identified at the previous care inspection. The areas identified in the previous care inspection were evidenced to be actioned satisfactorily; • bed tables had been replaced • pressure relieving cushions had been purchased • additional specialised seating had been purchased and some repaired • profiling beds had been purchased • clinical waste bins had been repaired • an alternative method of identifying wheelchairs had been identified.	

	During a tour of the home these actions were evidenced. The registered manager advised that there was an ongoing programme of refurbishment and equipment replacement to ensure standards are met. This requirement has been met.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 20.2 **Stated:** First time	It is recommended that the registered manager/person(s) should ensure that end of life and after death arrangements should be discussed with the patient/their representatives, as appropriate, and documented in their care plan. This should include the patient's wishes and take account of their cultural and spiritual preferences and preferred place of death/care.	**Met**
	Action taken as confirmed during the inspection: A review of three care records evidenced that this area of practice had been developed and end of life, spiritual and death and dying arrangements were recorded. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 39 **Stated:** First time	It is recommended that the registered manager/person(s) ensures that staff receive training on the following; 1. Palliative /End of life care 2. Communication including the "breaking of bad news".	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager, staff and a review of training records evidenced a number of training opportunities had been provided. Six care staff had attended Palliative and End of Life Care, RCN, February 2016, four registered nurses had completed the e learning programme for Palliative and End of Life Care, RCN and the registered manager and palliative care link nurse had attended the RCN, Palliative and End of Life Care event, October 2015. This recommendation has been met.	

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies and procedures regarding continence management, urinary catheterisation and stoma care were available to guide and direct staff. The policies were last reviewed February 2014.

A resource file on continence management was available for staff to consult and the registered manager was provided with additional guidance information references and these were subsequently made available to staff during the inspection process.

Discussion with staff and the registered manager confirmed that staff had received training in regards to the management of urinary incontinence, catheterisation and stoma care. Training records evidenced that six staff had completed training in November 2015 in relation to the use and application of incontinence aids and this information had then been shared with other staff members. Stoma care training had also been completed July 2015. Training in regards to male catheterisation had been completed by registered nurses and records of supervised practice were available.

Staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Observation during the inspection and discussion with staff evidenced that there were adequate stocks of continence products available in the home.

The home had identified three link nurses for continence management to provide guidance for staff during all shift patterns.

Is Care Effective? (Quality of Management)

Review of three patient's care records evidenced that a continence assessment was recorded on admission and reviewed thereafter on an annual basis or more often if required. The assessments reviewed had not been completed comprehensively.

Continence care plans were in place for each of the three patients with evidence of monthly review.

The promotion of continence, skin care, and patient's dignity were addressed in the care plans inspected. Care plans reviewed did not include all relevant information regarding the patient's toileting needs for example the patient's ability to manage their individual toileting needs, patient's normal bowel patterns and types. Again this information was also not included in the assessment. A recommendation has been made.

A review of bowel management records evidenced that the Bristol Stool Chart was being referred to for the recording of bowel movements. However, two recording systems were in use a paper record and a computer record. A review of both systems identified inconsistencies in the information being recorded. A discussion with registered nurses advised that care staff recorded bowel movements in the paper record and the night duty nurse then recorded the information on to the computer record, however a review of the computer record identified gaps in recording indicating significant gaps in patient's bowel habits. The computer

record is the identified record for assessing, planning, implementing and evaluating care therefore, it is important that this record is maintained accurately to ensure continuity of care. A recommendation has been made.

The management of urinary catheters was reviewed. Registered nurses spoken with were knowledgeable regarding the management of urinary catheters and the rationale for use of urinary catheters. Urinary catheters were only inserted on the instructions of the patients GP or consultant. There was evidence in the records reviewed that staff had consulted the relevant practitioner when issues pertaining to the management of the urinary catheter had arisen and actions had been implemented as per the advice given.

Two care records relating to the management of urinary catheters were reviewed and included detailed information in accordance with best practice guidelines. A review of records relating to catheter insertion and/or change evidenced that these had been completed in accordance with the plan of care in place and the necessary information was recorded appropriately.

Reviews of patients' care records evidenced that patients and/or their representatives were informed of changes to patient needs and/or condition and the actions taken.

Is Care Compassionate? (Quality of Care)

During the inspection staff were observed to treat the patients with dignity and respect. Good relationships were evident between patients and all grades of staff. Staff was observed to respond to patients requests in a timely manner. Patients spoken with confirmed that they were happy in the home and that staff were kind and attentive.

Areas for Improvement

Continence assessments and care plans should be completed comprehensively to include all aspects of continence management and reflect patients individual toileting needs.

Records pertaining to bowel management are maintained and managed accurately and up to date for individual care records.

Number of Requirements:	0	Number of Recommendations:	2

5.4 Additional areas examined

5.4.1 Management of Weight Loss

A review of two patients care records found insufficient evidence that patient's weight loss was being identified and appropriately managed.

A review of one patients care record identified that they had a weight loss of 3.8 kilograms in a seven week period. The following was evidenced:

- The Malnutrition Universal Screening Tool (MUST) had not been completely appropriately
- The care plan had not been reviewed to highlight the weight loss
- The amount of weight loss had not been referred to in the daily progress notes and or evaluation statements

- Registered nurses had failed to recognise the weight loss and take relevant actions.

A second care record evidenced that the patients weight loss had been previously identified and a dietician referral was made at this time however the patient had a further weight loss of 5.7 kilograms in one month and there was no evidence available that registered nurses had followed up the previous referral made or liaised with the GP regarding the patients continued weight loss. Again the care plan had not been reviewed to highlight the weight loss and appropriate actions taken to monitor the management of weight loss.

This was concerning as this could have the potential to impact on patients health and welfare. An urgent actions record was issued at the inspection and a requirement has been made. Post inspection, RQIA received information by email that appropriate actions had been taken and care records updated to reflect the current care and treatment required.

A review of care records evidenced that the Malnutrition Universal Screening Tool (MUST) was not being completed appropriately. A recommendation has been made that training is provided in this regard.

5.4.2 Care records

A review of two patients care records evidenced that the care plans examined were not reflective of the treatment and care being delivered.

A review of care records and observation of care delivery for one patient identified conflicting information regarding their swallowing needs. A care staff member was observed preparing fluids for the identified patient and advised that the patient required stage three fluids. The care plan recorded stage two and the SALT assessment available evidenced stage one.

Discussions with staff indicated that staff including registered nurses who were responsible for assessing, planning and directing care were not knowledgeable of the needs of the patient. This matter is concerning as it could have a direct impact on the health and welfare of patients and the care delivered. A requirement has been made.

A review of one patient's care records identified as requiring wound care evidenced some ambiguity regarding the regime of care required. A discussion with registered nurses and a review of wound care documentation evidenced that the dressings were required to be re-dressed every four days however the care plan indicated alternate days. The care plan had not been updated to reflect the current regime of care prescribed. A recommendation has been made.

5.4.3 Safeguarding of Vulnerable Adults (SOVA)

A review of the complaints record evidenced that a recorded compliant which had a potential allegation of abuse had not been dealt with in accordance with policy and procedures in place for safeguarding consistent with Departmental policy on Safeguarding. A discussion with the registered manager and a review of records evidenced that the incident had not been appropriately reported to the Trust Safeguarding team. This was discussed at length at the inspection and the correct procedure reinforced with the registered manager. It was agreed that the registered manager would liaise with the Trust and action accordingly. Post inspection, RQIA received confirmation from the registered manager of actions taken and to be taken. It would appear from the management of this incident that further arrangements and/or

training are required to ensure that the registered manager and relevant others understand their specific role in relation to safeguarding. A requirement has been made.

Areas for Improvement

Number of Requirements:	**3**	**Number of Recommendations:**	**2**

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed during feedback as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be Completed by:** 11 February 2016	The registered person must ensure that the treatment and any other services provided to each patient meets their identified assessed needs and reflects current best practice in relation to the management of weight loss. An urgent actions record was issued. **Ref Section: 5.4.1**
	Response by Registered Person(s) Detailing the Actions Taken: As advised in the Home's reply to the 'Urgent Actions Record', action was taken and continues to be implimented. Weight loss is being monitored and managed in response to the outcome of the Malnutririon Universal Screening Tool score, leading to liaison with the G.P. and the dietician.
Requirement 2 **Ref:** Regulation 13(1) (a) (b) **Stated:** First time **To be Completed by:** 14 March 2016	The registered person must ensure that patients identified with swallowing difficulties are referred to SALT and reviewed as and when required. A care plan should be developed and or updated to reflect any recommendations made and care is provided accordingly. A system should be developed to ensure that all staff is knowledgeable in relation to the consistency of fluids suitable for the needs of patients. **Ref Section: 5.4.2**
	Response by Registered Person(s) Detailing the Actions Taken: Care plans have been reviewed to ensure that they are currently applicable to the needs of the patients as advised by SALT. SALT advice is, as always, also readily available in paper form for care and catering staff to access at any time. Staff are updated when a change takes place. Recent training (provided by a representative of a company that supplies a thickening agent) has taken place in relation to thickening and nutrition.
Requirement 3 **Ref:** Regulation 14 (4) **Stated:** First time **To be Completed by:** 14 March 2016	The registered person shall make arrangements, by training or by other measures that the registered manager and relevant others understand their specific role in relation to safeguarding. The correct procedures must be adhered to and reported to relevant authorities. **Ref Section: 5.4.3**
	Response by Registered Person(s) Detailing the Actions Taken: Management have had much discussion regarding this specific complaint and have benefitted from the learning provided. The

	complaint was satisfactorily resolved. In future, management will strictly follow the appropriate protocol and procedure.
Recommendations	
Recommendation 1 **Ref**: Standard 4 Criteria (1) (7) **Stated:** First time **To be Completed by:** 14 March 2016	It is recommended that continence assessments and care plans are completed comprehensively to include all aspects of continence management. **Ref Section: 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Care plans and continence assessments continue to be reviewed and personalised in greater detail in order to provide insight regarding patients' needs.

Recommendation 2 **Ref**: Standard 37 Criteria 4 **Stated:** First time **To be Completed by:** 14 March 2016	It is recommended that the information recorded in the bowel record is entered into the electronic records to ensure that patient's care records are accurate and up to date. **Ref Section: 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: This discrepancy was followed up and rectified.
Recommendation 3 **Ref**: Standard 39 **Stated:** First time **To be Completed by:** 4 April 2016	It is recommended that registered nurses receive training in relation to the management of weight loss to include the Malnutrition Universal Screening Tool (MUST) and ensure that learning has been embedded into practice. **Ref Section: 5.4.1**
	Response by Registered Person(s) Detailing the Actions Taken: Registered Nurses have received an in-house update from the Link Nurse who cascades this knowledge. The update included a review of the completion of the MUST on the Home's computer system. To date, five of those nurses have also received one to one supervision. The remainder will have supervision sessions during April.

Recommendation 4 **Ref**: Standard 4 **Stated:** First time **To be Completed by:** 4 April 2016	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. **Ref Section: 5.4.2** **Response by Registered Person(s) Detailing the Actions Taken:** Care plans have been reviewed and updated. The importance of not only carrying out the prescribed care and recording the fact, but also of checking that the care plan is accurate has been stressed to Registered Nurses.

Registered Manager Completing QIP	Marion G. Wilson	**Date Completed**	05/04/2016
Registered Person Approving QIP	Elaine Hill	**Date Approved**	05/04/2016
RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	11/04/2016

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address