Unannounced Care Inspection Report
04 June 2018

Iveagh House Private Nursing Home

Type of Service: Nursing Home (NH)
Address: 62 Castlewellan Road, Banbridge, BT32 4JD
Tel No: 028 4062 8055
Inspector: Linda Thompson

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 33 persons.

3.0 Service details

Organisation/Registered Provider: Harold Mitchell (Belfast) Ltd **Responsible Individual:** Mr Harold Leslie Mitchell	**Registered Manager:** Mrs Patricia Purvis
Person in charge at the time of inspection: Dawn Maginnis Registered Nurse	**Date manager registered:** 23 March 2015
Categories of care: Nursing Home (NH) I – Old age not falling within any other category.	**Number of registered places:** 33

4.0 Inspection summary

An unannounced inspection took place on 04 June 2018 from 09.30 to 13.45 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 sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the delivery of patient care, the dining experience, general management of the home including management of nursing care records, staff training, supervision and annual appraisal and the general environment of the home.

No areas of improvement were identified at this inspection.

Patients 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 was evidence that the management team listened to and valued patients and their representatives and taking account of the views of patients.

The registered manager and staff are to be commended on sustaining the quality of service provision over the past two inspections.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

No areas of improvement were identified as a consequence of this inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 7 November 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 7 November 2017. There were no areas for improvement identified at this time.

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

5.0 How we inspect

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

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

During the inspection we met with 25 patients, 6 staff, and 3 patients' visitors or representatives. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was provided which directed staff to an online survey and staff not on duty during the inspection.

The following records were examined during the inspection:

- duty rota for all staff from 28 May 2018 to 11 June 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

The findings of the inspection were provided to the person in charge at the conclusion of the inspection. A further follow up phone call with the registered manager was made upon her return from planned leave.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 7 November 2017

The most recent inspection of the home was an unannounced care inspection.

No areas for improvement were identified during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 7 November 2017

There were no areas for improvement identified as a result of the last care inspection.

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 nurse in charge confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 28 May 2018 to 11 June 2018 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff. The staff duty rota was discussed with the registered manager post inspection and it was agreed that it would more clearly identify the designation of the staff teams.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

Staff spoken with, were satisfied that there was sufficient staff on duty to meet the needs of the patients. Staff said that on occasions staffing levels were affected by short notice leave. However, they also confirmed that this only happened occasionally and that shifts were "covered." We also sought staff opinion on staffing via the online survey. No responses were received within the required time frame.

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Iveagh House Private Nursing Home. We also sought the opinion of patients on staffing via questionnaires. Five patient questionnaires were returned. All comments received were positive in the quality of the service provision.

Relatives spoken with did not raise any concerns regarding staff or staffing levels. We also sought relatives' opinion on staffing via questionnaires. Two questionnaires were returned and all indicated that they were satisfied that staff had 'enough time to care'.

One of the relatives' included the following comment:

"I feel the home do a terrific job and the staff are very welcoming. The staff always have time for me and keep me updated with any changes that occur."

As stated previously, observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

Review of two staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work. 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.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC.

We discussed the provision of mandatory training with staff and reviewed staff training records. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered nurse in charge confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

Review of three patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

We reviewed accidents/incidents records retained in the home, in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the registered manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. Following this review an action plan was devised to address any identified deficits. This information was also reviewed as part of the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

From a review of records, observation of practices and discussion with the registered nurse in charge and staff there was evidence of proactive management of falls.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounge/s, dining room/s and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients/representatives/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.

Observation of practices/care delivery, discussion with staff and review of records evidenced that infection prevention and control measures/best practice guidance were consistently adhered to.

Systems were in place to monitor the incidents of hospital/community acquired infections (HCAI's) and the registered nurse in charge understood the role of Public Health Authority (PHA) in the management of infectious outbreaks.

We discussed at length the recent directive from PHA regarding the identification and management of urinary tract infections. A further flow chart was left with the home as a reference tool. Staff should be reminded of the new protocols.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example bed rails, alarm mats. There was also evidence of consultation with relevant persons. Care plans were in place for the management of such restraint.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas of improvement were identified under 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 three patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient.

We reviewed the management of nutrition, patients' weight, management of infections and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), SALT and dieticians. Supplementary care charts such as food and fluid intake records evidenced that contemporaneous records were maintained. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), the speech and language therapist (SALT) or the dietician changed.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

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 or the nurse in charge.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was also evidence of regular communication with representatives within the care records.

The registered manager advised that patient and/or relatives meetings were held on a regular basis and minutes were available for inspection.

Patients and their representatives confirmed that they attended meetings/were aware of the dates of the meetings in advance.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management. They were also aware of who their named nurse was and knew the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, audits and reviews, communication between residents, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified under 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.

We arrived in the home at 09.30 hours and were greeted by staff who were helpful and attentive. The registered manager was on planned leave and the registered nurse in charge was involved in medicine administration. In order that the inspection would not impact upon the morning routines the administrator supported the inspection initially until medicine administration was completed. Patients were enjoying a late breakfast or a morning cup of tea/coffee in the dining room, in one of the lounges or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice and staff were observed assisting patients to enjoy their chosen activity and to eat and drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

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

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example appropriate signage, photographs, the provision of clocks and prompts for the date.

We observed the serving of the lunchtime meal. Patients were assisted to the dining room or had trays delivered to them as required. Staff were observed assisting patients with their meal appropriately and a registered nurse was overseeing the mealtime. Patients able to communicate indicated that they enjoyed their meal. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

"Staff are all very friendly on my first impression of the home when my … was admitted."

"I arrived unannounced at the home to see if it would suit my family member. I was very impressed, the home was very clean, no odours were noticed and staff appeared friendly and happy."

"My friend settled well into the home, her mobility is improved and her appetite is better. I am delighted with the care received."

There were systems in place to obtain the views of patients and their representatives on the running of the home.

Consultation with 18 patients individually, and with others in smaller groups, confirmed that living in Iveagh House Private Nursing Home was a positive experience.

Patient comments included;

"This is the next best thing to home."

"I am very happy and content here."

"The staff are very good and always there when I need them."

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.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

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

Since the last inspection there has been no change in management arrangements.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff/ patients/ representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The equality data collected was managed in line with best practice.

Review of the home's complaints records evidenced that systems were in place to ensure 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 nurse in charge and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, IPC practices, care records, catering arrangements. In addition robust measures were also in place to provide the registered manager with an overview of the management of infections and wounds occurring in the home.

Discussion with the registered nurse in charge and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

A review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified within this domain during the inspection.

	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.

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