Unannounced Care Inspection Report
18 July 2016

Iveagh House

Type of Service: Nursing House
Address: 62 Castlewellan Road, Banbridge, BT32 4JD
Tel No: 028 4062 8055
Senior Inspector: Linda Thompson

1.0 Summary

An unannounced inspection of Iveagh House took place on 18 July 2016 from 09.30 to 16.30 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if Iveagh House was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subjected to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives/relatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Patients and relatives spoken with confirmed that they were assured and confident of the staffs' ability to care for their loved ones and that they 'trusted' staff to always do the right thing. One example provided was in relation to the prompt detection and treatment when a patient developed an infection. Further details of the findings of inspection are recorded in section 4.3.

There were no areas for improvement identified.

Is care effective?

Relatives spoken with stated they had confidence in the staff to deliver the right care at the right time to ensure the best possible outcome for their loved one.

Staff stated that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were 'proud' to be a part of their team and to 'make a difference'. Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals. Refer to section 4.4 for details.

There were no areas for improvement identified.

Is care compassionate?

All patients and relatives spoken commented positively regarding the care they received and the staffs caring and kind 'nothing is any trouble' attitude from everyone. It was evident that good relationships had been developed and that there was a high level of confidence in the staffs' ability to deliver care and to address concerns effectively. Details of staff spoken about were provided to the registered manager and the attitude and actions of staff were commended. Refer to section 4.5 for details.

There were no areas for improvement identified.

Is the service well led?

Based on the inspection findings detailed in subsequent sections, review of records, systems and processes; and comments from patients, relatives and staff it was evident that Iveagh House was well led. The registered manager has demonstrated, over time, how she ensures delivery of safe, effective and compassionate care as part of her day to day operational control of the home. This was commended.

There were no areas for improvement identified.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**0**

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Patricia Purvis, Registered Manager, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 11 November 2015. Other than those actions detailed in the previous QIP there were no further actions required.

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

2.0 Service details

Registered organisation/registered provider: Harold Mitchell (Belfast) Ltd Harold Mitchell	**Registered manager:** Patricia Purvis
Person in charge of the home at the time of inspection: Patricia Purvis	**Date manager registered:** 23 March 2015
Categories of care: RC-I, NH-I	**Number of registered places:** 33

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events 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

During the inspection the inspector spoke with eight patients individually and greeted others in small groups, four relatives, four care staff, two registered nurses, one catering staff and two members of staff from housekeeping.

In addition questionnaires were provided for distribution by the registered manager; 10 for relatives, eight for patients and 10 for staff. Two relatives, three patients and six staff questionnaires were returned. Refer to section 4.5 for details.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspectors.

The following information was examined during the inspection:

- three patient care records
- staff roster for three weeks prior to the inspection
- staff training and planner/matrix for 2015 and 2016
- two staff recruitment records
- complaints record
- incident and accident records
- record of quality monitoring visits carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit/governance
- staff appraisal and supervision planners 2015/16
- records pertaining to consultation with staff, patients and relatives

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 November 2015.

The most recent inspection of Iveagh House was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This inspection will validate the actions recorded on the previous QIP.

4.2 Review of requirements and recommendations from the last care inspection dated 11 November 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (7) **Stated:** Second time	The registered persons must ensure that toileting slings are appropriately decontaminated between use or provide toileting slings for individual patient use in accordance with best practice in infection prevention and control.	**Met**
	Action taken as confirmed during the inspection: The inspector can confirm that all patients requiring use of moving and handling equipment i.e. hoists are supplied with their own toileting slings. These slings are transported around the home in individualised bags ready for patient use as required.	
Requirement 2 **Ref:** Regulation 20 (3) **Stated:** Second time	A competency and capability assessment must be carried out with any nurse who is given the responsibility of being in charge of the home in the absence of the manager.	**Met**
	Action taken as confirmed during the inspection: The inspector can confirm that all registered nurses who carry the responsibility for the management of the home in the absence of the registered manager are fully assessed and deemed competent prior to taking on this role. Two competency and capability assessments were examined and evidenced to be well recorded and comprehensive.	

Requirement 3 **Ref:** Regulation 12 (1) (a) (b) & (c) **Stated:** First time	The registered persons shall provide treatment, and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient – (a) meets his individual needs; (b) reflects current best practice; and (c) are (where necessary) provided by means of appropriate aids or equipment This is particularly in relation to pressure ulcer prevention and management.	**Met**
	Action taken as confirmed during the inspection: The Inspector confirmed that there was comprehensive guidance in respect of pressure ulceration available to the registered nursing and care staff team. Staff were knowledgeable of how to prevent pressure ulceration and of what to do should the initial signs of skin damage be noted. Patient care records were evidenced to be well maintained with appropriate risk assessments, general assessments, care plans and care reviews well recorded.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 23 **Stated:** Second time	Repositioning charts should be completed to reflect the following: • Frequency of repositioning • Outcome of skin inspections • The actual position of the patient	**Met**
	Action taken as confirmed during the inspection: The inspector can confirm that repositioning charts were evidenced to be well maintained and recorded the frequency of repositioning, the outcome of skin inspections and the actual positioning of the patient after the change of position.	

Recommendation 2 **Ref**: Standard 4, criterion 9 **Stated:** First time	Contemporaneous records should be kept of all nursing interventions, activities and procedures carried out in relation to each resident. This is particularly in relation to the documentation of repositioning. **Action taken as confirmed during the inspection**: The inspector can confirm that patient care records were well maintained in respect of repositioning.	**Met**
Recommendation 3 **Ref**: Standard 39, criterion 7 **Stated:** First time	The effect of pressure ulcer and management training on the practice of registered nurses should be evaluated by the registered manager as part of ongoing quality improvement. **Action taken as confirmed during the inspection**: The training provided and the guidance documents established as a resource tool have had a positive impact on the knowledge, skills and practice of the registered nursing and care team. Staff discussed the training, and guidance folders with the inspector, and were knowledgeable in regards to the actions to be taken should skin damage be noted.	**Met**

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subjected to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for three weeks prior to the inspection visit, evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives/ relatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. New staff were supported through their induction by a dedicated mentor. Review of one staff member's induction evidenced the record to be completed in full and signed/dated appropriately.

Review of the training planner/matrix for 2015 and 2016 indicated that training was planned to ensure that mandatory training requirements were met. Staff confirmed that they were required to complete mandatory training through the 'e-learning' portal and by attending 'face to face' training. The records reviewed confirmed that 100% of staff had, so far this year, completed mandatory training; this was commended by the inspector.

Discussion with the registered manager and review of electronic records evidenced that a robust system was in place to ensure staff attended mandatory training. For example, an electronic overview of staff yet to complete training modules was available and checked by the registered manager on a regular basis. Staff would then be reminded to ensure they completed the training module.

Observation of the delivery of care evidenced that training had been embedded into practice.

A planner was in place to manage staff supervision sessions and annual appraisals. Discussion with staff and the registered manager confirmed that supervision sessions were meaningful and relevant to their role and function in the home.

The registered manager and staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding. Staff described their role and responsibilities with enthusiasm and said that they were enabled to 'make a difference'. Patients and relatives spoken with confirmed that they were assured and confident of the staff's ability to care for their loved ones and that they 'trusted' staff to always do the right thing. One example provided was in relation to the prompt detection and treatment when a patient developed an infection.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). Safety and medical alerts were reviewed on a regular basis and relevant notices were 'actioned' and/or disseminated to staff as required.

Review of three 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.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since July 2015 confirmed that these were managed appropriately. Audits of falls and incidents were maintained and clearly evidenced analysis of the data to identify any emerging patterns or trends and action plans were in place as required. This information also informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts.
Patients, representatives and staff spoken with were complimentary in respect of the home's environment and stated that 'the home is always very clean and very well maintained'.

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

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.4 Is care effective?

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. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer a care plan was in place to direct staff on the management of this risk. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

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. Relatives confirmed that they were kept informed of any changes in their loved ones' care.

A number of relatives spoken with stated that they 'trusted staff' to care for their loved ones and that 'staff knew their stuff.' Other relatives described that prior to Iveagh House their loved one was always nursed in bed and never 'got up' despite having a specialised chair – now they were up for short periods and enjoyed the activity programme and the garden during good weather. Relatives stated they had confidence in the staff to deliver the right care at the right time to ensure the best possible outcome for their loved one.

Supplementary records such as repositioning charts, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

Observations evidenced that call bells were answered promptly and patients requesting assistance in one of the lounge areas or their bedrooms were responded to in a calm, quiet and caring manner. Patients were confident of the ability of staff to meet their needs effectively and in a timely manner. For example, patients described staff responses to call bells, 'when I call they answer prompt – if they are with someone else they let me know and say they will come back in a few minutes – they have always kept their word. This is very good in comparison to the hospital.'

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the handover reports at the beginning of their shift. Staff also confirmed that regular staff meetings were held, that they contributed to the agenda and that minutes were made available. Staff meetings for registered nurses and care assistants were held on 19th, 23rd and 31st May 2016. Minutes were available.

Staff stated that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were 'proud' to be a part of their team and to 'make a difference.' Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their representatives was evident on a one to one basis as recorded in the care records and through observations of interactions. Patients confirmed that the registered manager was available to them on a daily basis.

There was information available to staff, patients, representatives in relation to advocacy services.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. As stated in section 4.4 patient and relatives were very positive in the comments regarding the staff's ability to deliver care and respond to needs and or requests for assistance.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients and relatives confirmed that the details known by staff also ensured that staff provided assurance and comfort when needed. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. A recent review of residents and relatives satisfaction with service provision dated April 2016 was shared with the inspector. The findings of this survey were very positive and the home is commended.

All patients and relatives spoken with commented positively regarding the care they received and the staffs' caring and kind 'nothing is any trouble' attitude from everyone. It was evident good relationships had been developed between patients and staff and that there was a high level of confidence in the staffs' ability to deliver care and to address concerns effectively.

Patients spoken with said that staff 'made a difference to their life in the home.' For example, staff knowing what to do when 'something wasn't right' or when staff had conversations and 'bit of craic as an equal.'

It was evident that the home provided a varied and comprehensive programme of activities which was considerate of various levels of participation. Patients and relatives spoke highly in relation to the activity therapist. Details of the activity programme were provided by the registered manager.

In addition to speaking with patients, relatives and staff, RQIA provided questionnaires. At the time of writing this report two relatives, three patients and six staff had retuned their questionnaires.

Comments and outcomes were as follows:

Patients: respondents indicated that they found the home provided 'excellent' or 'good' care. Comments recorded included, 'staff are dedicated', 'staff are good, do their stuff, needs are always met.'

Relatives: respondents indicated that they found the home provided 'excellent' care. Comments recorded included, 'staff are always compassionate, courteous and polite.'

Staff: respondents indicated that they found the home provided excellent care. Comments recorded included, 'All ideas from staff are welcomed and discussed if suitable'.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff confidently described their role and responsibility in the home. In discussion patients were aware of the roles of the staff in the home and to whom they should speak to if they had a concern. Patients and relatives spoke in very positive terms in relation to the registered manager and their confidence in her leadership skills.

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

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would address any concern raised by them appropriately.

Staff were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function. A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents/accidents.

Records also evidenced that the results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Review of reports and discussion with the registered manager evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives.
There was an effective system in place to ensure nursing staff were registered with the nursing and Midwifery Council; and that care staff were registered with the Northern Ireland Social Care Council (NISCC). New care staff not registered with NISCC were required and supported to register.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed.

Discussion with the registered manager and observations evidenced that the home was operating within its registered categories of care.

Based on the inspection findings detailed in the preceding domains, review of records, systems and processes; and comments from patients, relatives and staff it was evident that Iveagh House was well led. The registered manager has demonstrated, over time, how she ensures delivery of safe, effective and compassionate care as part of her day to day operational control of the home. This was commended.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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