Inspection Report

20 January 2022

Mountvale

Type of service: Nursing Home
Address: Brewery Lane, Meeting Street, Dromore, BT25 1AH
Telephone number: 028 9269 9480

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Mountvale Private Nursing Home Ltd **Responsible Individual:** Mr William Trevor Gage	**Registered Manager:** Miss Heather Joan Maxwell **Date registered:** 13 January 2020
Person in charge at the time of inspection: Miss Heather Joan Maxwell	**Number of registered places:** 51
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH (E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 42
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 51 patients. Bedrooms and living areas are located over two floors with access to communal lounges, dining rooms and outdoor spaces.	

2.0 Inspection summary

An unannounced inspection took place on 20 January 2022 from 9.15 am to 5.50 pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Areas for improvement were identified during the inspection as discussed throughout this report and quality improvement plan (QIP) in Section 7.0. Two areas for improvement in relation to fluid intake management and supplementary recording charts have been stated for a second time.

Based on the inspection findings RQIA were assured that compassionate care was being delivered in Mountvale and that management had taken relevant action to ensure the delivery of safe, effective and well led care.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff members are included in the main body of this report.

The findings of this report will provide the management team with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the management team at the conclusion of the inspection.

4.0 What people told us about the service?

The inspector spoke with ten staff, one visiting professional, 16 patients individually and others in groups during the inspection. Patients told us that they felt well cared for, enjoyed the food and that staff members were helpful and friendly.

A visiting professional commented very positively about the care delivery and the level of communication from staff. There were no questionnaires returned from patients or relatives.

Staff said that the manager was very approachable, there was great teamwork and that they felt supported in their role. One staff member said "Love my work."

There was one response from the staff online survey. The respondent commented regarding the provision of staff to meet all patients' needs. Comments were shared with the Responsible Individual who agreed to investigate and action where necessary.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last medicines management inspection on 1 March 2021 and care inspection on 18 March 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time	The registered person shall ensure that the treatment and other services provided to each patient meet individual needs and reflect current best practice in relation to : • responding to behaviours • fluid intake management.	**Partially met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with staff evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure that accurate records are maintained, on a daily basis, of staffs' temperatures as per regional and departmental guidance.	**Met**
	Action taken as confirmed during the inspection: Review of relevant records evidenced that this area for improvement had been met.	

Area for Improvement 2 **Ref:** Standard 48 **Stated:** First time	The registered person shall ensure that evidence is present that all staff have participated in a fire drill at least once a year.	**Met**
	Action taken as confirmed during the inspection: Review of relevant records and discussion with the manager evidenced that this area for improvement had been met.	
Area for Improvement 3 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that the patient dining experience is reviewed to ensure it is in accordance with best practice. The dining experience should be monitored on a regular basis.	**Met**
	Action taken as confirmed during the inspection: Observation of the dining experience and discussion with patients and staff evidenced that this area for improvement had been met.	
Area for improvement 4 **Ref:** Standard 4.8 and 4.9 **Stated:** First time	The registered person shall ensure that supplementary care records, for example, repositioning records and weight management records are maintained in a clear and consistent manner and reviewed by the registered nurse in charge of the delivery of care.	**Partially Met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with staff evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	
Area for improvement 5 **Ref:** Standard 28 **Stated:** First time	The registered person shall review the arrangements for the disposal of medicines to ensure that these are in line with current guidance and standards.	**Met**
	Action taken as confirmed during the inspection: Review of relevant records and discussion with the manager evidenced that this area for improvement had been met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. Review of two staff recruitment and induction files evidenced that robust systems were in place.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC).

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics including moving and handling, fire safety and adult safeguarding. Discussion with the Manager regarding the Department of Health's (DoH) Deprivation of Liberty Safeguards (DoLS) training evidenced that staff had not completed this training and an area for improvement was identified.

A system was in place for staff supervisions and appraisals to ensure that all staff receive a minimum of two supervisions and one appraisal yearly. The Manager acknowledged that these had not been fully completed but advised that these were due to commence over the next few weeks.

Staff said they felt supported in their roles and that there was good team work with effective communication between staff and management. Staff also said that, whilst they were kept busy, the number of staff on duty was satisfactory to meet the needs of the patients.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Review of staff duty rotas clearly recorded the hours worked by staff and the person in charge in the absence of the Manager.

Competency and capability assessments for registered nurses taking charge of the home in the absence of the Manager had been completed and were available during the inspection.

Patients said that they felt well looked after by the staff and were very happy in Mountvale. One patient commented "Staff are exceptionally good" and another patient referred to the staff as being "Very friendly".

5.2.2 Care Delivery and Record Keeping

The Manager confirmed that staff members meet at the beginning of each shift to discuss any changes in the needs of the patients. Staff members were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly. This is good practice.

There was clear evidence of a relaxed, pleasant and friendly atmosphere between patients and staff. The inspector also observed where staff facilitated the patient's favourite music or television programme for those patients who were on bed rest. Patients had access to a nurse call alarm and said that staff were very attentive at responding to the alarm.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients and the lunchtime dining experience was seen to be calm and relaxed. Patients who choose to have their lunch in their bedroom or within the lounge had trays delivered to them and the food was covered on transport.

There was a choice of meals offered, the food was attractively presented by the catering staff and smelled appetising. Staff knew which patients preferred a smaller portion and demonstrated their knowledge of individual patient's likes and dislikes. Menus were also on display within each dining room. Patients said they very much enjoyed the food provided in the home.

A variety of fluids were available within communal lounges and dining rooms. Staff were observed assisting patients with their meals and fluid intake in an unhurried manner and were knowledgeable regarding patients dietary requirements.

Whilst there were no concerns regarding the administration of fluids there were a number of deficits in the overall recording of fluid intake. For example, fluid balance charts for four patients did not contain the recommended daily fluid target; the recommended fluid type and the total daily fluid intake weren't consistently totalled within all charts. Care plans for one patient also contained conflicting information regarding their recommended daily fluid intake. Details were discussed with the Manager and an area for improvement has been stated for a second time.

Care records were mostly electronic with supporting documents maintained on paper records. Review of two patient care records evidenced that not all risk assessments were completed within the required time frame following admission to the home. Details were discussed with the Manager and an area for improvement was identified.

Patients who were less able to mobilise require special attention to their skin care. Review of three patient's care records relating to pressure area care evidenced that the recommended frequency of repositioning was not always documented within charts and a number of charts were also of poor photocopy quality. There was two different recommended frequency of repositioning within one patient's charts and a number of recorded entries evidenced that they were over the recommended frequency of repositioning. This area for improvement has been stated for a second time.

It was further noted that the recommended frequency of repositioning was not documented within electronic care plans and was inconsistently recorded within paper care records. Details were discussed with the manager and an area for improvement was identified.

Review of three patient's care records regarding wound care identified that one patient did not have any information on the electronic system to direct relevant wound care. The wound assessment chart for another patient had 'gaps' in the recording as per recommended frequency of dressing renewal within the patient's care plan. There were inconsistencies within the wound assessment chart and the care plans both electronically and on paper regarding the recommended frequency of dressing renewal which had the potential to impact on the healing of the wound. The Manager acknowledged the shortfalls in relation to wound management and an area for improvement was identified.

A folder containing confidential patient information was observed within a corridor area of the home which was brought to the immediate attention of the registered nurse who removed it to a secure area. This was discussed with the Manager who agreed to monitor this type of practice during daily walk around and to discuss with relevant staff.

5.2.3 Management of the Environment and Infection Prevention and Control

The environment was fresh smelling, neat and tidy with the majority of communal areas such as lounges, the dining room and corridors tidy and free from obstruction. Patients' bedrooms were found to be personalised with items of memorabilia and special interests.

The home's most recent fire risk assessment completed on 8 April 2021 was reviewed. There were a number of recommendations as a result of this assessment. All recommendations were signed and dated by management as having been completed.

Dining rooms on both floors were being used to accommodate staff breaks outside of the patients' meal times. The importance of rooms being used for the purpose they are registered was discussed with the Manager. Following the inspection written confirmation was received from the Manager that relevant action had been taken.

The Manager told us that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Agency (PHA).

All visitors to the home had a temperature check and a health declaration completed when they arrived at the home. They were also required to wear personal protective equipment (PPE) such as aprons, masks and/or gloves. Visiting and care partner arrangements were managed in line with the DoH and infection prevention and control (IPC) guidance.

There was a good supply of PPE and hand sanitising gel throughout the home. Observation of staff practices evidenced that they were not consistently adhering to appropriate IPC measures, including the storage of patient equipment, the wearing of PPE and hand hygiene. Aprons were observed draped over hand rails throughout the home rather in in dispensers to reduce the risk of becoming contaminated. Details of all identified IPC issues were discussed with the Manager and an area for improvement was identified.

5.2.4 Quality of Life for Patients

Observation of life in the home and discussion with staff and patients established that staff engaged well with patients individually or in groups. Patients were afforded the choice and opportunity to engage in social activities and some were observed engaged in their own activities such as; watching TV, sitting in the lounge resting or chatting to staff. Patients appeared to be content and settled in their surroundings and in their interactions with staff.

The activity coordinators were enthusiastic in their role and an activity planner was on display within each unit. Live music was facilitated in the afternoon in accordance with COVID-19 guidelines which patients appeared to enjoy.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted patients to make phone or video calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection and the Manager said they felt well supported by the Responsible Individual.

Review of accidents/incidents records in comparison with the notifications submitted by the home to RQIA confirmed that records were maintained appropriately.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. The audit process included an action plan with the person responsible for completing the action, a time frame for completion and a follow up to ensure the necessary improvements had been made. However, care record audits did not contain the full audit cycle and hand hygiene audits were not being completed on all relevant staff. Details were discussed with the Manager and an area for improvement was identified.

Discussion with the Manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the Responsible Individual.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	3*	5*

* The total number of areas for improvement includes one regulation and one standard that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Heather Joan Maxwell, Registered Manager and Mr Trevor Gage, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that the treatment and other services provided to each patient meet individual needs and reflect current best practice in relation to: • fluid intake management. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Fluid balance charts have been redesigned to identify minumum target intake for all residents.
Area for improvement 2 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** 20 March 2022	The registered person shall ensure that staff are to receive mandatory training in relation to the Department of Health's Deprivation of Liberty Safeguards (DoLS) relevant to their role and a record of this training is maintained and available for inspection. Ref: 5.2.1
	Response by registered person detailing the actions taken: All staff have received Deprivation of Liberty Safeguards training relavent to their role. Certificates for senior staff are filed as evidence of such and records of all staffs completion is maintained.

Area for improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that infection prevention and control practices are reviewed. Specific reference to: • staff are bare below the elbow • PPE is worn in accordance with the regional COVID-19 guidelines • patient equipment is stored appropriately • the storage of aprons is reviewed. Ref: 5.2.3
	Response by registered person detailing the actions taken: Staff continue to be monitored on a daily basis for nail varnish/ bare below the elbow. Records of this are available. PPE is monitored and recorded as such. Smaller masks have been purchased for one member of staff. Patient equipment is stored correctly and checked daily. The storage of aprons has been reviewed however until aprons on a roll are availble, aprons continue to have the potential to be untidy. This is monitored daily.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 4.8 and 4.9 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that supplementary care records, for example, repositioning records are maintained in a clear and consistent manner and reviewed by the registered nurse in charge of the delivery of care. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Supplementary care records have been reviewed and are maintained in a clear and consistent manner.
Area for improvement 2 **Ref:** Standard 4.1 **Stated:** First time **To be completed by:** 20 February 2022	The registered person shall ensure that risk assessments for newly admitted patients are completed within the required timeframe. Ref: 5.2.2
	Response by registered person detailing the actions taken: Risk assessments for all new residents are completed within 24 hours of admission, following a fall/ change and during the monthly care plan review process. Where a risk assessment is not required, it is not completed. Staff have been reminded to ensure all risk assessments relavent to each residents personal circumstance are present and correct. This is also montored during care plan audits.

Area for improvement 3 **Ref:** Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that where a patient has been assessed as requiring repositioning: • care plans electronically and on paper are consistent in relation to the recommended frequency of repositioning. Ref: 5.2.2
	Response by registered person detailing the actions taken: Care plans have been reviewed and are consistent in relation to the recommended frequency of re-positioning.
Area for improvement 4 **Ref:** Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that where a patient has been assessed as requiring wound care: • the care plan contains the recommended dressing and frequency of renewal • wound assessment charts are reflective of the frequency of dressing renewal and type of dressing as per care plan • care plans electronically and on paper are consistent in relation to the frequency of dressing renewal and type of dressing. Ref: 5.2.2
	Response by registered person detailing the actions taken: To date wound care and care plans have been audited monthly. This continues. Staff nurses have been reminded to ensure that wound care plans are up to date and are consistent electronically and on paper.

Area for improvement 5 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 20 February 2022	The registered person shall ensure that effective quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to: • hand hygiene • care records. Ref: 5.2.5
	Response by registered person detailing the actions taken: Extensive hand hygiene audits have been completed using NHS audit tool prior to and during the pandemic and this continues. All groups of staff are recorded as having been audited. There was a focus on care staff due to the resident contact however a separate audit is now recorded for laundry staff. Action plans did highlight nail varnish as a problem area. Staff compliance has been an issue however compliance has improved. Care planning audits have been tweeked to evidence those care plans audited more in depth in a particular month.

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