Nightingale Care Home
RQIA ID: 1492
34 Old English Road
Dungannon
BT71 7PA

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Unannounced Care Inspection
of
Nightingale Care Home

25 February 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 25 February 2016 from 09.15 to 15.30 hours.

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. Refer also to section 1.2 below.

The purpose of this inspection was to seek assurances that the care and welfare of patients specifically in Nightingale Care Home was in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes, April 2015.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

For the purposes of this report, the term 'patients' will be used to describe those living in Nightingale Care Home which provides both nursing and residential care.

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 1 September 2015.

1.2 Actions/Enforcement Resulting from this Inspection

As a result of the inspection, RQIA were concerned that the quality of care and service within Nightingale Care Home was below the minimum standard expected. The inspection findings were discussed with senior management in RQIA. It was agreed that the matters of concern should be communicated in correspondence to the regional manager for follow up as a matter of priority.

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	4	*4

*The total number of recommendations above includes two recommendations that were stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the manager and then by telephone with the regional manager on 26 February 2016, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons (Bamford) Ltd Dr Maureen Claire Royston	**Registered Manager:** Mrs Hazel Margaret Black
Person in Charge of the Home at the Time of Inspection: Jolly Joseph	**Date Manager Registered:** 18 June 2012
Categories of Care: NH-PH, RC-PH, NH-I, NH-MP, RC-I	**Number of Registered Places:** 48
Number of Patients Accommodated on Day of Inspection: 42	**Weekly Tariff at Time of Inspection:** £470 - £637

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/Process

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

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with seven patients, three care staff, three registered nurses, four patient's representatives and four visiting professionals.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- three fluid intake and output monitoring forms
- staff training records
- the regulation 29 monthly monitoring report.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Last Care Inspection on 01 September 2015.

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 19.1 **Stated:** Second time	The registered manager should ensure accurate records in keeping with Schedule 3 are maintained Records such as: • Fluid intake and output records must be maintained for all patients who have a catheter. Entries should be totalled and the information transferred into daily progress records.	**Met**
	Action taken as confirmed during the inspection: Three patient care records were reviewed. Fluid intake and output records were adequately maintained.	
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; and palliative and end of life care.	**Not Met**
	Action taken as confirmed during the inspection: The above policies were available; however there was no evidence that a system had been implemented to validate the staff's knowledge of the policies. Despite training having been provided in palliative care, discussion with two registered nurses identified that staff were not confident in identifying palliative care needs. For example, the staff felt that because a patient no longer received specialist palliative care input, they were no longer categorised as requiring palliative care. This recommendation was not met and has been stated for the second time.	

Recommendation 3 **Ref**: Standard 32.1 **Stated:** First time	It is recommended that registered nursing staff record efforts made to establish patients' preferences in respect of end of life care and that for patients who do not wish to discuss this, a record should be also be maintained in line with the policy on end of life care. Where a decision is made regarding end of life care, a care plan should be developed and should include identified religious, spiritual and cultural needs.	**Not Met**
	Action taken as confirmed during the inspection: Two patient care records were reviewed. There was no evidence that care plans regarding end of life care had been developed, in line with the home's end of life care policy. This recommendation was not met and has been stated for the second time.	
Recommendation 4 **Ref**: Standard 42.1 **Stated:** First time	The registered persons should review the provision of hours, dedicated to domestic staff, to ensure that appropriate levels of domestic staff are maintained during periods of annual leave.	**Met**
	Action taken as confirmed during the inspection: Discussion with two domestic staff confirmed that there was adequate numbers of bank staff available to ensure that appropriate levels of domestic staff are maintained during periods of annual leave.	

5.2 Additional Areas Examined

5.2.1. Governance and Management Arrangements

The registered manager had not been working in the home from 21 December 2015. An interim manager who had commenced employment in the home on 22 February 2016 stated that a manager from a different service had been providing management support to the home during the preceding period. The provider had not formally notified RQIA of the absence of the registered manager. Following the inspection, this was discussed with the regional manager. A notification of absence form was submitted to RQIA on 04 March 2016.

Complaints records and records pertaining to the safeguarding of vulnerable adults were not available for inspection. A requirement was made in this regard.

5.2.2. Care Records

A review of three patient care records identified that risk assessments and care plans were not consistently completed following admission. For example, two patients did not have any individual risk assessments or care plans completed nine days following admission and the needs assessments were not completed in sufficient detail to provide information on the patients' needs. One patient had a limited number of risk assessments in place. Following the inspection, the manager submitted an email to RQIA which confirmed that the assessments and care plans of the two identified patients had been completed.

In three care records, there was no evidence that a validated pain assessment had been completed. This was concerning given that two patients had required opioid transdermal patches for pain management. Care plans for pain management were either not in place or not reflective of the patients' prescribed pain relief regimen. In addition, oral analgesia had not been administered as prescribed on two consecutive days. A review of the patient's daily progress notes did not include the reason the analgesia had not been administered.

Patients' risk of developing pressure ulcers was not assessed in any of the records reviewed. There was also no nutritional risk assessment or malnutrition universal screening tool completed for two patients who were prescribed nutritional supplements.

A requirement has been made to ensure that the assessment of the patients' needs and relevant risk assessments are completed within 5 days of admission.

Care plans were not patient-centred and did not address the specific needs of the patients. For example, one patient who required a specific care intervention did not have a care plan in place to address this. The record of a patient who had difficulties communicating was also reviewed. It was evident that the staff did not have any insight into the needs of patients with communication impairments. For example, there was no care plan in place regarding the patient's communication ability/impairment. Assistance was not readily provided with eating and drinking and adaptive equipment had not been provided to promote the patient's independence in this area.

A requirement has been made to ensure that person-centred care plans are developed in consultation with the patient or patient's representative, to ensure that the patients' needs are met.

5.2.3. Care Practices

Comments from visiting professionals and the inspector's observations confirmed that communication was not well maintained within the home. For example, one registered nurse was not aware that a patient had been prescribed a topical antibiotic cream, until identified by the inspector. This information had not been handed over from the previous day. Another patient's analgesia was not in stock. Despite the efforts made by the registered nurse to obtain the medication, this was not communicated to the patient who requested pain relief, until prompted by the inspector. The manager confirmed that the analgesia had been received before the end of the inspection.

As indicated in section 5.2.1 above, the complaints records were not available for inspection. The shift handover sheet used to communicate information between shifts was utilised to record complaint information. The staff consulted with stated that the complaint would be verbally passed on to the manager. There was no formal system in place, for staff to record complaints. This was discussed with the manager, who implemented a complaints recording system before the end of the inspection.

The staff consulted with, were not clear regarding which patients required 'residential' care and those patients who required 'nursing care'. For example, the registered manager confirmed that there were 13 patients accommodated under the 'residential' category. It was therefore concerning that the registered nurse identified five of these patients as requiring 'nursing' care. Following the inspection, dependency levels were submitted by email to RQIA. A review of the dependency levels identified that four patients identified as requiring 'residential' care had a 'high' dependency level. A requirement has been made to ensure that those patients residing under the residential category are appropriately reassessed. Refer to comments on staffing arrangements and comments made by the staff and visiting professionals in sections 5.2.4 and 5.2.5.

5.2.4. Staffing Arrangements

Discussion with the manager confirmed that the home had recently reduced the staffing levels in response to a reduction in bed occupancy. The manager also stated that the planned staffing levels were based upon the numbers of those requiring 'residential' care.

Staff consulted confirmed that the recent reduction in staffing had increased pressure on their workload. Refer to section 5.3.4 for further details on staff comments. A review of the patient dependency levels evidenced that the recommended skill mix of at least 35% and up to 65% care assistants was being maintained, as specified in the DHSSPS Care Standards for Nursing Homes, April 2015. However, a review of staff duty rosters from 15 February to 25 February evidenced that the twilight shift had not been covered on four occasions.

A recommendation has been made to ensure that the staffing levels are reviewed to ensure that there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home, taking into consideration the patients/residents assessed needs and dependency levels; the layout of the home and deployment of staff; and the home's statement of purpose. Refer also to section 5.2.3, above.

The manager confirmed that the home had been using agency staff to cover four night shifts per week. A review of the records in this regard did not evidence that agency staff had consistently received induction to the home. For example, the records identified that one out of three agency staff had an induction completed. Agency staff profiles, which verify the staff members' training, competency and capabilities, were only available for two out of eight records reviewed. A recommendation has been made in this regard.

5.2.5. Staff, Patients' and Patients' Representatives' Comments

A sample of comments received are detailed below:

Staff

'I have no concerns, other than the nurses not having enough time to do the paperwork'
'It's all ok here'
'I have no concerns'
'At times we are so busy, we are actually running from patient to patient'
'The dependency levels are very high and it is very confusing when the patients are moving from residential to nursing'
'Some patients need the assistance of three staff and some of the residential people, really (need to be) nursing'.

Patients

'The staff are all very kind and thoughtful'
'They are kind, very thorough. I have no complaints. I get what I want and generally don't even have to ask'
'I have no complaints. They are very good'
'They are good enough'
'I have no complaints'
'They are very good'.

Patients' Representatives

'I do not have one concern. The (staff) are all saints, who go over and above what is expected'
'I would give them ten out of ten'
'There are no concerns here that I am aware of'.

Visiting Professionals

The inspector met with four visiting professionals who commented that communication was not well maintained in the home. Examples provided included nursing staff being unaware of referrals being made, resulting in several phone call being made by the home, regarding the same issue. Concerns were also made regarding prescribed advice not being followed and staff not being able to provide information on patients, when requested. These comments were passed to the manager to address.

5.2.6. Environment

A general tour of the home was undertaken which included review of a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy and warm throughout. There was evidence of ongoing redecoration on the day of inspection.

Areas for Improvement

The manager must ensure that records are available for inspection at all times.

The assessment of the patients' needs and relevant risk assessments must be completed within 5 days of admission.

Nursing care plans must be developed in consultation with the patient or patient's representative, to ensure their needs are being met.

Patients who are accommodated under the 'residential' category must have their needs reassessed. A report of the outcome of this reassessment must be shared with staff and also submitted to RQIA with the returned QIP.

The staffing levels should be reviewed to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home.

Agency staff inductions should be completed and records retained in the home. Agency staff profiles, which evidence the training and competency level achieved, should also be retained.

Number of Requirements:	**4**	**Number of Recommendations:**	**2**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the manager and then by telephone with the regional manager on 26 February 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 19 (3)(b) **Stated:** First time **To be Completed by:** 24 April 2016	The registered manager must ensure that records are available for inspection at all times. **Ref: Section 5.2.1**
	Response by Registered Person(s) Detailing the Actions Taken: This issue has now been resolved.The identified records are available for inspection for all times.
Requirement 2 **Ref:** Regulation 15 (2)(a) **Stated:** First time **To be Completed by:** 24 April 2016	The assessment of the patients' needs and relevant risk assessments must be completed within 5 days of admission. **Ref: Section 5.2.2**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager has discussed this with all Registered Nurses and they have been reminded that all assessments and relevant risk assessments must be completed within 5 days of admission. Compliance will be monitored via the internal auditing process.
Requirement 3 **Ref:** Regulation 16 (1) **Stated:** First time **To be Completed by:** 24 April 2016	Nursing care plans must be developed in consultation with the patient or patient's representative, to ensure their needs are being met. This refers specifically to patients who are newly admitted to the home. **Ref: Section 5.2.2**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered manager has discussed this withRegistered Nurses. Further training will be organised with the nurses to regards the writing of person centered Care Plans. Compliance will be monitored via the internal auditing process
Requirement 4 **Ref:** Regulation 15 (1)(c) **Stated:** First time **To be Completed by:** 24 April 2016	Patients who are accommodated under the 'residential' category must have their needs reassessed. **A report of the outcome of this reassessment must be shared with staff and also submitted to RQIA with the returned QIP.** **Ref: Section 5.2.3**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager has requested through the respective Care Manager for all current Residential Residents to have a review taken place. Care reviews will commence to ensure residents are within the

	correct category of care.

Recommendations	
Recommendation 1 **Ref**: Standard 32.1 **Stated:** Second time **To be Completed by:** 24 April 2016	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; and palliative and end of life care. **Ref: Section 5.1**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager has made available all current Polices and Procedures within an evidence file. Staff have been advised of these evidence files and the requirement for them to read and sign they understand the policies. Their knowledge will be validated via records of discussion and via planned supervision .
Recommendation 2 **Ref**: Standard 32.1 **Stated:** Second time **To be Completed by:** 24 April 2016	It is recommended that registered nursing staff record efforts made to establish patients' preferences in respect of end of life care and that for patients who do not wish to discuss this, a record should be also be maintained in line with the policy on end of life care. Where a decision is made regarding end of life care, a care plan should be developed and should include identified religious, spiritual and cultural needs. **Ref: Section 5.1**
	Response by Registered Person(s) Detailing the Actions Taken: The Home Manager has discussed with all Registered Nurses that the End of Life care plans must be developed accordingly and to include the resident's wishes taking into account their religious, cultural and spiritual preferences. Training to take place via the Resident Experience Team week commencing 11th April 16.
Recommendation 3 **Ref**: Standard 41.4 **Stated:** First time **To be Completed by:** 24 April 2016	The staffing levels should be reviewed to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home, taking into consideration: • patient/residents assessed needs • patient and resident's dependency levels; • layout of the home • deployment of staff; and • the home's statement of purpose and aims

	Ref: Section 5.2.4
	Response by Registered Person(s) Detailing the Actions Taken: Dependency levels within the home are completed on a regular basis and more often if the needs of a resident changes. At present staffing levels within the home more than meets the required minimum staffing required. This will continue to be monitored.
Recommendation 4 **Ref**: Standard 39.1 and 39.9 **Stated:** First time **To be Completed by:** 24 April 2016	Agency staff inductions should be completed and records retained in the home. Agency staff profiles, which evidence the training and competency level achieved, should also be retained. **Ref: Section 5.2.4**
	Response by Registered Person(s) Detailing the Actions Taken: The identified staff profile is now in place. The Registered Manager will monitor this and ensure all agency staff inductions and profiles are available.

Registered Manager Completing QIP	Jolly Joseph	**Date Completed**	7.4.16
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	11.04.16
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	13/05/2016

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