Unannounced Care Inspection Report
30 January 2017

Nightingale Care Home

Type of Service: Nursing Home
Address: 34 Old Eglish Road, Dungannon, BT71 7PA
Tel no: 02887752666
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Nightingale Care Home took place on 30 January from 09.50 to 16.00 hours.

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

On the day of inspection patients, relatives and staff spoken with commented positively in regard to the care in the home. A review of records, discussion with the registered manager and staff; and observations of care delivery evidenced that all of the requirements and the majority of recommendations made as a result of the previous inspection have been complied with. However, areas for improvement were identified. Two requirements and four recommendations were made as a result of this inspection.

Throughout the report the term 'patients' is used to describe those living in Nightingale Care Home which provides both nursing and residential care.

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	2	5

The total number of recommendations above includes one recommendation that has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Adam Kane, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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 premises inspection undertaken on 21 December 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons (Bamford) Ltd Dr Maureen Claire Royston	**Registered manager:** Mr Adam Kane (Acting)
Person in charge of the home at the time of inspection: Mr Adam Kane	**Date manager registered:** Not applicable
Categories of care: NH-PH, NH-I, NH-MP, RC-I, RC-PH A maximum of 3 patients in category NH-PH and a maximum of 2 residents in category RC-PH	**Number of registered places:** 48

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- 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.

A poster was prominently displayed in the home, inviting feedback from patients and their representatives. During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with five patients, five care staff, one registered nurse, four patients' representatives and one visiting professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- accident and incident records
- complaints received since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.
- records relating to adult safeguarding.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 December 2016

The most recent inspection of the home was an unannounced premises inspection. There were no issues required to be followed up during this inspection and any action taken by the registered persons, as recorded in the QIP will be validated at the next estates inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 25 July 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 (2) (a) **Stated:** Second time	The assessment of the patients' needs and relevant risk assessments must be completed within 5 days of admission.	**Partially Met**
	Action taken as confirmed during the inspection: A review of patient care records confirmed that the majority of risk assessments and care plans were completed within the five day recommended timeframe. One assessment was not in place and was completed by the manager on the day of the inspection. This recommendation was partially met and will not be stated again. A new recommendation has been made in relation to record keeping audits. Refer to section 4.3.5 for further detail.	
Requirement 2 **Ref**: Regulation 16 (1) **Stated:** Second time	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.	**Partially Met**

	Action taken as confirmed during the inspection: As previously stated the review of the care records confirmed that the majority of care plans had been completed within the recommended five day timeframe. One care plan was not in place and was completed by the manager on the day of the inspection. This recommendation was partially met and will not be stated again. A new recommendation has been made in relation to record keeping audits. Refer to section 4.3.5 for further detail.	
Requirement 3 **Ref**: Regulation 13 (1) (a) **Stated:** First time	The registered persons must ensure that patients' total fluid intake are recorded in the daily progress notes, to evidence validation by registered nurses and to identify any action taken in response to identified deficits.	**Met**
	Action taken as confirmed during the inspection: A review of food and fluid intake charts confirmed that patients' fluid intake had been monitored appropriately.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 41.1 **Stated:** Second time	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	**Met**
	Action taken as confirmed during the inspection: A review of the staffing rota for the week commencing 23 January 2016 evidenced that the planned staffing levels were adhered to. Staffing levels had been increased from the last inspection. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty.	

Recommendation 2 **Ref**: Standard 22.6 **Stated:** First time	The registered persons should ensure that the falls risk assessment is reviewed in response to patients' falls.	**Not Met**
	A review of care records confirmed that risk assessments for falls had not been updated after a patient had fallen. This meant that patients were potentially not being adequately protected against further risks of falls. This recommendation was not met and has been stated for the second time.	
Recommendation 3 **Ref**: Standard 12.13 **Stated:** First time	The registered persons should ensure that a choice of meal and snacks is provided at each mealtime to ensure choice and that any special dietary requirements are catered for; for example; pureed food.	**Not Met**
	Action taken as confirmed during the inspection: A review of the food order sheet appeared to evidence that patients had been offered a choice of meals; however, a review of the food intake records evidenced that the food offered to patients was not varied and was not reflective of the choices made. This recommendation was not met and has been subsumed into a requirement. Refer to section 4.3.2 for further detail.	
Recommendation 4 **Ref**: Standard 7.1 **Stated:** First time	The registered persons should review the methods available for engagement with patients and relatives to ensure they are effective.	**Met**
	Action taken as confirmed during the inspection: An electronic feedback system was situated in the reception area. This was available to patients, relatives and other visitors to give general feedback. The feedback provided was reviewed and evidenced that there had been no negative comments received. Consultation with patients' representatives also did not evidence any dissatisfaction with the care provided.	

4.3 Inspection findings

4.3.1 Staffing arrangements

The manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 23 January 2017 evidenced that the planned staffing levels were adhered to. Discussion with staff and patients' representatives evidenced that there were no concerns regarding staffing levels. One patient informed the inspector that 'at times' there can be delays being brought to the toilet on the night shift. This was discussed with the manager who confirmed that they had consulted with the night staff in relation to providing an additional twilight staff member. Following the inspection the manager confirmed to RQIA, by telephone on 10 February 2017, that recruitment efforts were in progress to commence the second staff member. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings. The manager explained there was only one registered nurse vacancy for night duty and that this was being covered by an agency nurse, who was block-booked, to ensure continuity of patient care.

The review of the duty rota also evidenced that the manager had been covering a number of registered nursing shifts on day duty. Advice was given in relation to the need to record the manager's clinical hours worked, separate from the hours worked in the management role.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.3.2 Care practices

Staff interactions with patients were observed to be compassionate, caring and timely. 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. Consultation with five patients individually and with others in smaller groups, confirmed that they felt they were afforded choice, privacy, dignity and respect. However, inspection findings evidenced that the patients' meal choices were not consistently respected. As discussed in section 4.2, a recommendation had previously been made to ensure that a choice of meals and snacks was provided at each mealtime to patients who required their diets to be modified. One staff member raised concerns that patients who required modified diets, were not provided with a varied diet. The review of the food intake charts also confirmed that the meals provided lacked variety and were not reflective of the choices made. This was discussed with the manager, who provided assurances that they would monitor the food intake of patients on a daily basis. The previous recommendation has been subsumed into a requirement in this regard.

One patient consulted with was unable to hear the inspector because they were not wearing their hearing aid. Staff consulted with gave varying answers when asked about the level of assistance the patient needed to insert their hearing aid and they had not recognised that it was important for the patient, to enable them to hear. A review of the patient's care plan evidenced that the level of assistance the patient required, in relation to inserting the hearing aid, had not been included. A similar observation had also been made during the care inspection,

undertaken on 25 July 2016 and assurances were provided at the time, that this would be addressed with staff. A recommendation has now been made in this regard.

A number of patients required electronic pressure mattresses on their beds. Observation of two electric pressure relieving mattresses evidenced that the pressure mattress had to be 'set' according to the patients' weight. One mattress was observed to be too high for the patient requiring it. Specific details of the findings were discussed with the manager who immediately responded to the concern by informing staff and reviewing all electric mattresses in the home and confirming, to the inspector, that all were operating correctly. The manager immediately developed a template, to ensure that recording of mattress settings would commence from the day of the inspection. RQIA were satisfied that this concern had been managed appropriately.

Areas for improvement

A requirement has been made that the food provided to patients is nutritious and varied; and meets their nutritional needs. This refers specifically to the choices of meals provided to patients who require a modified diet.

A recommendation has been made that the patients' care plans for individualised care and support, reflects the level of assistance required in relation to inserting their hearing aids.

Number of requirements	1	**Number of recommendations**	1

4.3.3 Care Records

There was evidence of good practice within the care records. Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Patients who had acute infections had care plans developed and there was evidence that these were reviewed when the patient completed any prescribed antibiotics. There was evidence that appropriate action was taken to identify patients who were at risk of pressure damage to their skin. Skin checks of patients who were identified as being at high risk were diarised, to ensure that the registered nurses checked the skin integrity of these patients.

Although there was evidently improvements in the patients care records, some areas for improvement were identified. For example, the review of one patient's repositioning records evidenced long gaps in repositioning, particularly on the night shift. This posed a risk to the patient's skin integrity. A requirement has been made in this regard.

As discussed in section 4.2, the review of patient care records evidenced that the majority of validated risk assessments and care plans were completed as part of the admission process and reviewed as required. One was not in place and was completed by the manager on the day of the inspection. The auditing process was discussed with the manager. Refer to section 4.3.5 for further detail.

Patients who were prescribed regular analgesia had care plans developed and these were reviewed on a regular basis. However, the review of care records evidenced that one patient did not have their pain assessment updated from March 2016. Given that the care plan was very specific to the care provided, we were assured that the patient's needs were being met in this aspect of their care. A recommendation has been made in this regard.

Where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound. However, the wound assessments did not include wound measurements, therefore it was difficult to assess the degree of wound healing. A review of the daily progress notes evidenced that the dressing had been changed according to the care plan. Wound care records had been supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines; however, no photos had been taken from 7 July 2016. A recommendation has been made in this regard.

Areas for Improvement

A requirement has been made that where nursing needs are identified, care must be delivered to ensure individual patient needs are met. This refers specifically to the repositioning records of patients who are at risk of developing pressure sores and require regular repositioning, in keeping with their care plan.

A recommendation has been made that pain assessments are completed (if applicable) for all patients requiring regular or occasional analgesia. This assessment should review the effectiveness of the analgesia and the outcome should be reflected in the patients' care plans. The pain assessment tool to be used must be commensurate with the patient's ability to communicate.

A recommendation has been made that wound measurements are included in the wound assessments, as appropriate.

Number of requirements	1	**Number of recommendations**	2

4.3.4 Consultation

During the inspection, we met with five patients, five care staff, one registered nurse, four patients' representatives and one visiting professional. Some comments received are detailed below:

Staff

"The care is very good, I enjoy my work and there is a better atmosphere here now".
"It is a lot better here than it was, the care is good and there is good communication".
"I have no concerns, sometimes it can be tight with staff, but it is a lot better".
"Everything is ok here".
"We have a great home here".

One staff member raised comments in relation to the lack of a varied diet, for patients who required a modified diet. Refer to section 4.3.2 for further detail.

Patients

"I am getting on fine here".
"They are very polite alright".
"It is not too bad here, life goes on".
"It is a very happy home, there is no pressure and I couldn't say that the home was anything less than perfect".

One patient stated that at times, there are delays being assisted to the toilet, specifically on night duty. Refer to section 4.3.1 for further detail.

Patients' representatives

"'They are great staff, very caring".
"Everything is alright".
"Sometimes there is not enough staff".
"It is all very good, sometimes missing laundry can be a problem".

Visiting Professionals

"I have no concerns here".

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Four staff, three patients and two relatives had returned their questionnaires, within the timeframe for inclusion in this report. All respondents indicated that they were either 'very satisfied' or 'satisfied' that the care was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.3.5 Governance and management arrangements

The manager had commenced employment in the home in July 2016 and had only recently been appointed as the acting manager. All those consulted with described the manager in very positive terms and described them as being 'absolutely fabulous', 'very professional', 'approachable' and 'supportive'. There was a system in place to identify the person in charge of the home, in the absence of the registered manager; however the manager explained that the staff could telephone him, at any time.

Discussion with the manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the 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.

Discussion with the 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, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. However, given the findings of this inspection, a recommendation has been made in relation to the development of the auditing processes, specifically in relation to the records of new admissions; and the monitoring of patients' food choices.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives.

Areas for improvement

A recommendation has been made that the auditing processes are further developed, to include auditing of the records of new admissions; and the monitoring of patients' food choices.

Number of requirements	0	**Number of recommendations**	1

4.3.6 Environment

A review of the home's environment was undertaken which included a number 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, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Fire exits and corridors were maintained clear from clutter and obstruction.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Adam Kane, manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP via the web portal for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref**: Regulation 12 (4)(b) **Stated:** First time **To be completed by:** 27 March 2017	The registered persons must ensure that the food provided to patients is nutritious and varied; and meets their nutritional needs. This refers specifically to the choices of meals provided to patients who require a modified diet. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Formal Supervision completed and recorded with catering manager. Registered Manager and or Nurse in Charge will conduct spot checks which will be signed as evidence that choice is given to residents who require a modified diet. Menus are availble for viewing at all times. Nutrition tracca can be completed on Qol to monitor compliance. .
Requirement 2 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 27 March 2017	The registered persons must ensure that where nursing needs are identified, care must be delivered to ensure individual patient needs are met. This refers specifically to the repositioning records of patients who are at risk of developing pressure sores and require regular repositioning, in keeping with their care plan. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Formal Supervision conducted with Nursing and Senior Care staff covering record keeping (24th Feb 2017). Also discussed at recent staff meeting meeting (21st Feb 2017).
Recommendations	
Recommendation 1 **Ref**: Standard 22.6 **Stated:** Second time **To be completed by:** 27 March 2017	The registered persons should ensure that the falls risk assessment is reviewed in response to patients' falls. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Nurses were advised at staff meeting on 21st Feb 2017, to ensure that whilst completing reviews of care files on a monthly basis that all risk assessments are appropriately updated. Registered Manager will monitor during completion of care plan tracca
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 27 March 2017	The registered persons should ensure that the patients' care plans for individualised care and support, reflects the level of assistance required in relation to inserting their hearing aids. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Registered manager discussed at staff meeting the importance of

	providing a high standard of personal care and attention to detail includes providing assistance with glasses, hearing aids and dentures. Registered Nurses were advised to reflect this in person centred care plans. Registered manager will monitor this during daily walk about.

Recommendation 3 **Ref**: Standard 4.7 **Stated:** First time **To be completed by:** 27 March 2017	The registered persons should ensure that pain assessments are completed (if applicable) for all patients requiring regular or occasional analgesia. This assessment should review the effectiveness of the analgesia and the outcome should be reflected in the patients' care plans. The pain assessment tool to be used must be commensurate with the patient's ability to communicate. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Registered Manager discussed during staff meeting 21st February 2017 a resident who requires analgesia to have a care plan in place and pain assessment. Review of both should evidence effectiveness of analgesia and any communication with GP as and when required.
Recommendation 4 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 27 March 2017	The registered persons should ensure that wound measurements are included in the wound assessments, as appropriate. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Registered manager discussed with Registered nurses at recent staff meeting the importance of recording wound measurements in the initial care plan and associated risk assessments. Evaluations should also record measurement which allows monitoring of progress. Registered staff are advised to record communications with Trust Tissue Viability and or GP. Registered manager will monitor and record once a month that wound has been inspected and record same within care plan
Recommendation 5 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 27 March 2017	The registered persons should ensure that the auditing processes are further developed, to include auditing of the records of new admissions; and the monitoring of patients' food choices. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: Registered manager or nurse in charge will complete a care tracca on QOL on day five following a new admission or re admission to home. Audit findings will be discussed with Registered Nurse to complete within one week when it will be re audited to ensure that initial non-compliant areas have been addressed.

The Regulation and Quality Improvement Authority

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