Unannounced Care Inspection Report
19 January 2017

Our Mother of Mercy

Type of Service: Nursing Home
Address: 1 Home Avenue, Newry, BT34 2DL
Tel no: 028 3026 2086
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Our Mother of Mercy took place on 19 January 2017 from 09.40 to 16.15 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection.

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.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	4	3*

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Elizabeth Doran, registered 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 medicines management inspection undertaken on 15 August 2016. Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent 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: Kilmorey Care Ltd Peggy O'Neill	**Registered manager:** Elizabeth Doran
Person in charge of the home at the time of inspection: Elizabeth Doran	**Date manager registered:** 4 November 2013
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), RC-I, RC-MP, RC-MP(E), NH-LD, NH-LD(E) A maximum of 13 patients in category NH-DE and maximum of 2 patients in category NH-LD/LD(E).	**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 previous care inspection report and the returned QIP
- pre inspection assessment audit.

During the inspection we met with10 patients individually and others in small groups, one patient representative, four care staff, two registered nurses and one ancillary staff member.

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 inspector.

The following information was examined during the inspection:
- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- minutes of staff meetings
- monthly monitoring reports in keeping with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- Incidents / accidents records
- complaints records
- duty rota for the period 16 to 22 January 2017
- auditing documentation in regard to infection prevention and control.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 August 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector and will be validated during the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 16 May 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.	**Met**
	Action taken as confirmed during the inspection: During a review of the environment, compliance with infection prevention and control (IPC) was observed to have been achieved. Isolated issues with IPC were appropriately managed during the inspection.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 4 Criteria (9) **Stated:** Second time	The registered person should ensure that supplementary care records are regularly monitored by registered nursing staff to ensure they are correctly completed and are contemporaneously recorded following care delivery.	**Not Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced that repositioning and bowel management records reviewed had not been completed accurately and/or consistently. See section 4.3.3 for further information. This recommendation has not been met and has now been stated as a requirement following consultation with senior management in RQIA.	

Recommendation 2 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Met**
	Action taken as confirmed during the inspection: IPC audits had been conducted, managed and recorded appropriately.	
Recommendation 3 **Ref:** Standard 4 **Stated:** First time	The registered person should ensure that continence assessments are completed on admission and reviewed as required.	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced that continence assessments had been completed and reviewed accordingly.	
Recommendation 4 **Ref:** Standard 12 **Stated:** First time	The registered person should ensure that nutritional screening is conducted monthly using a recognised screening tool such as Malnutrition Universal Screening Tool (MUST).	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced that monthly nutritional screening was conducted using MUST.	
Recommendation 5 **Ref:** Standard 4 **Stated:** First time	The registered person should ensure that continence care plans are written in a person centred manner and identify specific continence products required to meet individuals assessed needs.	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced that continence care plans had been completed appropriately.	
Recommendation 6 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** First time	The registered person should ensure that care records evidence patients and/or their representatives' involvement in the care planning of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record.	**Not Met**

	Action taken as confirmed during the inspection: There was no evidence within three patient care records reviewed of any patient/representative involvement in the care planning process. This recommendation has not been met and will be stated for a second time.	

4.3 Inspection findings

4.3.1 Staffing

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 16 to 22 January 2017 evidenced that the planned staffing levels were adhered to. Discussion with staff evidenced that one staff had concerns regarding staffing levels. Discussion with patients and representatives 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.

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

Inspection of patient care and accident records evidenced that an unwitnessed fall had occurred. Records indicated that the appropriate actions had been taken. Central nervous system (CNS) observations were taken immediately following the incident and monitored for a minimum of 24 hours. Records also indicated that medical advice had been requested following the fall.

Discussion with a patient indicated that the moving and handling practices described to reposition them in bed had not been conducted in line with current best practice. This was discussed with the registered manager and a recommendation was made to ensure that moving and handling practices are observed to ensure that training has been embedded into practice.

Areas for improvement

It is recommended that moving and handling practices are observed to ensure that training has been embedded into practice.

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

4.3.3 Care Records

Patient care records were maintained electronically in the home. Three patient care records were reviewed during the inspection.

Review of records pertaining to the management of wounds evidenced that registered nurses were not adhering to regional guidelines and the care planning process. For example, Patient 'A' did not have an initial or ongoing assessment or care plan of a sacral wound. Reference to the sacral wound was only made when a registered nurse had appropriately documented detail of a change to the wound dressing regime. An assessment and care plan was drafted to support the decision to change the dressing regime although wound dimensions were not monitored and there was no wound photograph taken. The wound was not recorded as reviewed until five days after the actual review date scheduled on the observation chart. This was discussed with the registered manager and a requirement was made.

Patient 'B' required a hoist for all transfers. The patient's care plan had not been updated to reflect this new assessment and continued to direct care as transferring the patient with the aid of a wheeled zimmer frame and two staff. A requirement was made.

Patient 'C' nutritional assessment evidenced a MUST score of two which would indicate a high risk of malnutrition. The previous MUST score was zero and the records indicated a body weight loss of approximately 10 percent. There was no evidence that the patient had been referred to a dietician or general practitioner at this time and/or commenced on a food and fluid intake chart. The patient had not been commenced on weekly weight monitoring. This was discussed with the registered manager and a requirement was made. Information received by RQIA following the inspection confirmed that the appropriate actions had now been implemented and referrals made.

Repositioning charts had been inconsistently recorded on patients 'A' and 'B'. For example, patient 'A' repositioning chart had four entries recorded in a four day period. Discussion with staff and the registered manager indicated that the patient often refused to be repositioned when offered. It was agreed that any refusal should also be recorded on the repositioning chart.

Bowel management had been recorded well in two of the patient care records reviewed. However, a period of nine days had been observed between bowel movements on a third patient. This had not been referenced within the patient's nursing evaluation records. There was no indication within any records reviewed of any actions taken in response to this deficit. Furthermore, one respondent from relatives questionnaires returned expressed concern in relation to the monitoring of bowel management. This was discussed with the registered manager and a recommendation which had been stated for the second time in the previous care inspection, in regard to review of supplementary documentation, has now been stated as a requirement following consultation with senior management in RQIA.

Areas for improvement

It is required that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.

It is required that patients' care plans are reviewed regularly and updated accordingly to meet any new and/or change to current assessed needs of patients.

It is required that when a MUST risk assessment identifies a high risk of malnutrition, appropriate actions/referrals are implemented and documented in response to such risk. Outcomes of the response/s initiated must also be reviewed and documented.

It is required that supplementary care records are regularly monitored by registered nursing staff to ensure they are correctly completed and are contemporaneously recorded following care delivery.

Number of requirements	4	Number of recommendations	0

4.3.4 Consultation

On inspection two registered nurses, four carers and one ancillary staff member was consulted to ascertain their views of life in Our Mother of Mercy. Staff consulted confirmed that when they raised a concern, they were happy that the home's management would take their concerns seriously. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Two of the questionnaires were returned within the timescale for inclusion in the report. Both respondents were very satisfied with care provision within the home.

Some staff comments were as follows:
"It is a very good home."
"I enjoy it. I'm happy here."
"I love it here."
"It's ok. I like it here."
"It is very good working here."
"I like working here."

On inspection 10 patients were consulted and the patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Nine patient questionnaires were left in the home for completion. Five patient questionnaires were returned within the timeframe. All five respondents were very satisfied with the care provided in the home.

Some patient comments were as follows:
"I am very happy here."
"I'm happy. Staff are very kind."
"It's very very good and they (the staff) are awful good."
"It's excellent here."
"The home is very nice."

One patient representative was consulted with on the day of inspection. The representative confirmed that they were, 'very contented with the care provided in the home and would recommend the home to anyone'. Seven relative questionnaires were left in the home for completion. Four relative questionnaires were returned. All respondents were either satisfied or very satisfied with the care provided in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.3.5 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, laundry, 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. The home was generally compliant with IPC measures. Isolated issues with IPC were managed immediately when identified on inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.3.6 Staff Training

Staff consulted confirmed they were satisfied that the training which they received was relevant to their role. However, four staff also identified a shortfall in their training in that they had not received dementia awareness or distressed reaction training. This was discussed with the registered manager and given that dementia care was provided in the home, a recommendation was made to review staffs' training to ensure that all relevant staff, caring for patients with dementia, receive suitable training in regard to dementia care and managing distressed reactions.

Areas for improvement

It is recommended that all relevant staff, caring for patients with dementia, receive suitable training in regard to dementia care and managing distressed reactions.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Elizabeth Doran, registered 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 to nursing.team@rqia.org.uk 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 19 (1) (a) Schedule 3 (1) (a) (b) (3) (K) **Stated:** First time **To be completed by:** 19 January 2017	The registered person should ensure that supplementary care records are regularly monitored by registered nursing staff to ensure they are correctly completed and are contemporaneously recorded following care delivery. **Ref: Section 4.2, 4.3.3**
	Response by registered provider detailing the actions taken: I met all of the nurses individually and they have been made aware of their responsibility to provide supervision of carers work and documentation. They are also aware of the importance of ensuring that the supplementary care records are completed accurately and contemporaneously. These records will be monitored regularly.Carers have been advised of their responsibilities by the clinical lead and Registered Person.
Requirement 2 **Ref:** Regulation 19 (1) (a) Schedule 3 (1) (a) (b) (3) (K) **Stated:** First time **To be completed by:** 23 January 2017	The registered person must ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: All nurses have been reminded of the importance of adhering to wound management guidelines and documentations. The information documented must be comprehensive and include body maps and photographs which are held on the goldcrest system.
Requirement 3 **Ref:** Regulation 16 (1) (2)(a)(b) **Stated:** First time **To be completed by:** 23 January 2017	The registered person must ensure that patients' care plans were developed following identification of assessed needs; reviewed regularly and updated accordingly to meet the current needs of patients. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: All care plans were audited but reccomendations were not always followed up within the allocated time scale. All nurses were reminded of their responsibilities in this regard to ensure that the current needs of the patients can be met at all times.

Requirement 4 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person must ensure that when a MUST risk assessment identifies a high risk of malnutrition; appropriate actions/referrals are implemented and documented in response to such risk. Outcomes of the response/s initiated must also be reviewed and documented. **Ref: Section 4.3.3**
To be completed by: 23 January 2017	**Response by registered provider detailing the actions taken:** Each nurse was reminded that MUST risk assessment must be completed and appropriate actions/referrals made if required. MUST training was provided on 7th and 21st February. A list of attendees is attached.
Recommendations	
Recommendation 1 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** Second time	The registered person should ensure that care records evidence patients and/or their representatives' involvement in the care planning of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record. **Ref: Section 4.2**
To be completed by: 18 February 2017	**Response by registered provider detailing the actions taken:** Nurses have met with patients and/or their relatives to have care plans agreed and signed as agreed.
Recommendation 2 **Ref:** Standard 47 Criteria (3) **Stated:** First time	The registered manager should observe staffs moving and handling of patients within the home to ensure training is embedded into practice. **Ref: Section 4.3.2**
To be Completed by: 1 February 2017	**Response by registered provider detailing the actions taken:** The registered manager and the nursing staff have been advised to monitor and observe closely that all staff carry out moving and handling procedures as directed in the care plan and in line with the training delivered.
Recommendation 3 **Ref: Standard 25** **Stated:** First time	The registered person should ensure that all relevant staff, caring for patients with dementia, receives suitable training in regard to dementia care and managing distressed reactions. **Ref: Section 4.3.6**
To be completed by: 30 April 2017	**Response by registered provider detailing the actions taken:** Between 2014 and 2017 sixteen training sessions were held at head office on the topics of SOVA and Dealing with Behaviours that Challenge and Dementia and Dealing with Behaviours that Challenge. Attached is a list of staff from Our Mother of Mercy who attended this training. We have advised any member of staff who requires further training to attend a planned session.

The Regulation and Quality Improvement Authority

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