Unannounced Care Inspection Report
25 April 2018

Drombane

Type of Service: Nursing Home
Address: 39 Glen Road, Blackskull, Dromore, BT25 1JX
Tel no: 028 4062 6064
Inspector: Dermot Walsh

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 20 persons.

3.0 Service details

Registered organisation/registered person: Elizabeth Kathleen Mary Lisk	**Registered manager:** Daizy Samuel
Person in charge at the time of inspection: Daizy Samuel	**Date manager registered:** 9 January 2015
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. MP – Mental disorder excluding learning disability or dementia. Residential Care (RC) I – Old age not falling within any other category.	**Number of registered places:** 20 Category NH-MP for 1 identified patient only. There shall be a maximum of 3 named residents receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 25 April 2018 from 09.30 to 15.30 hours.

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 Care Standards for Nursing Homes 2015.

The term ‘patient’ is used to describe those living in Drombane which provides both nursing and residential care.

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

Evidence of good practice was found in relation to staffing arrangements, recruitment, training and development of staff and with record keeping. Good working relationships were maintained and patients’ opinions were sought and valued. Patients were treated with dignity and privacy was maintained. Governance arrangements in respect of accident and incident management and quality improvement was managed appropriately.

An area requiring improvement under regulation was identified in relation to the storage of patient care records.

Patients described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. There was evidence that the management team listened to and valued patients and their representatives and taking account of the views of patients.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	0

Details of the Quality Improvement Plan (QIP) were discussed with Daizy Samuel, 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.

4.2 Action/enforcement taken following the most recent inspection dated 31 May 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 31 May 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with eight patients, six staff and three patients' representatives. A poster was displayed at a staffing area in the home inviting staff to respond to an online questionnaire. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten questionnaires for patients and 10 for patients' representatives were left for distribution.

A poster indicating that the inspection was taking place was displayed at the entrance to the home and invited visitors/relatives to speak with the inspector.

The following records were examined during the inspection:

- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff duty rota for week commencing 16 April 2018
- staff training records
- incident and accident records
- one staff recruitment and induction file
- three patient care records
- three patients' daily care charts including bowel management, personal care, food and fluid intake charts and reposition charts
- a selection of minutes from staff meetings
- a selection of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, not met or partially met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 31 May 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 31 May 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Requirement 1 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person must ensure that all cleaning chemicals are securely stored in keeping with COSHH legislation, to ensure that patients are protected from hazards to their health.	**Met**
	Action taken as confirmed during the inspection: There were no chemicals observed which were accessible to patients during a review of the environment.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Recommendation 1 **Ref:** Standard 30 Criteria (1) **Stated:** First time	The registered person should ensure that medications are stored in accordance with professional guidance, care standards and legislative requirements.	**Met**
	Action taken as confirmed during the inspection: Medications in the home had been stored appropriately.	
Recommendation 2 **Ref:** Standard 44 **Stated:** First time	The registered person should ensure that nurse call provision provided within the home is accessible to patients and is fit for the purpose it is designed for.	**Met**
	Action taken as confirmed during the inspection: Nurse call provision had been adjusted appropriately within the home where appropriate and was accessible to patients.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Recommendation 3 **Ref:** Standard 18 **Stated:** First time	The registered person should ensure that when restraint and/or restrictive practice are used, they are managed and recorded in accordance with legislative, professional and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: A review of two patient care records evidenced that the restrictive practice had been managed appropriately and relevant consultations and consents had been obtained.	
Recommendation 4 **Ref:** Standard 41 Criteria (8) **Stated:** First time	The registered person should ensure staff meetings take place on a regular basis for all staff to attend and at a minimum quarterly.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and staff and a review of minutes from staff meetings evidenced that this area for improvement has now been met.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 for week commencing 16 April 2018 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Discussion with patients, patients' representatives and staff evidenced that there were no concerns regarding staffing levels. Staff consulted confirmed that staffing levels met the assessed 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 and that staff attended to patients needs in a timely and caring manner.

Review of one staff recruitment file evidenced that this was maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records

also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work. A review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC).

We discussed the provision of mandatory training with staff and reviewed staff training records. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. An adult safeguarding champion had been identified and training pertinent to this role had been arranged. The registered manager confirmed that there were no ongoing or recent safeguarding concerns relating to the home. The home's safeguarding policy had been updated in December 2016.

Review of three patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

We reviewed accidents/incidents records since the previous care inspection in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the registered manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. This information was also reviewed as part of the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients and staff spoken with were complimentary in respect of the home's environment. One patient commented on 'the lovely views' around the home. Fire exits and corridors were observed to be clear of clutter and obstruction. Compliance with best practice in infection prevention and control had been well maintained. Infection rates were monitored on a monthly basis in the home.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example, the use of alarm mats. There was also evidence of consultation with relevant persons. Care plans were in place for the management of alarm mats. Restrictive practices were monitored on a monthly basis in the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, recruitment practice, staff training, monitoring registration status of staff, accident management and the home's general environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of nutrition, patients' weights, management of infections and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, general practitioners, speech and language therapists and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals. Supplementary care charts such as reposition, bowel management and food and fluid intake records evidenced that contemporaneous records were maintained. Repositioning records did not specify the position in which the patients had been positioned to. This was discussed with the registered manager who agreed to review and action the recording of repositioning immediately.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Comments from staff included teamwork was 'very good' and 'team members are very supportive of each other'. Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge. Staff commented that the home's management were 'very friendly' and 'welcoming and listen to concerns'.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

There was evidence of regular staff meetings since the previous care inspection. Minutes of the meetings were available for review and contained attendees, dates, topics discussed and any decisions made. An area for improvement made in this regard has now been met.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to risk assessment, care planning, teamwork and communication between residents, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 09.25 hours and were greeted by staff who were helpful and attentive. Patients were enjoying a late breakfast or a morning cup of tea/coffee in the dining room, in one of the lounges or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice and staff were observed assisting patients to enjoy their chosen activity and to eat and drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality. However, patient care records were observed to be stored within an identified room which was accessible to any persons passing by thus presenting the potential for a breach of patient confidentiality. This was discussed with the registered manager and identified as an area for improvement under regulation.

The registered manager advised that patient and relatives meetings were held on a twice yearly basis. There was evidence that the most recent meeting had been conducted on 17 April 2018. Minutes were available. The registered manager confirmed that a notice would be displayed at the entrance to the home to inform of upcoming meetings.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with processions that were meaningful to the patient and reflected their life experiences.

The serving of lunch was observed in the dining room. Lunch commenced at 12:30 hours. Patients were observed singing favourite songs with staff prior to the serving of the meal. Patients were seated around tables which had been appropriately set for the meal. Food was served when patients were ready to eat or be assisted with their meals. The food served appeared nutritious and appetising. Portions were appropriate for the patients to which the food was served. The mealtime was well supervised. Staff were organised to assist patients in the patients' preferred dining area. Staff were observed to encourage patients with their meals and patients were observed to be assisted in an unhurried manner. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors where required. A range of drinks were offered to the patients. Patients appeared to enjoy the mealtime experience. One patient commented 'the food is good and there is plenty of it'. Staff were knowledgeable in respect of patients' dietary requirements.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

- ''Thank you to all the staff at Drombane for the care and attention given to my mum."
- "Thank you for all your kindness and care."
- "My heartfelt thanks and appreciation for all your kindness and compassion."

Consultation with eight patients individually, and with others in smaller groups, confirmed that living in Drombane was a positive experience.

Patient comments:

- ''It is lovely. Staff are very nice."
- "It's fine here."
- "Not too bad here. Good home."
- "This is a wonderful place. Good staff."

Two questionnaires were returned which did not identify if they were from patients or patients' representatives. Both respondents indicated that they were very satisfied with the service provision across all four domains. Comments included:

- "The staff are very friendly and helpful."
- "Very happy all round with everything."

Three patient representatives were consulted during the inspection. Some patient representative comments were as follows:

- "My relative is very happy here and very content."
- "Staff and the manager are very approachable. I have no problem with the care delivered here."

Staff were asked to complete an online survey, we had no responses within the timescale specified. Comments from six staff consulted during the inspection included:

- "I find it very homely here. It is my second home."
- "The patients are like family to us."
- "It's dead on. I love it here."

- "It is home from home. Patients are family."
- "You couldn't say a bad thing about this place."

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

An area for improvement was identified under regulation in relation to the storage of patient care records.

	Regulations	Standards
Total number of areas for improvement	1	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with the registered manager and staff, and observations confirmed that the home was operating within its registered categories of care.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The equality data collected was managed in line with best practice.

Review of the home's complaints records evidenced that systems were in place to ensure 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. The registered manager confirmed that the last complaint received was in September 2017. Complaints procedures were displayed in patients' bedrooms.

Discussion with the registered manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, infection prevention and control practices, care records and restrictive practice. In addition robust measures were also in place to provide the registered manager with an overview of the management of infections occurring in the home.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis in accordance with Regulation 29 of The Nursing

Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Daizy Samuel, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 19 (1)(b) **Stated:** First time **To be completed by:** 30 April 2018	The registered person shall ensure that patient care records maintained within the home are stored securely in line with legislative and professional guidance. Ref: Section 6.6
	Response by registered person detailing the actions taken: The patient care records in the Home are stored securely in line with legislative and professional guidance. The records are kept in the staff room with a keypad lock on the door in which only the staff have access to the code.

Please ensure this document is completed in full and returned via Web Portal

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