

Unannounced Care Inspection Report 4 April 2017



St Macartans

Type of Service: Nursing Home

Address: 74 Main Street, Clogher, BT76 0AA

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Inspectors: Bridget Dougan and Sharon McKnight

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced care inspection took place on 4 April 2017 from 22.45 to 00.00 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.

Staffing levels in the dementia unit (Kilmorey Suite) had been reviewed and we were assured that action had been taken to ensure that staffing was appropriate. A recommendation in respect of staff allocation sheets had been partially met and has been stated for the second time. An additional recommendation was made to implement systems to ensure records of staff allocation are completed.

For the purposes of this report, the term 'patients' will be used to describe those living in St Macartans 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	0	7*

*The total number of recommendations included two which have been stated for the second time; five recommendations have been carried forward from the previous inspection and will be for reviewed at the next inspection.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Kieran O'Neill, nurse in charge, at the conclusion of the inspection and with Noreen Monaghan, registered manager and Peggy O'Neill, responsible person, by telephone following the inspection on 5 April 2017. 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 care inspection on 20 February 2017. This inspection identified serious concerns with regard to:

- Staffing levels and the supervision of patients within the Kilmorey Suite (dementia unit) particularly at night
- the number of accidents/incidents in the Kilmorey Suite

As a consequence of the inspection findings, a serious concerns meeting was held on 27 February 2017 to discuss the issues raised during the inspection and how the home planned to ensure that compliance was achieved. Assurances were provided that the issues would be addressed and evidence was provided to support these assurances. A further inspection to assess the level of compliance with the requirements and recommendations was planned.

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 provider: Kilmorey Care Ltd / Mrs Peggy O'Neill	Registered manager: Noreen Monaghan,
Person in charge of the home at the time of inspection: Kieran O'Neill, Registered Nurse	Date manager registered: 29 September 2016.
Categories of care: NH-LD, NH-LD(E), RC-LD, RC-LD(E), NH-DE, NH-I, NH-PH, NH-PH(E), RC-I A maximum of 8 patients in category NH-DE. A maximum of 6 persons accommodated within categories NH-LD/LD(E), RC-LD/LD(E)	Number of registered places: 33

3.0 Methods/processes

Prior to inspection we analysed the following information:

- the previous care inspection report
- notes of the serious concerns meeting held on 27 February 2017
- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- pre-inspection assessment audit

During the inspection we met with one registered nurse and three care assistants.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- patient care records
- incidents/accidents reports recorded since the last care inspection
- duty rota for week commencing 03 April 2017
- staff allocation sheets for weeks commencing 20 and 27 March and 03 April 2017

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 20 February 2017

The most recent inspection of the home was an unannounced care inspection. Those requirements and recommendations in the QIP not validated at this inspection will be validated by the nursing inspector at the next care inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 20 February 2017

Last care inspection statutory requirements		Validation of compliance
Requirement 1 Ref: Regulation 20 (1) (a) Stated: Second time	The registered person must ensure that staffing levels are reviewed in the Kilmorey Suite to ensure the health and welfare needs of patients are appropriately met at all times.	Met
	Action taken as confirmed during the inspection: Staffing levels in the Kilmorey Suite had been reviewed and corrective actions had been taken. This requirement as stated has been met.	
Last care inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 44.8 Stated: First time	The registered provider should ensure the nurse call system in the Kilmorey Suite has been reviewed and is audible to staff working in Kilmorey Suite and other areas of the home.	Met
	Action taken as confirmed during the inspection: We were informed that remedial work had been carried out on the nurse call system since the previous inspection. Observations made confirmed that the nurse call bells were audible in the dementia unit and in other areas of the home.	

<p>Recommendation 2</p> <p>Ref: Standard 41.4</p> <p>Stated: First time</p>	<p>The registered provider should ensure that a minimum skill mix of at least 35% registered nurses and up to 65% care assistants is maintained over 24 hours.</p> <p>Action taken as confirmed during the inspection: Due to the focus of this inspection this recommendation was not examined and has been carried forward for review at a future inspection.</p>	<p>Carried forward for review at a future inspection</p>
<p>Recommendation 3</p> <p>Ref: Standard 41.1</p> <p>Stated: First time</p>	<p>The registered provider should ensure staff allocation sheets have been completed and signed by the registered nurse/registered manager responsible for the allocation of staff.</p> <p>Action taken as confirmed during the inspection: Review of three weeks staff allocation sheets for weeks commencing 20, 27 March and 03 April 2017 evidenced that they had not been fully completed for night duty. This recommendation was assessed a partially met and has been stated for a second time.</p> <p>Staff allocation sheets are further discussed in section 4.3.1</p>	<p>Partially Met</p>
<p>Recommendation 4</p> <p>Ref: Standard 35.7</p> <p>Stated: First time</p>	<p>The registered provider should ensure the monthly quality monitoring reports contain a review of actions taken in response to the previous RQIA Quality Improvement Plan(QIP)</p> <p>Action taken as confirmed during the inspection: Due to the focus of this inspection this recommendation was not examined and has been carried forward for review at a future inspection.</p>	<p>Carried forward for review at a future inspection</p>
<p>Recommendation 5</p> <p>Ref: Standard 35.9</p> <p>Stated: First time</p>	<p>The registered provider should ensure a comprehensive analysis of accidents/incidents has been completed on a monthly basis and an action plan has been developed to address any deficits identified.</p> <p>Action taken as confirmed during the inspection: Due to the focus of this inspection this recommendation was not examined and has been carried forward for review at a future inspection.</p>	<p>Carried forward for review at a future inspection</p>

<p>Recommendation 6</p> <p>Ref: Standard 4</p> <p>Stated: Second time</p>	<p>The registered provider should ensure the admission process should be reviewed to ensure that appropriate documentation and assessments are completed and recorded and that a plan of care is developed to reflect the outcomes of assessments. This recommendation refers specifically to the completion and recording of: pre-admission assessments.</p>	<p>Carried forward for review at a future inspection</p>
<p>Action taken as confirmed during the inspection:</p> <p>Due to the focus of this inspection this recommendation was not examined and has been carried forward for review at a future inspection.</p>		
<p>Recommendation 7</p> <p>Ref: Standard 11</p> <p>Stated: First time</p>	<p>The registered person must ensure that the activities programme is reviewed to ensure that activities are structured and planned and provided with regards to the needs of the patients. Activities should be delivered and managed in line with standard 11 of the Care Standards for Nursing Homes, DHSSP's.</p>	<p>Carried forward for review at a future inspection</p>
<p>Action taken as confirmed during the inspection:</p> <p>Due to the focus of this inspection this recommendation was not examined and has been carried forward for review at a future inspection.</p>		
<p>Recommendation 8</p> <p>Ref: Standard 22.10</p> <p>Stated: First time</p> <p>To be completed by: 28 February 2017</p>	<p>The registered provider should ensure that all accidents and incidents occurring in the nursing home are reported to RQIA in accordance with legislation and current guidance and a record is maintained.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>A review of accidents/incidents records completed since the previous care inspection evidenced that appropriate notifications had been made to RQIA. This recommendation has been met.</p>		

4.3 Inspection findings

4.3.1 Staffing arrangements

Discussion with the nurse in charge and review of duty rotas evidenced that one registered nurse and two care assistants had been rostered to work in the home 20:00– 08:00; an additional care assistant was rostered to work from 16:00– 23:30 each night.

At the commencement of the inspection we were accompanied into the dementia unit (Kilmorey Suite) by the nurse in charge. We were informed that one care assistant was allocated to work in the unit from 20:00 to 08.00 each night. Upon arrival, we observed a period of ten minutes when there was no staff present in the dementia unit. We were informed that the care assistant who had been allocated to work in the unit had left to assist a colleague on another floor. The atmosphere in the unit was calm and when one patient's alarm mat sounded, the care assistant was observed to return to the unit in a timely manner and provide assistance. Discussion with the care assistant evidenced that they were aware of their responsibilities and duty of care to patients within the unit.

Eight patients were accommodated in the dementia unit at the time of the inspection. Seven patients were in bed and one patient was sitting up in the day room. Staff explained that alarm mats were in place for a number of the patients. Care records clearly indicated if the alarm mat was a safety measure for the management of falls or, for patients assessed as low risk of falls, as a means to alert staff that the patient may require assistance.

Staffing arrangements were discussed with the registered manager and responsible person following the inspection. We were informed that as a result of a review of staffing within the dementia unit the twilight shift had been extended from 20.00 to 23.30 each night to ensure that there sufficient staff to facilitate one member of staff remaining in the dementia unit. Plans were also in place for a clinical lead nurse role to be introduced within the home.

Review of the staff allocation sheets for weeks commencing 20 and 27 March and 03 April 2017 evidenced that they had not been fully completed. The allocation sheets had been completed for three nights of the week commencing 20 March 2017, two nights during week commencing 27 March 2017 and for one night during week commencing 03 April 2017. Discussion with the nurse in charge confirmed that a verbal direction was given to each member of staff at the commencement of duty in respect of which unit they were allocated to work in. This was confirmed by the member of care staff allocated to the dementia unit. A recommendation made at the previous inspection that staff allocation sheets are completed and signed by the registered nurse/registered manager responsible for the allocation of staff has not been fully met and has been stated for the second time. A further recommendation was made that systems are implemented to ensure records of staff allocation are completed.

4.3.2 Accidents/incidents

A review of accidents/incidents records evidenced that two accidents had occurred in the dementia unit over a six week period since the previous care inspection on 20 February 2017. This was a significant reduction in the numbers of accidents/incidents within the unit.

The care records of all patients accommodated in the dementia unit were reviewed. There was evidence that a falls risk assessment was in place for all patients and had been reviewed and updated on a regular basis and following all falls. Falls risk assessments had also been completed within 24 hours of admission for patients recently admitted.

Care plans were in place for those patients identified as being at medium or high risk of falls. Care plans were person-centred and identified a range of measures put in place to reduce the risk of falls. There was evidence that care plans had been reviewed on a regular basis.

Supplementary care records (sleep charts and bed rail assessment charts) were reviewed. These records evidenced that patients had been checked every hour and records had been well maintained and signed by the member of staff following each check. We observed that the sleep chart for one patient accurately reflected the patient's condition during the inspection.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plans.

Areas for improvement

Systems should be implemented to ensure records of staff allocation are completed.

Number of requirements	0	Number of recommendations	1
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Noreen Monaghan, registered manager and Peggy O'Neill, responsible person, 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 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 - None

Recommendations

<p>Recommendation 1</p> <p>Ref: Standard 41.4</p> <p>Stated: First time</p> <p>To be completed by: 30 April 2017</p>	<p>This recommendation was not examined at this inspection and will be carried forward until the next care inspection.</p> <p>The registered provider should ensure that a minimum skill mix of at least 35% registered nurses and up to 65% care assistants is maintained over 24 hours.</p> <p>Ref: Section 4.2</p>
	<p>Response by registered provider detailing the actions taken: Clinical lead has been appointed and 2 nurses are on duty in the mornings 5 days per week. Overall skill mix meets the 35% requirement. We are actively recruiting nurses.</p>
<p>Recommendation 2</p> <p>Ref: Standard 41.1</p> <p>Stated: Second time</p> <p>To be completed by: 30 April 2017</p>	<p>The registered provider should ensure staff allocation sheets have been completed and signed by the registered nurse/registered manager responsible for the allocation of staff.</p> <p>Ref: Section 4.3</p>
	<p>Response by registered provider detailing the actions taken: Staff have been instructed to complete and sign the allocation sheet on every shift. The Manager/Clinical Lead will monitor and sign weekly.</p>
<p>Recommendation 3</p> <p>Ref: Standard 35.7</p> <p>Stated: First time</p> <p>To be completed by: 30 April 2017</p>	<p>This recommendation was not examined at this inspection and will be carried forward until the next care inspection.</p> <p>The registered provider should ensure the monthly quality monitoring reports contain a review of actions taken in response to the previous RQIA Quality Improvement Plan(QIP)</p> <p>Ref: Section 4.2</p>
	<p>Response by registered provider detailing the actions taken: A review of actions taken in response to previous QIP will be included on the monthly monitoring report.</p>

<p>Recommendation 4</p> <p>Ref: Standard 35.9</p> <p>Stated: First time</p> <p>To be completed by: 30 April 2017</p>	<p>This recommendation was not examined at this inspection and will be carried forward until the next care inspection.</p> <p>The registered provider should ensure a comprehensive analysis of accidents/incidents has been completed on a monthly basis and an action plan has been developed to address any deficits identified.</p> <p>Ref: Section 4.2</p> <p>Response by registered provider detailing the actions taken: Accidents/Analysis Audit Form was reviewed and developed further to address identified deficits . This was forwarded to the inspector for her appraisal and satisfactory confirmation was received. This form is now in use.</p>
<p>Recommendation 5</p> <p>Ref: Standard 4</p> <p>Stated: Second time</p> <p>To be completed by: 30 April 2017</p>	<p>This recommendation was not examined at this inspection and will be carried forward until the next care inspection.</p> <p>The registered provider should ensure the admission process should be reviewed to ensure that appropriate documentation and assessments are completed and recorded and that a plan of care is developed to reflect the outcomes of assessments. This recommendation refers specifically to the completion and recording of: pre-admission assessments.</p> <p>Ref: Sections 4.2</p> <p>Response by registered provider detailing the actions taken: The admission process has been reviewed and all pre-admission assessments will be completed fully and signed.</p>
<p>Recommendation 6</p> <p>Ref: Standard 11</p> <p>Stated: First time</p> <p>To be completed by: 30 April 2017</p>	<p>This recommendation was not examined at this inspection and will be carried forward until the next care inspection.</p> <p>The registered person must ensure that the activities programme is reviewed to ensure that activities are structured and planned and provided with regards to the needs of the patients. Activities should be delivered and managed in line with standard 11 of the Care Standards for Nursing Homes, DHSSP's.</p> <p>Ref: Sections 4.2</p> <p>Response by registered provider detailing the actions taken: Activities Co-ordinator has been employed since 10/10/16 5 days per week, 2 hours daily. Additional activities are carried out daily by Carers and documented on the Goldcrest system.</p>

<p>Recommendation 7</p> <p>Ref: Standard 35.6</p> <p>Stated: First time</p>	<p>The registered persons should ensure that systems are implemented to ensure records of staff allocation are completed.</p> <p>Ref: Section 4.3.2</p>
<p>To be completed by: 2 May 2017</p>	<p>Response by registered provider detailing the actions taken: Staff have been instructed to complete and sign allocation sheets on every shift. The Manager/Clinical Lead will monitor and sign weekly.</p>



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