Unannounced Follow Up Care Inspection Report
14 April 2019

St Macartans

Type of Service: Nursing Home
Address: 74 Main Street, Clogher, BT76 0AA
Tel No: 0288554 8250
Inspector: Michael Lavelle

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 provider 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 nursing home registered to provide nursing and residential care for up to persons.

3.0 Service details

Organisation/Registered Provider: Kilmorey Care Ltd **Responsible Individual:** Cathal O'Neill	**Registered Manager:** Maria Lennon
Person in charge at the time of inspection: Diana McKeown, nurse in charge	**Date manager registered:** 21 December 2017
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. LD – Learning disability. LD(E) – Learning disability – over 65 years. DE – Dementia.	**Number of registered places:** 33 A maximum of 8 patients in category NH-DE. A maximum of 6 persons accommodated within categories NH-LD/LD(E). The home is also approved to provide care on a day basis to 1 person in the dementia unit. There shall be a maximum of 1 named resident receiving residential care in category RC-I and 1 named resident receiving residential care in category RC-LD(E)

4.0 Inspection summary

An unannounced inspection took place on 14 April 2019 from 10.00 hours to 13.20 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 DHSSPS Care Standards for Nursing Homes 2015.

The inspection was undertaken following information received by RQIA from an anonymous source, raising concerns in relation to wound management, staffing levels, record keeping and supervision of patients. The inspection also sought to assess progress with issues raised since the last care inspection on the 25 April 2018.

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, if RQIA is notified of a potential breach of regulations or minimum standards, it will review the matter and take appropriate action as required; this may include an inspection of the home.

The following areas were examined during the inspection:

- staffing – including deployment and care delivery
- environment
- care planning and risk assessment

- management of wounds, falls and nutrition
- record keeping.

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

The term 'patients' is used to describe those living in St Macartans which provides both nursing and residential care.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	2

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Diana McKeown, nurse in charge, as part of the inspection process and with Maria Lennon, registered manager, during a phone call on 15 April 2019. 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 8 May 2018

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 8 May 2018. No further actions were required to be taken.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received, for example, serious adverse incidents.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from weeks commencing 1 April 2019 and 8 April 2019
- domestic cleaning schedules
- incident and accident records
- four patient care records
- a selection patient care charts including personal care records, food and fluid intake charts, reposition charts, topical medicine administration records and bowel charts
- RQIA registration certificate.

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

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 8 May 2018

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 25 April 2018

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13 (1) (b)

Stated: Second time</td><td>The registered person must ensure good practice guidance is adhered to with regard to post fall management.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of the management of a recent unwitnessed fall evidenced that best practice guidance was generally well adhered to. This area for improvement has been met.</td></tr>
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Area for improvement 2 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure suitable arrangements are in place to minimise the risk of infection and spread of infection between patients and staff. This area for improvement is made with particular focus to the issues highlighted in section 6.4.	**Met**
	Action taken as confirmed during the inspection: Review of the environment evidenced improvements since the last care inspection with the deficits identified at the previous care inspection satisfactorily addressed.	
Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall ensure suitable arrangements for recording and safe administration of medicines. This is made with specific reference to administration of topical medicines.	**Met**
	Action taken as confirmed during the inspection: Review of a selection of topical medicine administration charts evidenced a robust system was in place for recording. Completion of these records was generally well adhered to. This area for improvement has been met.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 11 **Stated:** First time	The registered person shall ensure the programme of activities reflects the preferences and choices of the patients. This shall be displayed in a suitable format and a record kept of all activities that take place, with the names of the person leading them and the patients who participate.	**Met**
	Action taken as confirmed during the inspection: Review of the environment evidenced that activity planners were displayed in a suitable format in the lounges of the home. In addition the provision of activities was accurately recorded in patient care records. Discussion with the registered manager post inspection	

	evidenced activity provision is discussed at family and patient meetings which ensure the programme of activities is reflective of patient choice.	
Area for improvement 2 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that menus are displayed for patients/visitors information in a suitable format showing what is available at each mealtime.	**Met**
	Action taken as confirmed during the inspection: Review of the environment evidenced that menus accurately reflected the planned meals for the day. These were displayed both pictorially and individually on tables in the dining areas.	

6.3 Inspection findings

The inspection sought to validate the areas for improvement identified at the last inspection on 25 April 2018 and seek assurances in relation to wound management, staffing levels, record keeping and supervision of patients.

The nurse in charge 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 weeks commencing 1 April 2019 and 8 April 2019 evidenced that although the planned staffing levels were adhered to, there was not an appropriate skill mix of registered nurses and care assistants at weekends. This was discussed with the registered manager who agreed to review the skill mix of staff within the home. An area for improvement under the care standards was made. Duty rotas also confirmed that catering and housekeeping staff were on duty daily to support the nursing and care staff in the delivery of care to patients.

Observation of the delivery of care evidenced that patients' needs were met by the skill mix of staff on duty and that staff attended to patients needs in a caring manner. However, we did observe two volunteers supervising patients in the lounges upstairs on the morning of the inspection. This was discussed with the nurse in charge who confirmed staff were assisting patients with personal care. This was discussed with the registered manager post inspection who agreed to review the supervision of patients. This will be reviewed at a future care inspection.

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in St Macartans. Some comments received included,

"I can't say a bad word about it."
"I have no complaints."

We discussed the provision of mandatory training with staff. 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. However, we evidenced that elements of training received

had not been embedded into practice. Deficits were identified in relation moving and handing for some staff. An area for improvement under the regulations was made. In addition some staff who were assisting patients with fluids were not knowledgeable in relation to the new International Dysphagia Diet Standardisation Initiative (IDDSI) indicators which ensures that patients are safely given the correct foods and fluids. This was discussed with the registered manager and was identified as an area for improvement under the regulations.

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 and fresh smelling throughout. Fire exits and corridors were observed to be clear of clutter and obstruction. Stairwells were also observed to be clear. We did observe the used of wedges in the home to wedge doors open at the reception and the nurses office. This was discussed with the nurse in charge and registered manager who gave assurances that these would be disposed. This will be reviewed at a future care inspection. Compliance with infection prevention and control had been well maintained. Patients, relatives and staff spoken with were complimentary in respect of the home's environment.

There was evidence within four patients' care records reviewed that appropriate risk assessments were completed on admission and reviewed on a regular basis. Risk assessments had been completed on falls management, nutrition, pressure ulcer risk and restrictive practice. Care plans had been developed which were reflective of the risk assessments. The care plans had also been reviewed regularly or as the patients' needs changed. We reviewed the management of nutrition, falls 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.

Review of wound management for two patients evidenced that when a wound was identified, an initial wound assessment would have been completed and a wound care plan developed to direct the care in managing the wound. Body maps were completed identifying the location of the wound and wound observation charts completed to monitor the progress of the wound at the time of wound dressing. However, a review of one patient's wound records evidenced that one care plan did not detail what dressings the wound was required to be dressed with. There was further evidence that the wound was not dressed on alternate days on two occasions. This was discussed with the registered manager for action as required.

Discussion with the registered manager confirmed falls in the home were monitored on a monthly basis for any patterns and trends in times or locations of the fall. This would be to review the pattern to proactively plan measures to reduce the incidences of falls where possible. Accident records were maintained following any fall in the home. A review of one patient's accident records evidenced that the appropriate actions had been taken following the fall and the patient's falls care plan had been reviewed and updated following the fall. The registered manager was reminded to ensure that post fall risk assessments are completed within 24 hours of all falls.

Review of care records and supplementary care charts such as food and fluid intake records and repositioning charts evidenced deficits in recording. The registered manager must ensure that all care records are wholly reflective of care planning directions and completed to demonstrate adherence to the plan as required. This was discussed with the registered manager and an area for improvement was made under the care standards.

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.
Consultation with eight patients individually, and with others in smaller groups, confirmed they were happy and content living in St Macartans. Some of the patient's comments included,

"I am getting on well. I can't complain."
"The food is great."
"I want for nothing."

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.

Four relatives/visitors were spoken with during the inspection. Some of the comments received included the following,

"It's a grand spot. The staff are friendly."
"I come here a few times a week.
"My friend is fed and watered and well looked after. I couldn't say a bad word about the place."
"It's a very good home. I am happy with the care."
"The staffing is good. No needs are being neglected. The staff are lovely and my relatives faith needs are met. Management are approachable and communication is good. The family and my relative have been involved in the care planning and their needs are reassessed. The family are supported by staff. I wouldn't change a thing about the place."

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

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff, patients and patients representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the home's environment, the culture and ethos of the home and maintaining patients dignity and privacy.

Areas for improvement

Two areas for improvement under regulation were identified in relation to embedding training into practice and ensuring all staff access mandatory training.

Two areas for improvement under the care standards were identified in relation to the skill mix of staff and contemporaneous record keeping.

	Regulations	Standards
Total number of areas for improvement	2	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Diana McKeown, nurse in charge, as part of the inspection process and with Maria Lennon, registered manager, during a phone call on 15 April 2019. 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 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 DHSSPS 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 20 (1) (a) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure training is embedded into practice and all staff are competent in relation to moving and handling. Ref: 6.3
	Response by registered person detailing the actions taken: Moving & Handling training has been provided to all staff & volunteers and is embedded into daily practice. Refresher training was provided on 15/05/19 and another session is arranged for 06/06/19.
Area for improvement 2 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that the persons employed by the registered person to work in the nursing home receive mandatory training appropriate to the work they are to perform. This area for improvement is made with specific reference to volunteers working in the home. Ref: 6.3
	Response by registered person detailing the actions taken: The volunteer in question, whilst aware of their requirement to administer fluid thickeners to a modified diet was not fully au fait with the new IDDIS terminology. The Nursing home has provided awareness sessions in the past to all staff regarding the new IDDIS terminology, further awareness sessions have been arranged for all staff & volunteers.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 41.4 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that a skill mix of 35 percent registered nurses and 65 percent care assistants is maintained over 24 hours. Ref: 6.3
	Response by registered person detailing the actions taken: The home will endeavour to achieve whenever possible the requested skill mix & maintain this over the 24hr period.

Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient, in accordance with NMC guidelines. Registered nurses should evidence review of supplementary care records in the patient's daily evaluation. Ref: 6.3
	Response by registered person detailing the actions taken: The staff involved have received supervision in regard to maintenance of contemporaneous nursing records. Additional audit checks have been put in place to ensure that these issues do not reoccur in the future.

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

The Regulation and Quality Improvement Authority

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