Unannounced Care Inspection Report
1 August 2017

Lough Neagh

Type of Service: Nursing Home
Address: 23 Maghery Road, Portadown, BT62 1SZ
Tel no: 028 3885 2600
Inspector: Gerry Colgan

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.

3.0 Service details

Organisation/Registered Provider: Lough Neagh Nursing Home **Responsible Individual(s):** Mr Cathal Quinn Mrs Marie Quinn	**Registered Manager:** Ms Eileen Quinn
Person in charge at the time of inspection: Ms Eileen Quinn	**Date manager registered:** 21 April 2015
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. Residential Care (RC) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment.	**Number of registered places:** 26 comprising: 14 – NH-1 NH-PH 10 – NH-DE 2 –RC-1,RC-PH

4.0 Inspection summary

An unannounced inspection took place on 1 August 2017 from 08.30 to 15.00 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 ‘patients’ is used to describe those living in Lough Neagh 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, staff recruitment, induction, supervision and appraisal, adult safeguarding, infection prevention and control, risk management .record keeping, audits and reviews, communication between residents, staff and other key stakeholders, the culture and ethos of the home, dignity and privacy, listening to and valuing patients, governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships .

Areas requiring improvement were identified in relation a male and female toilets area in the environment and the creation of a training matrix.

Patients said
"I love it, the home is magnificent."
"The care I get couldn't be any better."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

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	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Eileen Quinn, Registered Manager, and Marie and Cathal Quinn, Registered Persons, 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 25 May 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 25 May 2017. There were no further actions required to be taken following the most recent 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
- 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 two patients, nine staff, and two patients' visitors. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

The following records were examined during the inspection:

- duty rota for all staff for the period 24 July to 6 August 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment and induction file
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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 25 May 2017

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 30 August 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **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: Work has been undertaken to ensure that all the areas identified on inspection in August 2016 now comply with best practice in infection control within the home	
Area for improvement 2 **Ref:** Standard 47 Criteria (1) **Stated:** First time	The registered person should ensure that radiators within the home are reviewed to ensure any potential burn risks to patients are minimised.	**Met**
	Action taken as confirmed during the inspection: Radiators within the home have been reviewed and those deemed a burns risk to patients have been appropriately covered	
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time	The registered person should ensure that when core care plans are used, these should be appropriately amended to reflect the individuals' specific needs.	**Met**
	Action taken as confirmed during the inspection: Three random patient care records were examined. Where core care plans have been used these have all been amended to reflect the individuals specific needs	

Area for improvement 4 **Ref:** Standard 41 Criteria (8) **Stated:** First time	The registered person should ensure staff meetings take place on a regular basis and at a minimum quarterly. Records maintained should include: • the date of all meetings • the names of those attending • minutes of discussions • any actions agreed	**Met**
	Action taken as confirmed during the inspection: Staff meetings now take place on a three monthly basis and records were available at inspection	

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 weeks commencing 24 July, 31 July and 6 August 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff 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.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

Discussion with staff and review of two most recent staff recruitment records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

Staff receive regular supervision and appraisals are completed yearly.

Review of staff training and conversation with the registered manager confirmed that training was planned to ensure that mandatory training requirements were met. Staff training was all up to date but an actual training matrix has not been formally developed. This has been identified as an area for improvement.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

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

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns.

Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. Where any shortcomings were identified safeguards were put in place.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last care inspection confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of all bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean apart from one toilets area on the middle floor which was in need of refurbishment. This has been identified as an area for improvement. Patients, relatives and staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored. There is an on-going refurbishment programme in place. The identified toilets area was discussed with the registered manager and was required to be addressed without delay to ensure the safety and wellbeing of patients in the home. An area for improvement had been identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control and risk management.

Areas for improvement

The following areas were identified for improvement in relation to developing a staff training matrix and refurbishment of the identified toilets area on the middle floor.

	Regulations	Standards
Total number of areas for improvement	0	2

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 a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislation.

Review of three patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift.

Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), SALT, dietician, TVN. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Discussion with the registered manager and staff confirmed that staff meetings were held on a three monthly basis and records were maintained.

Staff stated that there was good morale and effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager

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

Discussion with the registered manager and review of records evidenced that patient and relatives meetings were held on an annual basis. Minutes were available.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, audits and reviews, 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.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

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.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. There was evidence that suggestions for improvement had been considered and used to improve the quality of care delivered.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. As part of the inspection process, we issued questionnaires to staff (ten), patients (eight) and their representatives (ten). Three patients, one patient's representative and six staff completed and returned questionnaires.

The questionnaires from patients, patient's representative and staff highlighted that all were either very satisfied or satisfied that the home was well led and provided safe, effective and compassionate care. No comments were received.

Consultation with patients individually, and with others in smaller groups, confirmed that Lough Neagh was a good place to live.

Patient comments:

"It's great in here."
"It wouldn't be any better in a hotel."
"This home is magnificent, plenty of nursing staff to look after us."

Representatives comments:

"Everything is fine here. We have no problems at all."

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

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	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.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff/ 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.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager; review of records and observation evidenced that the home was operating within its registered categories of care.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis.

Discussion with the registered manager and review of the home's complaints record evidenced that there were no complaints since the previous care inspection. The registered manager confirmed that complaints would be managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. A copy of the complaints procedure was available in the home. Staff were knowledgeable of the complaints process.

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 the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. Audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, quality improvement, fire prevention, infection prevention and control, environment, complaints, incidents/ accidents and patient satisfaction. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been embedded into practice.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Discussion with the registered manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Home Regulations (Northern Ireland) 2005. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Discussions with staff confirmed that there were very good working relationships and that management were 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 complaints and 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 Eileen Quinn, Registered Manager, and Marie and Cathal Quinn, Registered Persons, 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 to Nursing.Team@rqia.org.uk to RQIA office for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 31 August 2017	The registered person shall develop a training matrix to include induction and record of all professional development activities completed by staff. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Training Matrix developed to include induction and record of all professional training undertaken by staff.
Area for improvement 2 **Ref:** Standard 44.1 **Stated:** First time **To be completed by:** 30 September 2017	The registered person shall refurbish the identified toilets area on the middle floor to a standard acceptable for patients **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Refurbishment of the identified toilet has been completed.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

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