The Regulation and Quality Improvement Authority

Inspection Report

7 August 2024

Harold McCauley House

Type of Service: Nursing Home
Address: 7 Camowen Terrace, Omagh BT79 0AX
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Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Presbyterian Council of Social Witness **Responsible Individual:** Mr Dermot Parsons	**Registered Manager:** Miss Megan James – not registered
Person in charge at the time of inspection: Miss Megan James, Manager	**Number of registered places:** 32 A maximum of 7 patients in category NH-DE and a maximum of 2 patients in category NH-PH/PH(E).
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 30
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 32 patients. The home operates over two floors with shared communal lounges, a dining room and outdoor spaces.	

2.0 Inspection summary

An unannounced inspection took place on 7 August 2024 from 9.25 am until 6 pm. The inspection was carried out by a care inspector.

The purpose of the inspection was to assess progress with all areas for improvement identified in the home 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.

Patients told us that they felt well looked after. Patients who were less able to communicate their views were observed to be relaxed and comfortable in their surroundings and in their

interactions with staff. Comments received from patients and staff are included in the main body of this report.

Areas for improvement were identified during the inspection as detailed throughout this report and within the Quality Improvement Plan (QIP) in section 6.0.

The findings of this report will provide the management team with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the management team as part of the inspection process.

4.0 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "The carers are fantastic", "I like it very much here", "Getting well looked after", "The staff are all very good here" and "I am well attended to". Some patients said that when the activity person was not on duty that they were 'bored'. This is discussed further in section 5.2.4.

Staff said that the manager was very approachable, teamwork was great and that they felt well supported in their role. Comments from staff included: "Megan (Manager) is very good", "This is a good home" and "I really enjoy working here". Staff also said that staffing levels especially in the morning, were not sufficient. This information was shared with the management team to review and action as necessary.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 11 July 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the IPC issues identified during inspection are addressed and a system is implemented to monitor compliance going forward.	**Not met**
	Action taken as confirmed during the inspection: Observation of the environment and staff practices evidenced that this area for improvement had not been met and has been stated for a second time. This is discussed further in section 5.2.3.	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that where a patient requires pressure area care, a care plan is in place detailing the recommended frequency of repositioning; and that this is accurately reflected and recorded in the corresponding repositioning chart.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with the manager evidenced that this area for improvement had been met.	
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that the following action is taken where a wound has been assessed as requiring treatment: • the care plan includes the recommended dressing type and frequency of dressing renewal • wound assessment charts are fully completed following each dressing	**Partially Met**

	renewal and are reflective of the directions within the care plan • a body map is completed to provide the location of the wound and date identified • the type of pressure relieving equipment required is recorded within the care plan.	
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with the manager evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	
Area for improvement 3 **Ref:** Standard 4.8 **Stated:** First time	The registered person shall ensure that where a patient is at risk of dehydration the recommended daily fluid target is recorded within the patients' dietary/fluid intake chart and care plan. With the action to be taken, and at what stage, if the recommended target is not met, clearly documented within the care plan.	**Partially met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with the manager evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that care plans provide sufficient details that are reflective of the patients' health and personal care needs and any relevant medical conditions.	**Partially met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with the manager evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics including moving and handling, fire safety and adult safeguarding. Staff confirmed that they were provided with relevant training both online and practical to enable them to carry out their roles and responsibilities effectively.

Review of a sample of staff recruitment records evidenced that relevant checks were completed prior to commencing employment.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the manager was not on duty. Competency and capability assessments for the nurse in charge in the absence of the manager were completed.

Monthly checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC).

Staff said they felt supported in their roles and that there was good team work with effective communication between staff and management. As mentioned above in section 4.0, comments were received from staff in relation to staffing levels. This was discussed with the management team who advised that staffing levels were in accordance with the assessed needs of the patients.

The inspector requested the most recent patient dependency assessment. The manager said that this was last carried out by senior management in February 2024, and they did not have access to this assessment. An area for improvement was identified.

A record of staff supervisions and appraisal was maintained by the manager with staff names and the date that the supervision/appraisal had taken place.

5.2.2 Care Delivery and Record Keeping

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patients' needs, their daily routine, wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly.

Whilst most patients were well presented, a number of patients finger nails were long. This was discussed with the manager who agreed to have this addressed and to monitor going forward. Following the inspection, written confirmation was received from the manager that relevant action had been taken to address this.

Review of a sample of care records relating to the management of falls evidenced that these were mostly well completed, however, neurological observations for one patient who had an unwitnessed fall, evidenced that they had not been fully completed in line with best practice. The manager agreed to have this reviewed and to discuss with relevant staff. Following the inspection, written confirmation was received of the action taken to address this with ongoing monitoring by management.

Patients who were less able to mobilise require special attention to their skin care. Review of a sample of patients care records evidenced that these were mostly well maintained.

Review of a sample of care records specific to wound care evidenced inconsistencies regarding the recommended frequency of dressing renewal within one patient's care plan and a further patient did not have a body map completed to provide the location of the wound. Details were discussed with the manager and an area for improvement has been stated for a second time.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was a pleasant opportunity for patients to socialise and the atmosphere was calm and relaxed. Patients who choose to have their lunch in their bedroom had trays delivered to them and the food was covered on transport.

There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, staff recognised that patients may need a range of support with meals and were seen to helpfully encourage and assist patients as required.

There was a choice of meals offered, the food was attractively presented and smelled appetising. Staff knew which patients preferred a smaller/larger portion and demonstrated their knowledge of individual patient's likes and dislikes. There was a variety of drinks available and a pictorial menu was displayed within the dining room.

Staff described how they were made aware of patients' individual nutritional and support needs based on recommendations made by the Speech and Language Therapist (SALT).

Review of a sample of care records regarding risk of dehydration evidenced that not all care plans contained the recommended daily fluid intake and/or the action to take if the recommended target is not met. An area for improvement has been stated for a second time.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily.

A number of care records were not fully reflective of the patient's current needs, for example; the normal type and frequency of bowel elimination; and a number of patients care records did not contain care plans regarding relevant medical history. Specific details were discussed with the manager and an area for improvement has been stated for a second time.

Access to confidential patient information was evident within two areas of the home. This was brought to the attention of the manager who agreed to have these records secured. Following the inspection, written confirmation was received that relevant action had been taken to address this.

Daily progress records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was mostly neat and tidy, however, some areas of the home were cluttered with patient equipment. Details were discussed with the manager and following the inspection, written confirmation was received that relevant action had been taken to address this. Patient's bedrooms were found to be personalised with items of memorabilia and special interests. Outdoor spaces and gardens were well maintained with areas for patients to sit.

Whilst most areas of the home were clean, a number of carpets within communal areas and corridors were stained; light pull cords in some areas of the home were uncovered; surface damage was observed to a number of doorframes, pedal bins, radiator covers, bedframes and walls. The carpet in an identified bedroom was torn, grill covers were missing to fans within communal bathrooms and holes were evident to identified walls and a ceiling in a communal bathroom. Details of these and any other environmental/maintenance related issues were discussed with the management team and an area for improvement was identified. This is discussed further in section 5.2.5.

Pipes carrying hot water were exposed in a number of communal bathrooms. Details were discussed with the manager who agreed to have these reviewed and covered where necessary. An area for improvement was identified.

Review of the most recent fire risk assessment completed on 17 January 2024 evidenced that the actions required had not been signed off by management as having been completed. Following the inspection, the manager provided written confirmation that all actions had been completed.

There was evidence that fire evacuation drills had been completed and a system was in place to ensure that all staff attend at least one fire evacuation drill yearly.

Two kitchenettes were left unsupervised with access to food and fluids. The potential risks were discussed with the manager and following the inspection, both verbal and written confirmation was received that relevant action had been taken to address this.

A window restrictor within the laundry room was not tamper proof and could therefore be opened wider than the recommended distance. Following the inspection, the manager provided written confirmation that the necessary tamper proof fixture had been fitted to the window.

Access to wash hand basins within the laundry were obstructed with linen baskets and large detergent containers. It was further identified that the system for ensuring clean and used linen are kept separate required further review. The manager agreed to have this reviewed and following the inspection, provided written confirmation of the action taken to address this.

Personal protective equipment (PPE) and hand sanitising gel was available within the home.

Cleaning staff were using the incorrect colour coded cleaning equipment as per the home's policy. Details were discussed with the management team and following the inspection, both verbal and written confirmation was received that relevant action had been taken to address this.

Observation of staff practices and the environment evidenced that staff were not fully compliant with infection prevention and control (IPC) measures. For example; there was inappropriate storage of patient equipment and personal items in en-suites and communal bathrooms; and one care assistant did not wear appropriate PPE during the handling of used laundry. These and any other IPC related issues were discussed in detail with the manager and an area for improvement has been stated for a second time.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested. Patients appeared to be content and settled in their surroundings and in their interactions with staff.

The activity person was on planned leave during the inspection. Whilst there were positive interactions witnessed by care staff towards patients on an individual basis, there was no evidence of any meaningful activities. It was further identified that televisions were turned off during the morning in both of the lounges. As mentioned above in section 4.0 regarding the provision of activities; one patient said: “I am bored. There is nothing to do here. (The) TV does not work” and a further patient said: “When the activity person is here, she is great and plenty of things to do, but she is on holidays at the moment and I miss her. It is a dead town when the activity person is off”. This was discussed with the management team and an area for improvement was identified.

Patients commented positively about the food provided within the home with comments such as: “The food is great here”, “(The) food is lovely” and “The food is very good here.”

5.2.5 Management and Governance Arrangements

There has been a change in the management of the home since the last inspection with Miss Megan James now the acting manager since 12 April 2024. Staff said that the manager was very approachable and accessible.

Accidents/incidents records evidenced that one notifiable event had not been submitted to RQIA specific to a damaged windowpane on the first floor. This was discussed with the manager who had this submitted retrospectively during the inspection. Following the inspection, written confirmation was received that the necessary repair work had been completed.

There was evidence that a number of audits were being completed on a regular basis to review the quality of care and other services within the home. However, as stated above in sections 5.2.2 and 5.2.3, a number of areas for improvement were identified in relation to care records and the environment which had not been identified by the management team. An area for improvement was identified.

The manager confirmed that the home was visited each month by a representative of the responsible person to consult with patients, their relatives and staff and to examine all areas of the running of the home. However, written reports of these visits were not available within the home and an area for improvement was identified.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	4*	6*

* The total number of areas for improvement includes one regulation and three standards that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** Second time **To be completed by:** 7 August 2024	The registered person shall ensure that the IPC issues identified during inspection are addressed and a system is implemented to monitor compliance going forward. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: All staff have repeated IPC training online. Discussions held regarding IPC are carried out at daily staff huddles to ensure understanding of IPC. Manager sourced IPC leaflets from local health trust which have been shared with staff to highlight the imprtance of IPC within the home. IPC audits have been increased and are overseen by the manager to ensure compliance with hand-washing and the use of PPE.
Area for improvement 2 **Ref:** Regulation 27 (2) (b) **Stated:** First time **To be completed by:** 7 November 2024	The registered person shall ensure that the environmental/maintenance related issues identified during inspection are addressed. Ref: 5.2.3
	Response by registered person detailing the actions taken: An estates survey was completed on 10/09/2024 to outline all areas of maintenance that needed to be addressed. The specified items will be addressed by 07/11/2024 and a general refurbishment plan for the home is currently being finalised.

Area for improvement 3 **Ref:** Regulation 27 (2) (t) **Stated:** First time **To be completed by:** 7 September 2024	The registered person shall ensure that all exposed hot water pipes are reviewed and covered where necessary. Ref: 5.2.3
	Response by registered person detailing the actions taken: Exposed water pipes have now been covered with polythene foam insulation to prevent risk of burns.
Area for improvement 4 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** 7 August 2024	The registered person shall ensure that monthly monitoring reports are available within the home at all times. Ref: 5.2.5
	Response by registered person detailing the actions taken: Monthly monitoring reports have been received and are now accessible in the home. There is now a robust regional management system in place to ensure monthly monitoring reports are received by the home within a week of the visit.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 23 **Stated:** Second time **To be completed by:** 14 August 2024	The registered person shall ensure that the following action is taken where a wound has been assessed as requiring treatment: • the care plan includes the recommended dressing type and frequency of dressing renewal • wound assessment charts are fully completed following each dressing renewal and are reflective of the directions within the care plan • a body map is completed to provide the location of the wound and date identified • the type of pressure relieving equipment required is recorded within the care plan. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: All wound care charts and care plans have been reviewed. Documentation has been updated to prevent duplication and parts of the forms from being missed. This will ensure accuracy of recording and is audited monthly by manager to ensure records are completed fully.

Area for improvement 2 **Ref:** Standard 4.8 **Stated:** Second time **To be completed by:** 14 August 2024	The registered person shall ensure that where a patient is at risk of dehydration the recommended daily fluid target is recorded within the patients' dietary/fluid intake chart and care plan. With the action to be taken, and at what stage, if the recommended target is not met, clearly documented within the care plan. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: All fluid balance charts have been reviewed and have the recommended minimum intake amount included. Care plans for these residents have been updated and the minimum fluid intake is included, and any actions to be taken are recorded also.
Area for improvement 3 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 14 August 2024	The registered person shall ensure that care plans provide sufficient details that are reflective of the patients' health and personal care needs and any relevant medical conditions. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Care plan audits have been completed for all residents and the names nurse allocated to each resident have actioned outstanding care plans which reflect relevant medical conditions, personal care preferences and patients health needs.
Area for improvement 4 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 14 August 2024	The registered person shall ensure that patient dependency assessments are carried out on a regular basis to ensure that there are sufficient staffing levels on duty to meet the needs of the patients. Records of these assessments must be available within the home. Ref: 5.2.1
	Response by registered person detailing the actions taken: An updated dependency assessment was completed on 08/08/2024 with the regional manager. A monthly audit has been implemented to monitor resident dependency. Discussions are ongoing with line management to ensure there

	are sufficient staffing levels within the home to meet the needs of the residents.
Area for improvement 5 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 28 August 2024	The registered person shall ensure that the provision of activities is reviewed to ensure that there are meaningful activities at all times and especially in the absence of the activity person. Ref: 5.2.4
	Response by registered person detailing the actions taken: Weekly plans for activities are completed and displayed to ensure meaningful activities are provided within the home. This includes live music, weekly services and daily activities. Training has been completed by staff on meaningful activities and a plan will be put into place to cover absences of the activity co-ordinator going forward.
Area for improvement 6 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 7 September 2024	The registered person shall ensure that quality governance audits are effective at identifying and addressing the areas requiring improvement as outlined in this report. With specific reference to: • environmental audits • care record audits. Ref: 5.2.5
	Response by registered person detailing the actions taken: Quality governance audits are ongoing and will be reviewed in greater detail to ensure areas of improvement are outlined and an action plan in place with suitable timeframes recorded. Care plan audits are completed and will be reviewed quarterly.

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