Unannounced Care Inspection Report
2 May 2017

Arlington

Type of Service: Nursing Home
Address: 7-9 North Parade, Belfast, BT7 2GF
Tel no: 028 9049 1136
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Arlington Nursing Home took place on 2 May 2017 from 10:25 to 14:30 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The deputy manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

A recommendation was made that following a fall patients' risk assessments and care plans should evidence that they have been reviewed.

Is care effective?

Review of patient care records evidenced that care plans were reviewed on a regular basis. We reviewed the management of pressure area care, wound care, falls prevention and the admission process. Care records also reflected, where appropriate, that referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians.

Supplementary care charts such as repositioning, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance and care standards. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records and patient information.

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

There were no areas for improvement identified within this domain.

Is care compassionate?

We arrived in the home at 10:25 hours and were greeted by staff who were helpful and attentive. Patients were enjoying either a late breakfast or a morning cup of tea/coffee in the lounge or their bedroom, as was their personal preference. Some patients remained in bed, which was in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice depending of which they preferred and staff were observed assisting patient to drink as required.

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

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 some patients confirmed that living in Arlington was a positive experience.

There were no areas for improvement identified in this domain.

Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

Unannounced quality monitoring visits were completed on a monthly basis by the regional manager on behalf of the provider. Copies of the quality monitoring visits were available in the home.

Discussion with staff evidenced that there was a clear organisational structure within the home. In discussion, patients and representatives/relatives were aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

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	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Joanne McCollum, Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 7 December 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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 person: Arlington/Mr Brian Macklin and Mrs Mary Macklin	**Registered manager:** Jacinta Silva
Person in charge of the home at the time of inspection: Joanne McCollum, deputy manager.	**Date manager registered:** 22 February 2017
Categories of care: NH - I, PH, PH(E) and TI	**Number of registered places:** 25

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with seven patients individually and with others in small groups; the deputy manager, four care staff, two domestic staff and one relative.
Questionnaires were also left in the home to obtain feedback from relatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left.

The following information was examined during the inspection:

- duty rota for all staff week beginning1 May 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
- two patient 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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 December 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. The actions detailed in the returned QIP were validated during this inspection as detailed in the next section.

4.2 Review of requirements and recommendations from the last care inspection dated 7 December 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 30 **Stated:** First time	The registered provider must that RQIA are notified, without delay, of events or incidents occurring in the nursing home in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 – regulation 30.	**Met**
	Action taken as confirmed during the inspection: Review of incident and accidents records and a summary of events notified to RQIA from 1 January 2017 evidenced that this requirement had been met.	

4.3 Is care safe?

The deputy 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 from 1 to 7 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Staff said that on occasions staffing levels were affected by short notice leave. However staff confirmed that this only happened occasionally. We also sought staff opinion on staffing via questionnaires; five were returned following the inspection. Four respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?" One staff member answered 'no' to this question and recorded, "I do not feel like we have adequate staff, for the number of residents in our care …"

Patients spoken with during the inspection commented positively regarding the staff and the care delivered. Patients able to communicate indicated that they were satisfied that when they required assistance staff attended to them in timely manner. We also sought patients' opinion on staffing via questionnaires; eight were returned following the inspection. All respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?"

One relative spoken with commented that they had no concerns and felt assured that their loved one's needs were being met. The relative was complimentary regarding staff of all grades/roles. We sought other relatives' opinion on staffing via questionnaires; seven completed questionnaires were returned. All respondents indicated that staff had enough time to care for their relatives. There were no additional comments recorded regarding staffing.

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; and that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that the registered manager had a process in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2016/17. Records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Mandatory training compliance was monitored by the registered manager and was also reviewed by senior management as part of the monthly quality monitoring process. Additional training was also available to staff to ensure they were able to meet the assessed needs of patients.

Observation of the delivery of care evidenced that training had been embedded into practice.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process and that these assessment informed the care planning process. A recommendation was made that patients' risk assessments and care plans pertaining to the prevention of falls should be reviewed following a fall in accordance with falls prevention guidance.

Review of accidents/incidents records from 1 January 2017 and notifications forwarded to RQIA confirmed that these were appropriately managed. 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. Discussion took place regarding the inclusion of an 'audit evaluation' to evidence management's decision making and /or actions in respect of the audit outcomes. The falls audit information also informed the responsible individual's quality monthly monitoring visit, undertaken by the regional manager, in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and personal protective equipment (PPE) such as gloves and aprons were available throughout the home.

Areas for improvement

A recommendation was made that patients' risk assessments and care plans pertaining to the prevention of falls should be reviewed following a fall in accordance with falls prevention guidance and care standards.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

Review of three patient care records and two patients' care charts regarding repositioning evidenced that care plans were in place to direct the care required. The deputy manager who was also the nurse in charge was aware of professional requirements to review and update care plans as the needs of patient changed or when the recommendations made by other healthcare professionals such as, the speech and language therapist (SALT) or the tissue viability nurse (TVN), were changed.

We reviewed the management of pressure area care, wound care, falls prevention and the admission process. Care records contained details of the specific care requirements in each of the areas reviewed and a contemporaneous record was maintained to evidence the delivery of care. Care records also reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians. A recommendation was made in section 4.3 regarding the review/update of risk assessments and care plans following a fall.

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

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records and information.

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

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

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

We arrived in the home at 10:25 hours and were greeted by staff who were helpful and attentive. Patients were enjoying either a late breakfast or a morning cup of tea/coffee in the in the lounge or in their bedroom, as was their personal preference. Some patients remained in bed, in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice depending of which they preferred and staff were observed assisting patient to drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. There was clear evidence of good relationships between patients and staff.

Staff were aware of the requirements regarding patient information, confidentiality and issues relating to consent. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. The activity therapist was observed to facilitate a musical activity with a guest performer in the afternoon. Patients had said earlier that they were looking forward to the musician coming and were observed to be enjoying the activity. Patient also described their gardening activity the previous day and it was evident that they had enjoyed it.

Patients able to communicate their feelings indicated that they enjoyed living in Arlington. 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.

As stated previously one relative spoken with was very complimentary regarding the care their loved one received from all staff.

Ten relative questionnaires were issued; seven were returned within the timescale for inclusion in this report. Relatives were very satisfied or satisfied with the care provided across the four domains. One relative commented, "Excellent care…"

Ten questionnaires were issued to staff; five were returned prior to the issue of this report. The staff members were very satisfied or satisfied with the care provided across the four domains. One staff member raised a concern regarding staffing levels as detailed in section 4.3 and that they would prefer to approach the deputy manager if they required assistance.

Eight questionnaires were issued to patients; eight were returned prior to the issue of this report. Patients were very satisfied or satisfied with the care provided across the four domains. Additional comments were recorded by two patients in relation to the provision of a visiting clergy from a particular church and access to smoking facilities.

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

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered.

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 patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Review of records evidenced that monthly audits were completed to ensure the quality of care and services was maintained. For example, audits were completed for accidents/incidents, complaints, infection prevention and control and wound care. The records of audit evidenced areas for improvement had been identified, addressed and checked for compliance. As stated previously in section 4.3; discussion took place regarding the inclusion of an 'audit evaluation' to evidence management's decision making and /or actions in respect of the audit outcomes. Audit outcomes informed the monthly quality monitoring process undertaken by the regional manager on behalf of the provider.

Review of records for March 2017 evidenced that unannounced quality monitoring visits were completed on a monthly basis. Recommendations were made within the report to address any areas for improvement. Copies of the quality monitoring visits were available in the home.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

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

Discussion with staff evidenced that there was a clear organisational structure within the home. In discussion some patients and the relative spoken with were aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Joanne McCollum, Deputy Manager, 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 via 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	
Recommendations	
Recommendation 1 **Ref:** Standard 22 **Stated:** First time **To be completed by:** 31 May 2017.	The registered provider should that patients' risk assessments and care plans, pertaining to the prevention of falls, should be reviewed following a fall in accordance with falls prevention guidance and care standards. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: .supervisions were done with nurses to informed best procedure in accordance with falls prevention guidance and care standards

Please ensure this document is completed in full and returned via web portal

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