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Unannounced Care Inspection
of
Templemoyle

1March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 01 March 2016 from 09.30 to 15.30.

The purpose of this inspection was to seek assurances that the care and welfare of patients was in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes, April 2015.

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 03 September 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	*5

*The total number of recommendations above includes one recommendation that was stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager and Gerald Burns, Registered Nurse, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Elizabeth Kathleen Mary Lisk	**Registered Manager:** Jeya Pratheeksha
Person in Charge of the Home at the Time of Inspection: Jeya Pratheeksha	**Date Manager Registered:** 9 January 2015
Categories of Care: NH-I, NH-PH	**Number of Registered Places:** 30
Number of Patients Accommodated on Day of Inspection: 29	**Weekly Tariff at Time of Inspection:** £593

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to inspection the following records were analysed:

- notifiable events submitted 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 plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with five patients, three care staff, two nursing staff, two ancillary staff and one patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Last Care Inspection on 03 September 2015.

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 19 (2) Schedule 4 22 **Stated:** First time	The registered persons must review the current system for recording of visitors to the home. **A report regarding how this has been addressed must be submitted to RQIA, with the returned QIP.**	**Met**
	Action taken as confirmed during the inspection: A review of the visitor sign-in book confirmed that visitors to the home were signing in, on entering the building. Staff were also observed directing visitors to the home, to sign in.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 32.1 **Stated:** First time	The following policies and guidance documents should be developed and made readily available to staff: • A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the referral procedure for specialist palliative care nurses; the procedure for managing shared rooms; the process for notifying RQIA in the event of a death; and management of a sudden or unexpected death.	**Partially Met**
	Action taken as confirmed during the inspection: A policy on death, dying and communicating bad news was reviewed. Although there was evidence that the management of shared rooms had been included, the other elements outlined above had not been addressed. For example, the policy did not reflect best practice guidance documents, such as DHSSPSNI (2003) Breaking Bad News, or the Palliative Care Guidelines (GAIN 2013). Furthermore, the regulations referenced within the body of the policy were not The Nursing Homes Regulations (Northern Ireland) 2005. This recommendation was partially met and has been stated for the second time.	

Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time	Registered nursing staff should record efforts made to establish patients' preferences in respect of end of life care and that for patients who do not wish to discuss this, a record should be also be maintained in line with the policy on end of life care. Where a decision is made regarding end of life care, a care plan should be developed and should include identified religious, spiritual and cultural needs.	**Met**
	Action taken as confirmed during the inspection: A review of two patient care records confirmed that care plans regarding end of life care were completed, in consultation with the patients and or their representatives. The end of life care plans were holistic and included the patients' religious, spiritual and cultural needs.	

5.2 Additional Areas Examined

5.2.1. Care Practices

The interactions between patients and staff were appropriate, and good relationships were evident. Patients were observed to be generally well presented. However, three patients required greater attention with regards to the standard of personal care being delivered. For example, three patients' fingernails required attention. One identified patient's fingernails were very long and dirty both before and after personal hygiene needs had been attended to. Staff spoken with advised that some patients are not-compliant with nail care. It was evident from observations that the overall personal appearance of patients who resisted care intervention was below the standard expected. This impacted on the appropriate level of dignity and respect for these patients. A review of care plans for personal hygiene did not include strategies to manage non-compliance in this regard. This was discussed with the registered manager. Staff should be trained in the delivery of personal care, to ensure that patients are treated with respect and dignity and their personal care and grooming needs are met. A recommendation has been made in this regard.

A recommendation has also been made to ensure that the standard of personal care provided is monitored by management, as part of the regulation 29 monthly monitoring report.

5.2.2. Care Records

A review of five patient care records evidenced that the patients' risk assessments and care plans were in place.

However, in three care records, there was no evidence that the assessments and care plans were evaluated on a regular basis. For example, two patients who had been assessed as having a 'moderate' risk of developing pressure ulcers, did not have the validated risk assessment updated since December 2015. However, both patients skin integrity had been monitored during this period and no pressure damage had occurred..

Three patients did not have the Malnutrition Universal Screening Tool (MUST) updated on regular basis. One identified patient, who was assessed as having a 'medium' risk of malnutrition had not been re-assessed since 11 December 2015. The care plan also identified that this patient had a 'high' risk score. It was also concerning that one patient had two nutritional risk assessments completed, with contradictory outcomes. For example, the patient scored 'low risk' using the MUST tool and 'high risk' using another nutritional risk assessment.

Discussion with the registered manager and a review of care record audits evidenced the need for audits to be further developed, to ensure that specific areas are identified and follow up action is taken to address the identified deficits. A recommendation has been made in this regard.

Advice was also given in relation to archiving unnecessary documentation in the patient care records that was no longer necessary. The registered manager also agreed to provide new care record folders, to replace the current folders, many of which were poorly labelled and falling apart.

5.2.3. Staff, Patient and Patients' Representatives' Comments

All comments received were positive. Some comments received are detailed below:

Staff

'It is very good. We work as a team'
'I was scared when I started, but they trained me up and I love it here now'
'I am very happy here'
'I love it here'.

Patients

'The (staff) are very nice'
'I am very pleased with it'
'It appeals to me. They are very pleasant'
'It is not too bad here'.

Patients' Representatives

'The (staff) are very good with (my relative). It's good alright'.

5.2.4. Environment

A general tour of the home was undertaken which included review of a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be reasonably clean, tidy and warm throughout.

Two bed-side tables were observed to be chipped, resulting in the wood being worn and/or exposed. These could not be effectively cleaned in keeping with infection control measures. Following the inspection the registered manager confirmed that an audit of the furniture in the home had been conducted and those that were identified as being in need of replacement were removed from use.

Three commode lids were also observed to be torn, resulting in the foam being exposed. These could not be effectively cleaned in keeping with infection control measures. Equipment provided at the nursing home for use by patients should be in good working order, properly maintained in accordance with the manufacturer's guidance, and suitable for the purpose for which it is to be used. This was discussed with the registered manager, who agreed to remove the commodes on the day of the inspection. The commode decontamination records were reviewed and it was concerning that these did not identify the issues identified. A recommendation was made to ensure that the decontamination records are further developed to ensure that deficits are identified and appropriate action taken in response to specific areas identified for improvement.

Areas for Improvement

Staff should be trained in the delivery of personal care, to ensure that patients are treated with respect and dignity. This refers specifically to patients' personal care and grooming needs.

The regulation 29 monthly monitoring report, should monitor the standard of personal care and grooming of patients accommodated within the home, to ensure that the areas identified in this report are addressed.

Care record audits should be further developed, to ensure that specific areas are identified and follow up action is taken to address the identified deficits.

Decontamination records should be further developed to ensure that deficits are identified and appropriate action is taken in response to specific areas identified for improvement.

Number of Requirements:	**0**	**Number of Recommendations:**	**4**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager and Gerald Burns, Registered Nurse as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 32.1 **Stated:** Second time **To be Completed by:** 29 April 2016	The following policies and guidance documents should be developed and made readily available to staff: • A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the referral procedure for specialist palliative care nurses; the process for notifying RQIA in the event of a death; and management of a sudden or unexpected death. **A copy of the policies should be submitted to RQIA with the returned QIP.** **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: This policy has been completely rewritten to reflect the changes required. This has been made available to staff. Copies of the rewritten policies have been attached to this email.
Recommendation 2 **Ref**: Standard 6.1 **Stated:** First time **To be Completed by:** 29 April 2016	Staff should be trained in the delivery of personal care, to ensure that patients are treated with respect and dignity. This refers specifically to patients' personal care and grooming needs. **Evidence should be available in the home that the training, in whatever form, has taken place.** **Ref: Section 5.2.1**
	Response by Registered Person(s) Detailing the Actions Taken: Home manager has done training and supervision with care staff to ensure that residents personal care needs are met. The issues raised at the inspection were discussed at a staff meeting and all staff are aware of the areas for improvement

Recommendation 3 **Ref**: Standard 35.7 **Stated:** First time **To be Completed by:** 29 April 2016	The regulation 29 monthly monitoring report should monitor the standard of personal care and grooming of patients accommodated within the home, to ensure that the areas identified in this report are addressed. **Ref: Section 5.2.1**
	Response by Registered Person(s) Detailing the Actions Taken: The regulation 29 monthly monitoring report has been updated so that the standard of personal care and grooming of residents can be addressed.
Recommendation 4 **Ref**: Standard 4.7 **Stated:** First time **To be Completed by:** 29 April 2016	Care record audits should be further developed, to ensure that specific areas are identified and follow up action is taken to address the identified deficits. **Ref: Section 5.2.2**
	Response by Registered Person(s) Detailing the Actions Taken: As well as the full audit which is done every three months. An audit will be done monthly on areas that need improvement. To ensure that all files are kept updated.
Recommendation 5 **Ref**: Standard 46.3 **Stated:** First time **To be Completed by:** 29 April 2016	Decontamination records should be further developed to ensure that deficits are identified and appropriate action is taken in response to specific areas identified for improvement. **Ref: Section 5.2.4**
	Response by Registered Person(s) Detailing the Actions Taken: A section for auditing decontamination has been added to the Home Managers audit to ensure that defected items are identifed for improvement.

Registered Manager Completing QIP	Jeya Patheeksha	**Date Completed**	10/4/16
Registered Person Approving QIP	Elizabeth Lisk	**Date Approved**	10/4/16
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	21/04/2016

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