Valley Nursing Home
Unannounced Follow Up Care Inspection Report
Type of
16 and 17 December 2019
Inspectors: James Laverty, Karen Scarlett, Dermot Walsh Jane Laird and Dermot Parsons

4.0 Inspection summary
An unannounced inspection took place on 16 December 2019 from 09.40 hours to 18.02 hours, and 17 December 2019 from 12.16 hours to 14.30 hours. Following a previous inspection on 31 October 2019, a meeting was held in RQIA on 4 November 2019 with the intention of issuing and Notice of Proposal to Cancel the Registration of the Responsible Individual in respect of Valley Nursing Home (MPS Ltd). At this meeting an action plan was presented and ongoing monitoring arrangements were agreed. As a result the notice was not issued. This inspection forms part of ongoing monitoring arrangements agreed during this meeting.

4.1 Inspection outcome
We also assessed progress with areas for improvement identified since the previous care inspections in order to determine if the home was delivering safe, effective and compassionate care and if the service was well led. Any areas for improvement not reviewed during this inspection have been carried forward for review at a future care inspection.

Significant concerns were identified with regard to: the internal environment; infection prevention and control (IPC); fire safety practices; Control of Substances Hazardous to Health (COSHH) compliance; care delivery; care records; staff interaction with patients; managerial oversight and governance. Following the inspection, a meeting was held on 20 December 2019 in RQIA with the intention of cancelling the registration of Paul Warren-Gray, the Responsible Individual for the Valley Nursing Home (MPS Ltd.), in respect of the Valley Nursing Home under Article 15 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, (the 2003 Order).
The meeting was attended by Paul Warren-Gray, Responsible Individual, Joel Gray, Chief Executive, Vanessa Davis, Director of Care, Quality and Compliance, and Valerie Atcheson, Management Consultant. RQIA was advised during the meeting of some actions which had been taken immediately and others which were being proposed in relation to the deficits highlighted during this inspection. However, during the meeting RQIA did not receive the necessary assurance required. RQIA decided to issue a Notice of Proposal (NOP) to Cancel the Registration of the Responsible Individual (MPS Ltd) in respect of Valley Nursing Home.

RQIA informed relevant stakeholders including the Trusts, Health and Social Care Board and the Department of Health following the inspection and continue to liaise with them during this process.

Regulations		**Standards**	
Total number of areas for improvement	23*		10*

Unannounced Follow Up Care Inspection Report
15 January 2020

Inspector: Laura O'Hanlon

An unannounced inspection took place on 15 January 2020 from 13.00 to 14.00 hours. The inspection was carried out following information received by RQIA that neither the current acting manager of the home nor the proposed new manager, were appropriately registered with the Nursing and Midwifery Council (NMC). As a result neither individual could be the manager for the home under the relevant legislation and standards.

4.2 Action/enforcement taken following the most recent inspection dated 16 and 17 December 2019

Following an inspection on 16 and 17 December 2019 significant concerns were identified in relation to the quality of care and service delivered at Valley Nursing Home. As a result and meeting was held at RQIA on 20 December 2019 which resulted in the issue of a Notice of Proposal to Cancel the Registration of the Responsible Individual, Mr Paul Warren-Gray in respect of the Valley Nursing Home (MPS Ltd).

Regulations		**Standards**	
Total number of areas for improvement	23*		10*

Unannounced Follow up Care Inspection Report
28 January 2020
Inspectors: James Laverty, Dermot Walsh and Jane Laird

4.0 Inspection summary

An unannounced inspection took place on 28 January 2020 from 09.25 to 17.00 hours. The inspection was carried out following information received by RQIA duty desk. The issues highlighted raised concerns relating to some aspects of care delivery to patients, the internal environment, staffing arrangements and staff practices.

Following an inspection on 16 and 17 December 2019 significant concerns were identified in relation to the quality of care and service delivered at Valley Nursing Home. As a result a meeting was held at RQIA on 20 December 2019 which resulted in the issue of a Notice of Proposal to Cancel the Registration of the Responsible Individual, Mr Paul Warren-Gray in respect of the Valley Nursing Home (MPS Ltd). The inspection sought to provide assurances that patients were receiving safe and effective care. Shortfalls were found in regard to some aspects of care delivery to patients, patients' care records and staff facilities and three new areas for improvement were made. These are discussed further in section 6.2.

4.1 Inspection outcome

Following an inspection on 16 and 17 December 2019 significant concerns were identified in relation to the quality of care and service delivered at Valley Nursing Home. As a result a meeting was held at RQIA on 20 December 2019 which resulted in the issue of a Notice of Proposal to Cancel the Registration of the Responsible Individual, Mr Paul Warren-Gray in respect of the Valley Nursing Home (MPS Ltd). The inspection sought to provide assurances that patients were receiving safe and effective care.

Shortfalls were found in regard to some aspects of care delivery to patients, patients' care records and staff facilities and three new areas for improvement were made. These are discussed further in section 6.2.

Regulations		**Standards**	
Total number of areas for improvement	*23		*13

6.2 Inspection findings

Staffing arrangements / staff training

Following our arrival, we noted that Lorraine Cozma, manager, was in overall charge of the home with designated nurses in charge of each individual unit. Discussion with the manager further confirmed that contingency measures were in place to manage short notice sick leave when necessary; the manager stated that these measures had been followed on the morning of the inspection to address the absence of one staff member who was reportedly unable to arrive for duty due to inclement weather conditions. Discussion with staff and patients provided assurances that they had no concerns regarding staffing levels.

However, feedback from the manager and nursing staff highlighted one occasion during the previous week when a nurse had assumed responsibility for being in charge of the entire home; we confirmed that there was no relevant competency and capability assessment in place for this staff member. An area for improvement was stated for a third and final time. The manager has subsequently informed RQIA that a competency and capability will be in place for all nurses assuming overall responsibility for the home, by 14 February 2020.

Discussion with nursing staff within one unit highlighted that they possessed a limited and inadequate understanding of how to manage patients who may experience an epileptic seizure.

This was discussed with the manager and it was agreed that epilepsy management training should be provided as a priority to any nursing staff prior to them assuming responsibility for the care of such patients. This will be reviewed at a future care inspection.

Care delivery / care records

We observed care delivery in all the units within the home and generally the care was delivered in a timely manner. There was a delay with the serving of breakfast in Tullybroom House due to staff having to deal with an acutely unwell patient. Appropriate contingency measures were put in place to manage this.

Staff interactions with patients were observed to be compassionate and caring across all units within the home. However, we observed one patient being assisted with mobilising in an undignified manner within a communal area and immediately brought this to the attention of management. An area for improvement was stated for a second time.

The manager informed us that the home's electronic system (Person Centred Software, PCS) which had previously been used for maintaining patients' care records, had now been replaced by hard copy records, some of which had been used prior to the introduction of PCS. However, review of patients' care records evidenced that this transition had not been fully achieved by staff. This was discussed with the manager who stated that all patients had now been appointed a 'Named Nurse' and that nursing staff were being given additional supernumerary hours in order to fully update patients' hard copy records. Following the inspection, the manager submitted an action plan which outlined that all patients' care records would be updated no later than 3 April 2020 with care plans up to date within one week of the this inspection.

Review of the care records for three patients highlighted that daily care entries lacked sufficient detail with regard to the delivery of care and events and that identified care plans were not personalised. We noted inconsistences between what we read in two patients' care plans and staff feedback in relation to the patients' preferred time to rise from/retire to bed. The manager acknowledged the above deficits and agreed to

communicate with relevant staff regarding the importance of accurately documenting within patient care records. An area for improvement was made in relation to the management of patients' rising/retiring preferences.
A sample of dietary/fluid intake charts were reviewed which evidenced that there were inconsistencies in relation to the recording of the dietary type/fluid consistency and recommended daily fluid target to direct relevant care.
Discussion with staff and review of the repositioning records for one identified patient also highlighted a number of deficits, namely:
 conflicting information in risk assessment/care plans
 undated and unsigned amendments to current care plans
 insufficient detail and direction within care plans regarding the repositioning of the patient
 supplementary repositioning records completed poorly/inconsistently
 poor/inconsistent awareness among staff regarding the patient's repositioning needs
 ineffective communication between nursing and care staff in relation to repositioning of the patient

Due to these shortfalls, an area for improvement was stated for a second time. Following the inspection, the manager confirmed that the repositioning of patients would be closely monitored as part of her 'Daily walkabout' and that further training would be provided to staff in this area.
We also found that there were gaps within continence care records where a patient's hygiene needs had not been attended as per recommendations made within the care plan. An area for improvement was made.
The care records for one patient who required assistance with a modified diet were reviewed. Comprehensive and detailed risk assessments and care plans were in place; there was also clear evidence of ongoing collaboration with the multiprofessional team in regard to managing the patient's dietary needs.

General Environment
A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms, laundry, kitchen and storage areas. The home was found to be warm and fresh smelling throughout. However, while there was evidence of redecoration/refurbishment in some parts of the home, other areas remain drab in appearance and require further improvement. This was discussed with the manager who confirmed that an ongoing refurbishment plan remains in effect. The progress of this plan will be reviewed at a future care inspection. The manager also agreed to keep RQIA regularly updated as various improvements are made to the environment.
Discussion with kitchen staff highlighted that one fridge was currently not working although this had been reported to management and had not adversely impacted the kitchen routine. The manager confirmed that this matter was being addressed.
Discussion with the manager/staff highlighted that at present, staff do not have access to an appropriate area within the home in which to change and/or enjoy break periods. While it was noted that there is a designated part of the home for this, the manager confirmed that it was not currently fit for purpose. Staff told us that they typically take their breaks within communal areas for patients and would change into/out of their uniforms within staff toilet facilities. An area for improvement was made.

Infection prevention and control (IPC)
A number of infection prevention and control deficits were identified in relation to the cleanliness of furniture/equipment within patients' bedrooms and communal toilets.

Identified bed rail protectors and bed linen evidenced that these had not been effectively cleaned following use and dust was evident to ceiling fans which had not been included in any of the cleaning schedules. We also found that one patient commode had been ineffectively cleaned and was visibly stained. The above issues were discussed with the manager who provided assurances that these issues would be addressed and that the cleaning of ceiling fans would be included in the cleaning schedule and monitored during the environmental audits. An area for improvement was stated for a third and final time.

We also reviewed the laundry area and identified damaged areas within the floor surface that could not be effectively cleaned. We further identified that the hand paper towels were positioned at the opposite side of the laundry from where the wash hand basin was situated. This was discussed with the manager who agreed to review the hand washing facilities and stated that a new floor covering had already been ordered for the laundry.

Managerial oversight / governance arrangements

We were informed by the acting manager that Sheila O'Donaghue had been appointed as the new home manager, but was still awaiting registration with the Nursing and Midwifery Council. As such, the acting manager confirmed that she continues to have operational responsibility for the running of the home at present. In addition, the manager stated that she continue to be supported in her role by Mark Laight, Operations Director, on a regular basis.

A review of records submitted during and following the inspection evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. It was agreed that these would continue to be submitted to RQIA for review on an ongoing basis as previously agreed with the responsible individual on 4 November 2019.

The manager informed us that systems were in place to help drive improvement and quality assure care delivery to patients. However, review of care record audits highlighted that these were either incomplete and/or inaccurate. An area for improvement was stated for a second time.

Discussion with the manager and review of governance records highlighted that while there was a tool in place for reviewing the nursing dependency of patients, the completion of this was intermittent and insufficiently robust. The manager confirmed following the inspection that the dependency of patients would be reviewed on at least a monthly basis from now on.

Areas for improvement

Three new areas for improvement were highlighted in relation to care planning, the management of patients' continence/hygiene needs and staff facilities.

Valley
Announced Follow up Care Inspection Report
4 March 2020

Inspector: Jane Laird, Elaine Connolly and Lyn Buckley

4.0 Inspection summary
A short notice announced inspection took place on 4 March 2020 from 10.45 hours to 13.45 hours.
The purpose of the inspection was to meet with Health Care Ireland Ltd (HCI Ltd) management team who are currently operating the home on behalf of the current provider and who have applied for registration of the Valley Nursing Home. Mr Paul Warren-Gray, the responsible individual for the Valley Nursing Home (MPS Ltd) has applied to cancel his registration. A previous Notice of Proposal to cancel registration, issued on 27 December 2019 was lifted on 30 January 2020 as RQIA were assured that actions had been taken to mitigate any risk to patients.

4.2 Action/enforcement taken following the most recent inspection dated 28 January 2020
The inspection sought to provide assurances that patients were receiving safe and effective care during this transition period and to monitor progress with the homes action plan.
During this inspection we were able to evidence positive progress in developing and implementing new systems within the home. This included a review of the management structure, staff training, assessment of staff competency; and governance arrangements to assure the quality of patient care and other services provided by the nursing home.
Evidence of good practice was found in relation to staffing, communication with patients, relatives and staff, governance arrangements, quality improvement and maintaining good working relationships.
There were no new areas for improvement identified as a result of this inspection.
We saw patients relaxed and comfortable in their surroundings and in their interactions with other patients and with staff.
We spoke with staff on duty who commented positively in respect of the training and support they were receiving from the management team.

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

	Regulations	**Standards**
Total number of areas for improvement	*23	*13