

# Unannounced Follow Up Care Inspection Report 24 May 2018



## Belmont

**Type of Service: Nursing Home (NH)**  
**Address: Parklands Close, 81 Tillysburn Park,  
Belfast, BT4 2PD**  
**Tel No: 028 9076 3408**  
**Inspector: Kieran McCormick**

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 provider 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 nursing home registered to provide nursing care for up to 48 persons.

### 3.0 Service details

<b>Organisation/Registered Provider:</b> Four Seasons Health Care  <b>Responsible Individual:</b> Maureen Claire Royston	<b>Registered Manager:</b> Gillian Finlay
<b>Person in charge at the time of inspection:</b> Gillian Finlay – Registered Manager	<b>Date manager registered:</b> 10 October 2017
<b>Categories of care:</b> Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	<b>Number of registered places:</b> 48

### 4.0 Inspection summary

An unannounced inspection took place on 24 May 2018 from 08.55 to 15.40.

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.

It is not the remit of RQIA to investigate complaints/whistleblowing/adult safeguarding concerns made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, if RQIA is notified of a potential breach of regulations or standards, it will review the matter and take appropriate action as required; this may include an inspection of the home.

The inspection sought to assess progress with issues raised since the last inspection on the 17 April 2018 and following the receipt of further information of concern from the Belfast Health and Social Care Trust.

As a result of the inspection, RQIA was concerned that some aspects of the quality of care and service delivery within Belmont were below the minimum standard expected. A decision was taken to hold an intention to issue a failure to comply notice meeting in relation to the management of nursing care records without which there is an identified risk to the care and treatment of patients. This meeting took place at RQIA on 31 May 2018.

During the intention meeting the responsible individuals acknowledged the failings and provided a full account of the actions and arrangements made to ensure the improvements necessary to achieve full compliance with the required regulation. This included the completion of a detailed

action plan that RQIA were satisfied with, and which provided the necessary assurances required, therefore a decision was made not to serve the failure to comply notice. RQIA have requested that regulation 29 reports, for Belmont, from May 2018 and for the coming three months are forward to RQIA.

A further inspection will be undertaken to validate sustained compliance and drive necessary improvements.

Areas requiring improvement were identified as outlined in the quality improvement plan (QIP). Please refer to section 7.0.

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
<b>Total number of areas for improvement</b>	*3	*4

\*The total number of areas for improvement include one which has been restated for a third and final time, three which have been stated for a second time and which has been carried forward for review at the next care inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Gillian Finlay, registered manager and Janice Brown, regional manager as part of the inspection process. The timescales for completion commence from the date of inspection.

Further inspection is planned to validate compliance and drive improvements.

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

#### 4.2 Action/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced follow up care inspection undertaken on 17 April 2018. Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 17 April 2018.

#### 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
- the registration status of the home
- written and verbal communication received since the previous care inspection which includes information in respect of potential adult safeguarding issues
- the previous care inspection report

- information received from the commissioning Trust

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- seven patient care records
- a review sample of patient care charts including food and fluid intake charts, reposition charts, weights and bowel management records
- governance arrangements
- complaints record
- RQIA registration certificate
- certificate of employers liability
- training records

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 17 April 2017

The most recent inspection of the Belmont was an unannounced follow up care inspection.

The completed QIP was returned and approved by the care inspector.

### 6.2 Review of areas for improvement from the last care inspection dated 17 April 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 14 (2) (a) (c)	The registered persons must ensure that all chemicals are securely stored in keeping with COSHH legislation, to ensure that patients are protected from hazards to their health.	

<b>Stated:</b> Second time	<b>Action taken as confirmed during the inspection:</b> No concerns were identified during this inspection regarding the storage of chemicals in accordance with COSHH legislation.	<b>Met</b>
<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 13 (7)  <b>Stated:</b> First time	The registered persons must ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk and spread of infection.  <b>Action taken as confirmed during the inspection:</b> No concerns regarding infection prevention and control practices were identified on the day of inspection.	<b>Met</b>
<b>Area for improvement 3</b>  <b>Ref:</b> Regulation 12 (1) (a) (b)  <b>Stated:</b> First time	The registered persons must ensure that nursing staff carry out neurological observations of all patients following any actual or potential head injury in keeping with best practice guidelines. Such observations should be recorded within the patients' care records.  <b>Action taken as confirmed during the inspection:</b> Review of care files for three patients who had a suspected or confirmed head injury evidenced that clinical observations had been completed post incident.	<b>Met</b>
<b>Area for improvement 4</b>  <b>Ref:</b> Regulation 19 (1) (b)  <b>Stated:</b> First time	The registered persons must ensure that patients' care records are stored securely at all times.  <b>Action taken as confirmed during the inspection:</b> Care records were observed to be securely stored on the day on inspection.	<b>Met</b>
<b>Area for improvement 5</b>  <b>Ref:</b> Regulation 12 (1) (a)(b)  <b>Stated:</b> Second time	The registered persons must ensure the following in relation to patients receiving wound care: <ul style="list-style-type: none"> <li>• That all patient care plans accurately reflect the prescribed care and treatment which should be delivered in compliance with recommendations made by the multiprofessional care team.</li> <li>• That the delivery of care complies with the</li> </ul>	



	recommendations of the multiprofessional team and relevant care plans at all times. Any decision by nursing staff to deviate from such recommendations must be documented and demonstrate evidence based rationale.	<b>Not met</b>
	<p><b>Action taken as confirmed during the inspection:</b> Care records reviewed did not provide a consistent assurance that they had been accurately and timely updated following the recommendations made by the multiprofessional care team.</p> <p><b>This area for improvement has not been met and will be restated for a third and final time.</b></p>	
<b>Area for improvement 6</b>  <b>Ref:</b> Regulation 12 (2) (a)(b)  <b>Stated:</b> First time	The registered person shall ensure that patients care records accurately reflect the type of mattress required and the prescribed setting for individual patients. Governance arrangements should be established to ensure ongoing compliance with the prescribed settings.	<b>Partially met</b>
	<p><b>Action taken as confirmed during the inspection:</b> Governance arrangements had been established to ensure that the correct setting on mattresses was maintained. However patient care records reviewed did not consistently reflect the type of mattress actually in use.</p> <p><b>This area for improvement has not been met and will be stated for a second time.</b></p>	
<b>Area for improvement 7</b>  <b>Ref:</b> Regulation 12 (1) (a)(b)  <b>Stated:</b> First time	The registered person shall ensure that the weight monitoring requirements for all patients are contemporaneously completed and maintained in accordance with individual care needs.	<b>Met</b>
	<p><b>Action taken as confirmed during the inspection:</b> A review of records evidence that weights had been reviewed within the home and were now being completed in accordance with individual need.</p>	

<b>Area for improvement 8</b>  <b>Ref:</b> Regulation 12 (1) (a)(b)  <b>Stated:</b> First time	<p>The registered person shall ensure that the repositioning needs of each individual patient is accurately carried out and recorded in accordance with their individual plan of care.</p> <p><b>Action taken as confirmed during the inspection:</b> Repositioning records reviewed on the day of inspection evidenced that patients had been repositioned in accordance with their plan of care.</p>	<b>Met</b>
<b>Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</b>		
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 44  <b>Stated:</b> Second time	<p>The registered persons shall ensure that the home environment is well maintained and fit for purpose, specifically in relation to flooring within the designated smoking lounge.</p> <p><b>Action taken as confirmed during the inspection:</b> Observation of the smoking lounge evidenced that the flooring had been replaced.</p>	<b>Met</b>
<b>Area for improvement 2</b>  <b>Ref:</b> Standard E8  <b>Stated:</b> First time		
	<p>The registered persons shall ensure that patients have effective access to the nurse call system, specifically those patients seated within communal lounge areas and those patients being cared for in bed.</p> <p><b>Action taken as confirmed during the inspection:</b> Observation throughout the home evidenced that nurse call bells were available for patient use. Patients in their rooms were observed with the nurse call at their side; patients were also able to explain how they would use the system to call for assistance.</p>	<b>Met</b>
<b>Area for improvement 3</b>  <b>Ref:</b> Standard 39  <b>Stated:</b> First time		
	<p>The registered person shall ensure that training is provided to all relevant staff on the use of specialist pressure relieving mattresses and pumps.</p> <p><b>Action taken as confirmed during the inspection:</b> Training records reviewed evidenced that training had been provided to a total of 36 staff. Staff who had not attended training had received supervision or alternative arrangements had been made to ensure they</p>	<b>Met</b>



	understood their responsibilities with regards to the use of pressure relieving mattresses and pumps.	
<b>Area for improvement 4</b> <b>Ref:</b> Standard 4 <b>Stated:</b> First time	The registered person shall ensure that patients care records must only contain the current and live plan of care for the identified area of need.	<b>Not met</b>
	<b>Action taken as confirmed during the inspection:</b> Care records reviewed identified significant gaps in the consistent evaluation and review of individual patient care and treatment.  <b>This area for improvement has not been met and will be stated for a second time.</b>	
<b>Area for improvement 5</b> <b>Ref:</b> Standard 35.7 <b>Stated:</b> First time	The registered person shall ensure that following completion of any audit that where a shortfall/action has been identified a corresponding action plan is implemented to address this.	<b>Partially Met</b>
	<b>Action taken as confirmed during the inspection:</b> A review of records did not provide sufficient evidence that all required audits had been consistently completed and that a corresponding action plan had been completed.  <b>This area for improvement has not been met and will be stated for a second time.</b>	

### 6.3 Inspection findings

The inspection sought to validate the areas for improvement identified at the inspection on 17 April 2018. Whilst a high percentage of areas for improvement were compliant there were significant concerns around the following. On the day of inspection there were 38 patients in the home. A number of concerns were identified in relation to the following:

The inspector reviewed the care records for seven patients within the home. Significant concerns were identified regarding the accurate completion and the review/evaluation of patient care records. Three patients' records for pressure relieving mattresses were incorrectly documented and recorded the wrong type of mattress in use. An area for improvement has been stated for a second time.

Two sets of patient care records failed to evidence that care being provided was in keeping with the patients' current needs. Multiple care plans for one patient had not been updated since October 2017. For the same patient there were two different recordings for nutritional assessment on file with the last assessment having been completed in March 2018. There were similar findings evidenced in another patient's records with an absence of care reviews for the past six months and an absence of risk assessments for the past three months. The last audits of these patients care files was requested but was unable to be provided to the inspector. An area for improvement under the regulations, was made.

One care record also failed to be appropriately updated following a change of dressings prescribed by the multi professional team. The nursing care plan had not been updated to reflect the change. The staff nurse had then put a note stating "reviewed by TVN today, improvement continues carry on with current regime", this was a conflicting statement given that the regime had actually been changed. An area for improvement has been restated for a third time.

Care records for a patient admitted to the home in April 2018, had no care plans or assessments devised to support the patient's psychological and emotional needs. An area for improvement under the standards, was made.

The inspector reviewed the bowel management records for seven patients. For one patient, who was independent with elimination needs, there was a gap in recording of 17 days and for two other patients a gap of four days. In each case there was no evidence of action taken to address the gaps. An area for improvement under the standards, was made.

### Areas for improvement

Three areas for improvement have been made regarding the completion and the updating and evaluation of individual care records.

	Regulations	Standards
<b>Total number of areas for improvement</b>	1	2

## 7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Gillian Finlay, registered manager and Janice Brown, regional manager, 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 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 DHSSPS 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 via Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 12 (1) (a)(b)  <b>Stated:</b> Third time  <b>To be completed by:</b> With immediate effect	<p>The registered persons must ensure the following in relation to patients receiving wound care:</p> <ul style="list-style-type: none"> <li>• That all patient care plans accurately reflect the prescribed care and treatment which should be delivered in compliance with recommendations made by the multiprofessional care team.</li> <li>• That the delivery of care complies with the recommendations of the multiprofessional team and relevant care plans at all times. Any decision by nursing staff to deviate from such recommendations must be documented and demonstrate evidence based rationale.</li> </ul> <p>This matter is stated for a third and final time.</p> <p><b>Ref: Section 6.3</b></p>
	<p><b>Response by registered person detailing the actions taken:</b>            Staff have been reminded to ensure that following any visit from MDT that they check the MDT written notes to ensure that current Care plan in place meets current recommendations.            Staff have been reminded to ensure that they evidence changes of care that have been received over the telephone.            Spot checks to be carried out by Manager and RM to ensure compliance.            Written communication has been left in the Care Files for the attention of the podiatrist to ensure that they verbally inform the nurses of any dressing change and/or any change of dressing regime.            Home Manager/Nurse in charge receives a hand over report from TVN following each visit. Changes to be recorded in shift report.</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 12 (2) (a)(b)  <b>Stated:</b> Second time  <b>To be completed by:</b> With immediate effect	<p>The registered person shall ensure that patients care records accurately reflect the type of mattress required and the prescribed setting for individual patients. Governance arrangements should be established to ensure ongoing compliance with the prescribed settings.</p> <p><b>Ref: Section 6.3</b></p>
	<p><b>Response by registered person detailing the actions taken:</b>            Care plans have been reviewed and if required updated with mattress settings.            Guidance has been sought from BHSCT NHST regarding Trust supplied autologic Mattress.            Supervision is being carried out with all staff to ensure they fully</p>

	understand what information is required on the plan of care. The mattress settings are now being checked and documented as meeting plan of care twice daily at each visual hand over report.
<b>Area for improvement 3</b>  <b>Ref:</b> Regulation 16 (2)(b)  <b>Stated:</b> First time  <b>To be completed by:</b> With immediate effect	<p>The registered person shall ensure that the care plans and assessments for all patients are reviewed and evaluated at least monthly or more frequently if required.</p> <p><b>Ref: Section 6.3</b></p> <p><b>Response by registered person detailing the actions taken:</b> Each Primary nurse has a report to complete on a monthly basis to return to the Home Manager with the dates of care plan and assessment reviews. The Home Manager will carry out spot checks to monitor this.</p>
<b>Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 4  <b>Stated:</b> Second time  <b>To be completed by:</b> With immediate effect	<p>The registered person shall ensure that patients care records must only contain the current and live plan of care for the identified area of need.</p> <p><b>Ref: Section 6.3</b></p> <p><b>Response by registered person detailing the actions taken:</b> All wound Care and Pressure area care files were reviewed to ensure no duplicates were in file. Supervision sessions to take place with RN staff to reinforce the importance of only keeping relevant documentation in the care files.</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 35.7  <b>Stated:</b> Second time  <b>To be completed by:</b> With immediate effect	<p>The registered person shall ensure that following completion of any audit that where a shortfall/action has been identified a corresponding action plan is implemented to address this.</p> <p><b>Ref: Section 6.3</b></p> <p><b>Response by registered person detailing the actions taken:</b> Using the QOL system if any deficit or short fall is identified by audit this automatically generates an action to be addressed. The Manager must input the action taken to improve / fix the shortfall before it can be closed. Compliance will be monitored via the Rm during the Reg 29 visit.</p>

<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Standard 4</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> With immediate effect</p>	<p>The registered person shall ensure that a detailed and hollistic plan of care is generated for each patient and completed within five days of admission to the home.</p> <p><b>Ref: Section 6.3</b></p> <hr/> <p><b>Response by registered person detailing the actions taken:</b> All nursing staff are aware of Four Seasons Policy on documentation and time scales for completion. Nursing Staff should adhere to the NMC code record keeping. RM and Home Manager to carry out audits on new admission care profiles.</p>
<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Standard 4</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> With immediate effect</p>	<p>The registered person shall ensure that a robust and individualised system is established for the bowel management of patients in the home. Evidence should also be retained of active measures taken to address gaps in bowel activity.</p> <p><b>Ref: Section 6.3</b></p> <hr/> <p><b>Response by registered person detailing the actions taken:</b> Each resident has a supplementary chart with a record of bowel pattern. Care plans are in place for residents who have specific requirements for bowel care.</p>

*\*Please ensure this document is completed in full and returned via Web Portal*





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