Unannounced Care Inspection Report
14 February 2019

Comber Care Home

Type of Service: Nursing Home (NH)
Address: 17 Castle Street, Comber, BT23 5DY
Tel No: 028 9187 8200
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 72 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual(s):** Dr Maureen Claire Royston	**Registered Manager:** Anne Robertson
Person in charge at the time of inspection: Anne Robertson – registered manager	**Date manager registered:** 28 May 2014
Categories of care: 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.	**Number of registered places:** 72

4.0 Inspection summary

An unannounced inspection took place on 14 February 2019 from 10.00 to 15.00 hours.

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.

During this inspection we identified evidence of good practice in relation to the management of notifiable events, adult safeguarding, infection prevention and control (IPC) practices, falls management, care delivery, team work, and communication between patients, staff and other key stakeholders. Further areas of good practice were identified in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients, governance arrangements, monthly monitoring visits, quality improvement and maintaining good working relationships.

Patients described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. There was evidence that the management team listened to and valued patients and their representatives and taking account of the views of patients.

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
Total number of areas for improvement	1	0

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Anne Robertson, registered 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.

4.2 Action/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 7 October 2018. Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection 7 October 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
- written and verbal communication received since the previous care inspection
- the registration status of the home
- returned QIP's from the previous care inspection
- report from the previous care inspection
- pre-inspection audit.

During the inspection we met with four patients, six staff and one student. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten patients' questionnaires and ten patients' relatives/representatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. We provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision. A poster informing visitors to the home that an inspection was being conducted was displayed on the front door of the nursing home.

The following records were examined during the inspection:

- duty rota for all staff for weeks beginning 4 and 11 February 2019
- incident and accident records
- a sample of governance audits
- three patient care records
- RQIA registration certificate

- certificate of employer's liability insurance
- two staff recruitment files.
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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 7 October 2018

The most recent inspection of the home was an unannounced 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 7 October 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 44 **Stated:** Second time	The registered person shall ensure that a review of the storage arrangements in the home is carried out and that equipment not in use is appropriately and safely stored at all times.	**Met**
	Action taken as confirmed during the inspection: Observations throughout the home confirmed that equipment in use or equipment no longer in use was appropriately and safely stored.	

6.3 Inspection findings

6.3.1 Registration

The certificate of registration issued by RQIA was appropriately displayed in the home. The registered manager was knowledgeable in regards to the registered categories of care for the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered. Since the last inspection there has been no change of management arrangements for the home.

6.3.2 Governance

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager had a system in place for the monitoring and oversight of staff mandatory training. Review of records confirmed that the registered manager had a system in place to monitor the registration of staff with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council.

The registered manager demonstrated to the inspector the programme of audits in place to ensure governance and oversight of the home. A sample of audits were reviewed, comments or actions completed as part of the audit were recorded and the audits had been signed by the registered manager.

6.3.3 Environment and infection prevention and control

At the commencement of inspection we identified that entrance and egress from the home was controlled by a keypad, this had not been the case at previous inspections. This was discussed with the registered manager who provided a clear rationale for the current arrangement and advised that this was temporary. Prior to the conclusion of the inspection the code to egress the home was appropriately displayed, the registered manager agreed to update the inspector post inspection of when the current arrangement would be ceased.

An inspection of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, storage areas and dining room. Discussion with laundry staff and observation of the laundry area evidenced that clothing was labelled for individual patient use. Patients' bedrooms, lounges and dining rooms were found to be warm and comfortable. The home was fresh smelling and tidy throughout. We identified that laundry skips throughout the home were in a state of disrepair, this was discussed with the registered manager who agreed to ensure replacements were sought.

6.3.4 Staffing

A review of the staff duty rota for weeks beginning the 4 and 11 February 2019 evidenced that the planned staffing levels remained consistent, kept under review and appropriate to meet the current needs of patients in the home.

6.3.5 Patient experience

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

At the time of writing this report, there were six questionnaires returned from an unknown source. Responses from all questionnaires indicate a response of being very satisfied across the four domains of safe, effective, compassionate and well led care. A comment made on one questionnaire stated:

"….happy, no problems".

Questionnaire comments received after specified timescales will be shared with the registered manager, as necessary.

6.3.6 Care records

We reviewed the care records for three patients within the home. Records reviewed evidenced that for two of the patients who had recently been admitted to the home care records had been completed at or soon after admission. Relevant risk assessments had also been completed and referrals made to other professionals where required. We reviewed the care records for another patient who required wound care input. The care plan for the management of the wound had not been updated to reflect the current required frequency for changing the wound dressing. In addition, two recent occasions were the wound had been redressed; the wound assessment documentation and wound evaluation/progress records had not been completed. This was discussed with the registered manager and an area for improvement under the regulations was made.

6.3.7 Recruitment and selection

We reviewed the recruitment and selection records for two staff. Records reviewed evidenced that recruitment of staff was carried out in accordance with regulations; however for one of the files reviewed a clear explanation of the staff member's employment history had not been sought. This was discussed with the registered manager and the administrator who agreed to address.

Staff were asked to complete an online survey; we had no completed responses within the timescale specified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the environment, governance arrangements, staffing, dignity and privacy, staff knowledge of patients' wishes, preferences and assessed needs.

Areas for improvement

An area for improvement was identified regarding the completion of patient wound care documentation.

	Regulations	Standards
Total number of areas for improvement	1	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Anne Robertson, registered 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	
Area for improvement 1 **Ref:** Regulation 12(1)(a)(b) **Stated:** First time **To be completed by:** Immediate action required	The registered persons shall ensure the following in relation to patients receiving wound care: • That all patient care plans accurately reflect the prescribed care and treatment which should be delivered in compliance with recommendations made by the multi-professional care team. • That all records pertaining to the management of wound care are accurately and contemporaneously maintained. Ref: 6.3.6
	Response by registered person detailing the actions taken: All registered nurses have received a supervision with regards to the recording and maintaining of care documentation. The unit sisters have been requested at a clinical governance meeting to ensure that all care plans and supporting documentation are accurate and in line with the recommendations of the multidisciplinary teams. Quality of Life System is maintained to ensure regular auditing of care files by the Home Manager.

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

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