The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
19 April 2016

Dunlady House

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Tel No: 02890481002
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Dunlady House took place on 19 April 2016 from 09.40 to 16.20 hours.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices and staff training and development. The arrangements in place to confirm and monitor staff registration status with their professional bodies were reviewed. Through discussion with staff were we assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. There were systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A general inspection of the home confirmed that the premises and grounds were well maintained with no obvious hazards to the health and safety of patients observed. There were no issues observed with infection prevention and control practices.

One area of improvement was identified with the current record of the competency and capability assessment completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. A recommendation was stated.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that that the outcome of care delivery was positive for patients. A review of care records confirmed that patients were subject to a comprehensive assessment of need which was then used to develop appropriate care plans. There was evidence to confirm that there was regular communication with patients and their relatives regarding their care. There were arrangements in place to monitor and review the effectiveness of care delivery. Patients, relatives and staff reported that they were happy with the care they received. We examined the systems in place to promote communication between staff, patients and relatives and were assured that these systems were effective.

There were no areas of improvement identified in the delivery of effective care.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff were also observed to be taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding day to day issues affecting them. Patients spoken with commented positively in regard to the care they received.

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure evidenced within Dunlady House and staff were aware of their roles and responsibilities. A review of care confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

There was evidence of good leadership in the home and effective governance arrangements. Staff spoken with were knowledgeable regarding the line management structure within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. There were systems in place to monitor the quality of the services delivered.

One area for improvement was identified with the record of complaints. A recommendation was stated.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	1

Details of the QIP within this report were discussed with Ms Femina Marmeto, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an announced estates inspection undertaken on 8 September 2015. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents, potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Dunlady House Ltd William Hugh Wilson	**Registered manager:** Femina Marmeto
Person in charge of the home at the time of inspection: Femina Marmeto	**Date manager registered:** 17 February 2016
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 68

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 nine patients individually and with the majority in small groups, three registered nurses, two care staff and two patient's relatives.

The following records were examined during the inspection:

- five patient care records
- staff duty roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- reports of monthly visits 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

The most recent inspection of the home was an unannounced estates inspection undertaken on 8 September 2015. The completed QIP was returned and approved by the estates inspector and will be validated at the next estates inspection. There were no areas of concern required to be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 1 July 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 (2) **Stated:** Second time	The registered person shall ensure that the assessment of the patient's needs is (a) kept under review; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. • pain assessments must be utilised for any patient prescribed regular or occasional analgesia	**Met**
	Action taken as confirmed during the inspection: A review of four care records evidenced that pain assessments were completed for patients prescribed regular or occasional analgesia. The assessments viewed were subject to regular review. This requirement has been met.	

<table>
<tr><th colspan="2">Last care inspection recommendations</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 36

Stated: First time</td><td>It is recommended that the registered manager review and update the following policies;

• the communication policy should reference the regional guidance on ‘breaking bad news’
• the palliative care / end of life care policy should be expanded to include reference to the GAIN Palliative Care Guidelines November 2013, regional guidance on breaking of bad news and the use of a palliative care link nurse.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The policy Care of the Dying was available in the home and was reviewed during the inspection; the communication policy and palliative and end of life care policy were received by electronic mail after the inspection. All of the policies reviewed had been reviewed and updated following the previous inspection and referenced best practice guidance. This recommendation has been met.</td></tr>
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Recommendation 2 **Ref**: Standard 21 **Stated:** First time	It is recommended that the registered manager ensures that; • care plans are updated appropriately following directions from the multi professional team • risk assessments should be updated monthly in line with the home's policy • the assessment of daily living should be updated as the patient's health changes and at least annually • patient's vital signs observations should be maintained monthly in line with the home's policy.	**Met**
	Action taken as confirmed during the inspection: Care plans reviewed included recommendations made by healthcare professionals. Risk assessments were reviewed monthly. The assessment of daily living needs examined were all completed or reviewed within the past 12 months. Care records evidenced that patient's vital signs observations were recorded monthly. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 37 **Stated:** First time	It is recommended that the registered manager ensures that; The patients nursing care records are maintained centrally in an accessible format which enables easy retrieval of information.	**Met**
	Action taken as confirmed during the inspection: Care records were maintained individually for each patient; the records were well organised with the information easy to review. This recommendation has been met.	

Recommendation 4 **Ref**: Standard 35 **Stated:** First time	It is recommended that the registered manager ensures that; An effective file audit is developed and maintained in respect of the patient's nursing care records.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that regular audits of care records were included in the programme of audits undertaken monthly. This recommendation had been met.	
Recommendation 5 **Ref**: Standard 41 **Stated:** First time	It is recommended that the registered manager ensures that; A minimum skill mix of at least 35% registered nurses and up to 65% care assistants is maintained over 24 hours.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of staff rosters evidenced that the provision of registered nurses to ensure there are sufficient staff to meet the needs of the patients had been increased following the previous inspection. Observations made during this inspection and discussion with staff and patients evidenced that patients' needs were being met with the current provision of registered nurses. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 18 April 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic and laundry staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients commented positively regarding the staff and care delivery.

The registered manager and registered nurses spoken with were aware of who was in charge of the home when the registered manager was off duty. The nurse in charge was clearly identified on the staffing roster. A review of records evidenced that a competency and capability assessment had been completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessment in use at the time of the inspection listed the general areas for assessment; for example untoward incidents, safeguarding adults. There was no detail of what information had been discussed or what knowledge had been assessed. Each assessment was signed on completion by the registered nurse and the person completing the assessment. The registered manager explained that when the assessment was complete they met individually with each registered nurse to ensure they fully understand the role they are undertaking. Following this meeting the registered manager would sign the assessment to confirm that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

The benefit of recording the detail of what was assessed under each heading and the recording of signatures against each area was discussed with the registered manager and a recommendation stated.

Discussion with the registered manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed. The registered manager was knowledgeable regarding the management of the Northern Ireland Social Care Council (NISCC) registration process for newly employed care staff.

A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.

Discussion with staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The programme included a written record of the areas completed and the signature of the staff member and the person supporting the new employee. On completion of the induction programme the registered manager signed the record to confirm that the induction process had been satisfactorily completed.

The registered manager explained that as learning styles varied between staff, training was delivered in a variety of formats. Training was available via an e learning system and internal face to face training arranged by the home. Training opportunities were also provided by the local health and social care trust. The registered manager had systems in place to monitor staff attendance and compliance with training. These systems included a print out of which staff had completed an e learning training, signing in sheets to evidence which staff had attended face to face training in the home and a copy of any certificates of attendance issued to staff who attended training outside of the home.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses, care staff and domestic staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for improvement

The current competency and capability assessment completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager should be further developed to include greater detail of what is assessed under each heading. The signatures of the registered nurse and the person completing the assessment should be recorded against each area.

Number of requirements	0	Number of recommendations:	1

4.4 Is care effective?

A review of three patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information. A comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home. As previously discussed a range of validated risk assessments were completed as part of the admission process.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Care records were regularly reviewed and updated, as required, in response to patient need. Patient confidentiality in relation to the storage of records was maintained.

There was evidence within the care records that patients and/or their representatives were involved in the care planning process. There was also evidence of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with the registered manager and 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. Observation of a handover report in the afternoon confirmed that the shift handover provided information regarding each patient's condition and any changes noted. The handover also included the daily staffing and any administrative tasks to be completed.

The registered manager confirmed that staff meetings were held regularly, and staff were enabled to contribute to the agenda. The most recent meeting was held on 12 April 2016; the minutes of this meeting were still in note form. The previous meeting was held on 16 December 2015. The signatures of the staff who attended, issues discussed and any agreed outcomes were recorded. The record of each meeting was made available to staff.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the registered manager.

Ten relative questionnaires were issued; seven were returned prior to the issue of this report. All of the respondents indicated that they were very satisfied or satisfied with the delivery of safe, effective and compassionate care and that the home was well led.

One respondent expressed dissatisfaction with how the service was meeting their relative's toileting needs. They were very satisfied with all other aspects of care. The comment in this questionnaire was shared with the registered manager who agreed to review the issue further to ensure that patients' personal needs were being met.

Ten questionnaires were issued to nursing, care and ancillary staff; six were returned prior to the issue of this report. All of the staff were very satisfied or satisfied with the delivery of safe, effective and compassionate care. One respondent included comments regarding the management of staff and communication within the home. These were shared with the registered manager.

Areas for improvement

No areas for improvement were identified in the delivery of compassionate care during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.5 Is care compassionate?

Throughout the inspection there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Patients were sitting in the lounges, or in their bedroom, as was their personal preference.

Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

An activity session making decorations to commemorate Queen Elizabeth II birthday took place in the main lounge in the afternoon. Patient participation varied from those who could take an active role in activities to those engaged in talking about the activity to patients who were observers. Patients commented that they enjoyed the activities provided. Patients who chose to spend their days in their room confirmed that they were aware of what activities were taking place and that they could join in if they wished.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. A quality assurance questionnaire is sent out annually to relatives of each patient. These were last sent in January 2016. The registered manager explained that, currently, the results were being prepared for inclusion in the annual quality report for the period April 2015 to March 2016; a copy of this report is provided to each patient. We discussed what action would be taken if areas for improvement were identified in the returned responses. The registered manager explained that they would record these as complaints and, if they were not attributed to an identified patient, they would address the issues generally. The action taken would also be included in the annual report.

The registered manager confirmed that they have regular, daily contact with the patients and visitors and were available throughout the day, and some evenings, to meet with both on a one to one basis if needed. Patients and relatives spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

“I find Dunlady to be a happy, well run home and well-staffed nursing home where my mother’s needs are taken care of and she feels at home.”

“Dunlady is a place of joy in spite of the difficult health issues of the residents.”

“Everyone fantastic, very kind and caring.”

Relatives spoken with confirmed that they were made to feel welcome into the home by all staff. They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

Areas for improvement

No areas for improvement were identified in the delivery of compassionate care 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. The Statement of Purpose and Patient Guide were available in the home.

Staff spoken with were knowledgeable regarding line management and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients and their representatives confirmed that they were confident that staff and /or management would address any concern raised by them appropriately. Patients were aware of who the registered manager was.

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint, details of the investigation and the outcome. The records did not reflect the how the registered manager concluded that the complainant was satisfied that the complaint was resolved. A recommendation was stated to further develop the complaints record to include this information.

There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

As previously discussed there were systems in place to ensure that notifiable events were investigated as appropriate and reported to the relevant bodies. The registered manager completed a monthly analysis of falls to identify any trends or patterns.

There was a process in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to staff.

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included care records, falls and the admission process. A review of the record of audits evidenced that where an area for improvement was identified the evidence of re-audit to check that the required improvement was not robust. Following discussion it was agreed that the registered manager would review the current audit template to include greater evidence of service improvement through re-audit.

Communication between the registered person and registered manager was discussed. The registered manager explained that an electronic management system was in place which was accessible to the registered person and directors of the company. The management system was used to record human resource issues, for example return to work interviews, to communicate day to day operational issues, for example estates issues. The registered manager also recorded complaints and staff meetings on the system for ease of access for the registered person.

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any identified areas for improvement. The importance of ensuring that all areas identified are followed up and commented on was discussed.

Areas for improvement

The record of complaint did not reflect how the registered manager concluded that the complainant was satisfied with the outcome of the investigation and the action taken. A recommendation was stated to further develop the complaints record to include this information.

Number of requirements	0	Number of recommendations:	1

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Femina Mermeto, Registered Manager 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the 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 by the registered manager. 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 establishment. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/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 person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the establishment.

Quality Improvement Plan

No Requirements are stated as a consequence of this inspection.	
Recommendations	
Recommendation 1 **Ref**: Standard 41.7 **Stated:** First time **To be completed by:** 14 June 2016	It is recommended that the record of the competency and capability assessment completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager, is further developed to include greater detail of what is assessed under each heading. The signatures of the registered nurse and the person completing the assessment should be recorded against each area.
	Response by registered person detailing the actions taken: Attached revised new competency and capability form. Completed nurse in charge competency and capability assessment for 2016.
Recommendation 2 **Ref**: Standard 16.11 **Stated:** First time **To be completed by:** 14 June 2016	It is recommended that the record of complaint is further developed to include the evidence used by the registered manager to conclude that the complainant was satisfied with the outcome of the investigation and the action taken.
	Response by registered person detailing the actions taken: Attached copy of revised registering of complaints.

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

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