Unannounced Care Inspection Report
19 and 20 April 2016

Bannview House Care Home

Address: 23 Bannview Road, Banbridge, BT32 3RL
Tel No: 028 4066 0110
Inspector: Donna Rogan

1.0 Summary

An unannounced inspection of Bannview House Care Home took place on 19 April 2016 from 10:30 to 17:30 and on 20 April 2016 from 09:30 to 16:30.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence of positive outcomes for patients through the competent delivery of safe care. Recruitment and induction practices were evidenced to be well managed and there was evidence of appropriate management of staff registration with their various professional bodies. Staffing levels were well maintained and reflected the dependency levels of patients.

Staff training was well maintained and the home is commended for the level of staff trained in communication and safeguarding.

Two requirements are made in relation to the management of the late afternoon routine in the dayroom in the Bronte suite in the evenings and the management of wheelchairs

Is care effective?

There was evidence of good delivery of care with positive outcomes for patients. Care records were well maintained and included assessment of patient need, risk assessments and a comprehensive care plan which evidenced patient/representative involvement. There was also clear evidence of effective team working and excellent communication between patients and staff.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. All patients spoken with were complementary regarding the staffs' attitude and attentiveness to detail. Patients were very complimentary of staff. There was strong evidence of patient, representative and staff consultation.

There was evidence that practices and quality initiatives provided continuous positive outcomes for service users within this domain. Patient involvement in the daily routine was paramount. There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was evidence of systems and processes in place to monitor the delivery of care and services within Bannview Care Home.

Compliance with the requirements made in the, is care safe domain, will improve the overall services provided, the experience of service users and leadership within the home.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**2**	**1**

Details of the QIP within this report were discussed with Roberta Wilson, Registered Manager, who was available for feedback 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 Bannview Care Home was an announced estates inspection undertaken on 6 April 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action was not required following this inspection.
A review of documentation confirmed that adult safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA have been appropriately notified.

2.0 Service details

Registered organisation/registered person: Priory (Warrenpoint) Ltd Caroline Denny	**Registered manager:** Roberta Wilson
Person in charge of the home at the time of inspection: Cherith Rogers, deputy manager	**Date manager registered:** 22 December 2015
Categories of care: NH-PH, NH-I, NH-DE, RC-I 16 patients in category NH-PH NH-I 41 patients in category NH-DE 22 patients in category RC-I	**Number of registered places:** 80

3.0 Methods/processes

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

Prior to inspection the following information was 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 approximately 40 patients, eight care staff, six registered nursing staff, 2 senior carers and eight patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- staff training records
- accident and incident records
- notifiable events
- audits
- records relating to Adult Safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures
- quality review for year ending March 2016
- selection of quality indicators

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection

There were no further actions required to be taken following the last estates inspection 6 April 2016. The QIP following the inspection was returned and accepted by the estates inspector. There were no issues to be followed up by the care inspector at this inspection visit.

4.2 Review of requirements and recommendations from the last care inspection dated 06 May 2015

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

The deputy manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review in order to ensure that the assessed needs of patients were being met. The deputy manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients, this included details of patients dependency levels.

A review of the staffing roster for weeks commencing 18 and 25 April 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff staffing rosters it was confirmed that administrative, maintenance, 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. Relatives commented positively regarding the staff and care delivery.

Discussion with staff and 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 induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The registered manager also had signed the record to confirm that the induction process had been satisfactorily completed.

Review of two records and discussion with the deputy manager confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home.

Training was available via an e learning system known internally as Foundations For Growth, (FFG's). There were systems in place to monitor staff attendance and compliance with training. Review of staff training records for 2016 evidenced that the attendance/compliance levels with Adult Safeguarding was 85% compliant 9% had commenced training and 6% of staff were late in completing training. Infection control training attendance/compliance was 70.5% of staff had completed their training 20% of staff had commenced their training and 10% of staff were late in completing their training. Following discussion with the deputy manager it was ascertained that staff that had not yet completed their training were staff currently on long term leave or worked as bank staff. A management system is in place to ensure that those staff required to attend training are identified and reminded to complete their training when they return to work.

Discussion with the deputy manager, staff on duty and a review of records confirmed that there are systems in place to ensure that staff receives supervision and appraisal. Nursing and care staff confirmed that they receive supervision every two months and that they usually take a themed approach, the most recent theme for March 2016 was wound management.

Discussion with the deputy manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed.

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

A review of documentation confirmed that adult safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA have been appropriately notified. The registered manager had robust systems in place to monitor the progress of safeguarding issues with the local health and social care trust and the PSNI.

Review of four 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. A recommendation is made that all care records including supplementary records should be dated and signed by the person completing them.

Discussion with the deputy manager and review of records also 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. The registered manager completed a monthly analysis of falls to identify any trends or patterns.

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 smelt fresh, clean and was 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.

Concerns were raised regarding the management of the afternoon routine in the Bronte suite. During a review of the late afternoon routine it was observed that there was limited space available in the day room as a total of six people were placed in their wheelchairs and there were four empty wheelchairs placed beside patients ready for transferring. The dayroom was unattended by staff. The organisation of equipment in the dayroom was observed to be unsafe as the number of wheelchairs prevented the free flow of movement for staff and patients. One patient was observed to attempt to get in between two wheelchairs, placing themselves at risk, another two patients were attempting to get out of the wheelchairs unassisted. Staff were asked for the rationale for the management of patients in wheelchairs and we were informed that this was the normal routine to assist patients with their toileting needs prior to taking them for their evening meal. Concerns were also raised regarding the length of time patients were left in wheelchairs prior to and following their evening meal. The above concerns were discussed at length with the nurse in charge who stated that they were not aware that the above practice was occurring and agreed to ensure that this practice ceased with immediate effect. The issues were also discussed with the deputy manager and registered manager. A requirement is made to ensure the afternoon routine is immediately reviewed to ensure that the safety, health and welfare of patients are maintained at all times.

On day two of the inspection a patient was observed to be transported on a wheelchair without the use of footrests. The patient was having difficulty in keeping their feet up of the floor. A member of staff stated that they did not know where the footrests were and confirmed that wheelchairs are usually checked in the mornings to ensure they were safe for use. However, the member of staff also stated that footrests often go missing. This issue was also discussed with the member of staff involved and during feedback with the deputy and registered managers. A requirement is made that equipment provided for use in the nursing home for use by patients or persons who work at the home is 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.

Areas for Improvement

Two requirements are made, one is in relation to the afternoon routine in the Bronte suite and the other relates to the management of equipment. The recommendation is in relation to the management of supplementary care records.

Number of requirements	**2**	**Number of recommendations**:	**1**

4.4 Is care effective?

Review of four patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information. A comprehensive, holistic assessment of patient's nursing needs was completed 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. The outcome of patient assessments of need and risk assessments were evidenced to inform the care planning 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) or dieticians and palliative care nurse facilitators. Care records were regularly reviewed and updated, as required, in response to patient need.

Discussion with visiting professionals over both days of inspection, included district nursing staff, a community dentist and an occupational health therapist; all of whom confirmed that they had a good relationship with staff in the home and that they are appropriately referred and instructions provided are followed and records maintained.

Staff demonstrated awareness of the importance record keeping and of patient confidentiality in relation to the storage of records.

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 deputy manager and staff evidenced that nursing and care staff were required to attend handover meetings at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. In addition there are flash meetings every Tuesday at 11.00 by the staff in charge of each unit and the deputy and registered manager to discuss any issues which require action or for peer support.

The deputy manager confirmed that staff meetings were held regularly and that records of these meetings were maintained. The registered manager explained that they set the initial agenda and then staff could add items to the agenda. A review of records evidenced that the signatures of the staff attending, issues discussed and any agreed outcomes were recorded. The deputy manager confirmed that the record of each meeting was made available to staff.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted with 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 deputy or registered manager.

We discussed how management consulted with patients and relatives and involved them in the issues which affected them. The deputy manager explained that she held regular meetings with patients and relatives. The most recent relatives' meeting was held on 26 January 2016. Minutes of the meetings held were reviewed and confirmed attendance and the detail of the issues discussed. The deputy manager also stated that the minutes of relatives' meetings were also posted to all families following the meeting. The deputy manager also stated that families were also informed by post of the recent quality initiatives in which staff in the home have attended or are participating in; such as, (Staff who are skilled and have time to care, Partnership with carers, Assessment and support of people living with dementia, **C**are plans that are person centred and individualised, Environments that are dementia friendly, (SPACE) programme). Relatives have also been informed that staff have attended, RCN Dementia project and "My Home Life projects". The most recent patients' meeting was held on 11 April 2016. The minutes were retained and they were circulated round each patient's bedroom.

A notice board displaying information for relatives was provided on each floor of the home. Information displayed included the Statement of Purpose, Patient Guide, dates of the relatives meetings for 2016, how to make a complaint and the adult safeguarding procedures.

The serving of lunch was observed in all units. Tables were set with cutlery, condiments and napkins. Those patients who had their lunch in the lounges or bedrooms were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. Patients were enabled to choose which dish they preferred at the point of service. This is good practice.

Meals were transported from the kitchen in heated trolleys and served by the kitchen staff; this left the registered nurses and care staff free to attend to the nutritional needs of the patients.

The serving of the lunch was observed to be well organised with all of the patients being attended to in a timely manner. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch.

Areas for Improvement

There were no requirements or recommendations made.

Number of requirements	0	Number of recommendations:	0

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. 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.

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:

"The best home in the country"

"Thank you for the care my mother received"

"Staff are so kind and compassionate, …… loved it here"

Ten questionnaires were issued to patients; one was returned prior to the issue of this report. The patient responded that all aspects of care were "excellent" and that the service was "excellently led".

Ten relative questionnaires were issued to relatives; one was returned prior to the issue of this report.

The following comments were provided from patients and relatives during inspection and in the returned questionnaires;

“The home is fantastic”
“The staff are wonderful, kind and caring and full of good ‘craic’”
“Smiles all round”
“This home is great. I highly recommend it, best home in the country”
“The nurses are angels”
“I know they keep records about me, but I don’t bother getting involved”
“Cherith or Roberta come round every day”
“Very tasty food, great menu, my compliments to the chef”
“If I buzz, I never have to wait too long for someone to come”
“Staff are so kind and respectful”

Ten questionnaires were issued to nursing, care and ancillary staff; two were returned prior to the issue of this report. The responses to the questions were all positive and staff indicated that in their opinion the delivery of safe, effective and compassionate care was either excellent or good.

There were a number of quality initiatives ongoing in the home in order to improve service provision and the living experience in the home as previously stated. It is the ethos of the home to strive to ensure that the day to day routine in the home is managed around the patients’ needs abilities and their wishes and feelings. Patients were observed to be very involved and the management have put in place various opportunities to encourage patients to become involved in the daily routine. Throughout both days of inspection we observed activities which were patient led and in accordance with their wishes. Activities were observed to be focused on the life experience of the patients. The home has a chicken coop and patients informed me of how they are involved in the mornings to collect fresh eggs. Others stated that they enjoyed watching them and would sit outside in the clement weather to watch them and on colder days would watch them through the windows. On both days of inspection numerous patients were observed to enjoy the garden and they discussed how their gardening skills were encouraged and that they were glad of the opportunity to become involved. One patient informed the inspector that they enjoyed a daily power walk in the garden using their tripod. Patients also stated that they had recently taken part in “The Amore Care National Cake Off”. This was a project launched in October 2015 into December 2015 involving numerous patients in the home. Together they baked a Christmas cake to enter in the competition. There was photographic evidence that patients were very involved in the project and had enjoyed it most were able to reminisce of their use and how they baked cakes in the past. There was evidence in the activity programme of involvement of the local community. A new tunnel for gardening use has also been recently erected; patients stated that they are looking forward to getting involved when the work is completed. Patient involvement in the day to day management of the home is to be commended.

Areas for Improvement

No areas for improvement were identified in the assessment 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 displayed and available in each unit.

Discussion with the deputy and registered manager and staff evidenced that there was a clear organisational structure within the home.

Staff spoken with were knowledgeable regarding line management 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. 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. As previously discussed information on how to make a complaint was displayed in the home.

A record of complaints was maintained by the registered manager. The record included the date the complaint was received, the nature of the complaint, details of the investigation and a copy of the letter sent to the complainant. We discussed at length how the registered manager assessed that the complainant was satisfied with the outcome of the complaint and how this satisfaction was evidenced.

Any contract compliance issues raised by the local health and social care Trust were recorded as complaints. In these instances the Trust informs the registered manager if the complainant is satisfied with the outcome. Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

There were numerous thank you cards and letters received from former patients and relatives. The registered manager explained that initially these would be displayed in the home. Complaints and compliment records were also recorded electronically and forwarded to the human resource department for monitoring.

The registered manager demonstrated how some of the compliments received by Bannview Care Home were available in the “testimony” section of the corporate website.

The deputy manager discussed the systems in place to monitor the quality of the services delivered and explained that a programme of audits was completed on a monthly basis. Areas for audit included care records, infection prevention and control practices, falls, complaints and the environment. A review of the record of audits evidenced that where an area for improvement was identified and an action plan was developed, completed and the area re-audited to check that the required improvement has been completed.

We discussed further with the registered manager how patients and relatives were involved or consulted with regards to issues which affected them. As previously discussed the registered manager holds monthly meetings with patients and displays information for relatives on dedicated notice boards. Relatives meetings are arranged three monthly and minutes are posted to relatives’ homes.

Discussion with the deputy manager and review of records evidenced that 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 areas for improvement.

Areas for Improvement

Areas for improvement were identified in the previous domains of safe and effective care. Compliance with these recommendations will improve the overall services provided, the experience of service users and leadership within the home.

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

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Roberta Wilson, Registered Person 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 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 registered person/manager from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13 (1) **Stated:** First time **To be completed by:** 20 April 2016	The registered persons must ensure the afternoon routine is immediately reviewed to ensure that the safety, health and welfare of patients are maintained at all times. **Ref Section 4.3**
	Response by registered person detailing the actions taken: Completed Issues regarding the afternoon routine in the unit in question have been brought to the attention of all staff in the unit. Immediate action was taken on the day of the inspection and closely audited following the inspection. The afternoon routine has significantly improved in this unit and is in line with practice across the three other units in the home.
Requirement 2 **Ref:** Regulation 27 (2) (c) **Stated:** First time **To be completed by:** 20 April 2016	The registered persons must ensure that equipment provided for use in the nursing home for use by patients or persons who work at the home is 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. **Ref Section 4.3**
	Response by registered person detailing the actions taken: Completed With immeidate effect staff on duty in this area were reminded of their responsibilities regarding the safe use of wheelchairs and acknowledged that the practice observed did not comply with expected practices. All care staff were reminded of their responsibilities regarding the safe transportation of residents using wheelchairs and ensuring that footplates are in place at every transfer. Patient Safety is the practice focus for May 2016
Recommendations	
Recommendation 1 **Ref**: Standard 21 **Stated:** First time **To be completed by:** 30 May 2016	The registered persons should ensure that all care records including supplementary records are dated and signed by the person completing them. **Ref Section 4.4**
	Response by registered person detailing the actions taken: Completed Aspects of suplementary records previously ticked are now signed off by care staff using their initials rather that ticking off a section as completed as was the practice.

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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