Unannounced Care Inspection

Name of Establishment:	**Dunmurry Manor**
RQIA Number:	**12230**
Date of Inspection:	**21 January 2015**
Inspector's Names:	**Heather Sleator & Lorraine Wilson**
Inspection ID:	**021131**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Dunmurry Manor
Address:	Rowan Drive Seymour Hill Dunmurry BT17 9PX
Telephone Number:	02890610435
Email Address:	manager.dunmurry@runwoodhomes.co.uk
Registered Organisation/ Registered Provider:	Mr Nadarajah (Logan) Logeswaran
Registered Manager:	Mrs Debra Hawthorn (registration pending)
Person in Charge of the Home at the Time of Inspection:	Mrs Norma McAllister Regional Care Director
Categories of Care:	DE - dementia
Number of Registered Places:	76 40 – nursing 36 – residential
Number of Patients/Residents Accommodated on Day of Inspection:	20 patients 23 residents
Date and Type of Previous Inspection:	Secondary Unannounced 15 October 2014
Date and Time of Inspection:	Follow up inspection 21 January 2015 09:45 – 19:30 hours
Name of Inspectors:	Heather Sleator Lorraine Wilson

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the Provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

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

- discussion with the Regional Care Director
- discussion with staff
- discussion with patients individually and to others in groups
- consultation with two visiting relatives
- review of a sample of policies and procedures
- review of a sample of staff training records
- review of a sample of staff duty rotas
- review of a sample of care plans
- review of the complaints, accidents and incidents records
- observation during a tour of the premises
- evaluation and feedback.

5.0 Consultation Process

During the course of the inspection, the inspectors spoke with:

Patients/Residents	20
Staff	8
Relatives	1
Visiting Professionals	0

Questionnaires were provided during the inspection, to staff to seek their views regarding the quality of the service.

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	0	0
Relatives/Representatives	0	0
Staff	10	5

6.0 Inspection Focus

The focus of the inspection was to review the progress made to address the requirements and recommendations made as a result of the previous inspection on 15 October 2014.

The inspectors have rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Dunmurry Manor is situated within the Seymour Hill Estate in Dunmurry County Antrim.

The nursing home is owned and operated by Runwood Homes Limited.

The current manager is Mrs Deborah Hawthorne, who is not currently registered with RQIA. However, an application has been submitted to RQIA and is currently pending.

Accommodation for residents is provided on the ground floor of the home, and nursing patients are located on the first floor of the home. Access to the first floor is via a passenger lift and stairs.

Each floor has communal lounges and dining areas provided. A number of communal sanitary facilities are available throughout the home.

The home also provides for catering and laundry services on the ground floor.

In addition hairdresser facilities, a café, secure garden and clinical areas are also available.

The home is registered to provide care for a maximum of 76 persons under the following categories of care:

Nursing care

DE dementia care to a maximum of 40 patients accommodated within the dementia unit on the first floor.

Residential care

DE dementia care to a maximum of 36 residents accommodated within the dementia unit on the ground floor.

8.0 Executive Summary

This summary provides an overview of the services examined during an unannounced care inspection to Dunmurry Manor. The inspection was undertaken by Heather Sleator and Lorraine Wilson on 21 January 2015 from 09.45 hours to 19:30 hours.

The inspectors were welcomed into the home by Mrs Norma McAllister, regional care director who was available throughout the inspection. Ms Debra Hawthorne, home manager, was on leave at the time of the inspection.

Verbal feedback of the issues identified during the inspection was given to Mrs Norma McAllister, regional care director, at the conclusion of the inspection.

The requirements and recommendations made as a result of the previous inspection were reviewed. Five requirements and seven recommendations had been made. The review evidenced two requirements were compliant and three were moving towards compliance. These requirements have been restated for a second time in the quality improvement plan (QIP) of this report. The requirements that are being restated are in relation to staff induction and training, personal care and care practices and governance arrangements. Five recommendations were assessed as compliant, one was not compliant and one recommendation has been carried forward for review at the next inspection. Further information may be found in section 9.0 of this report.

During the course of the inspection, the inspectors met with patients, staff and one visiting relative. The inspectors observed care practices, examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspectors reviewed the home's management and governance arrangements, staffing rosters, care practices specifically in relation to restrictive practices and continence management, and the care records of four patients. The dining experience for patients and specific areas of the environment were also examined.

Additional areas were also examined including:

- staffing
- staff training
- care practices
- care records
- meals and nutrition
- notifications of accidents/incidents
- safeguarding of vulnerable adults
- environment
- fire safety
- finance
- complaints

Details regarding these areas are contained in section 10.0 of the report.

A number of the issues identified during this inspection had previously been highlighted following an inspection to the home in October 2014.

As a result of the issues identified during this inspection, the Regulation and Quality Improvement Authority (RQIA) have concerns that the quality of care and service within Dunmurry Manor falls below the minimum standard expected.

This was with regard to the quality of nursing and care specifically in relation to dementia practice, the use of restrictive practice for patients, continence management, staffing arrangements, staff training and fitness of the premises with specific regard to cleanliness.

The findings were reported to senior management in RQIA, following which a decision was taken to hold a serious concerns meeting. The inspection findings were communicated in correspondence to the registered provider who was invited to attend a serious concerns meeting at RQIA on the 11 February 2015.

17 requirements were made as a result of this inspection. Nine recommendations were also made. Three requirements have been stated for a second time. Details can be found in the main body of the report and attached quality improvement plan (QIP).

The inspectors would like to thank the patients, visiting relatives, Mrs McAllister, regional care director and staff for their assistance and co-operation throughout the inspection process.

8.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

There has been one notification to RQIA regarding safeguarding of vulnerable adults (SOVA) incident since the previous inspection. The incident is being managed in accordance with the regional adult protection policy by the safeguarding team within the South Eastern Health and Social Care Trust.

RQIA are not part of the investigatory process, however, the commissioning trust have agreed **to update RQIA at all stages of the investigations.**

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	12. 1)(a) (b) (c), (2)(a)(b)	The registered person shall provide treatment to patients that: (a)meet his individual needs; (b)reflects current best practice; and (c) are (where necessary) provided by means of appropriate aids or equipment. • The pressure relieving equipment required when the patient was sitting out of bed had not been recorded, and this information should be recorded in the patient's care plan. The maintenance arrangements should also be recorded.	Personal care of identified patients was not appropriately addressed. A number of patients were observed with long nails which were not clean. Some aids and equipment were not clean. This included fall out mats and mattresses. A record of specialist mattresses which were in use was maintained. The record included the name of the patient, the type of mattress and serial number and the date the patient commenced using the specialised mattress. The maintenance arrangements were not recorded. Manufacturer's information provided during the inspection indicated that an annual service was required. It was agreed that the record in use would be developed further to include the date of service. A separate requirement has been made in relation to dementia care practice.	Moving Towards Compliance

			This requirement has been partially addressed and the relevant sections will be stated for a second time.	
2	19 (1)(a)(b) (2) (3)(a)(b)(4)	The registered person shall maintain in the nursing home the records specified in Schedule 4. The registered person should maintain: • contemporaneous notes of all nursing provided to each patient. Repositioning charts and daily fluid records must be accurately maintained to evidence the care delivered.	Repositioning records and fluid records examined were appropriately recorded. The care records of one patient whose condition had significantly changed were reviewed. A care plan recording these changes was in place; however, other relevant assessments had not been updated to reflect the change in the patient's condition. This required urgent attention to ensure the patient's holistic care needs were being met. A review of a care record identified that a patient had gone to hospital unescorted. A patient's contract was provided which confirmed that the finance arrangements for escorting a patient to hospital were not included. The contract informed that information can be obtained from the nurse manager regarding additional charges. The regional care director was unable to confirm the actual amount which is charged. This was discussed with the regional care director and a requirement has been made.	Compliant

			A record of the nursing home's charges to patients, including any extra amounts payable for additional services must be maintained at all times. A recommendation has been made to devise an escort policy. Copies of the monthly regulation 29 reports which are completed on behalf of the responsible individual were requested. Reports were presented in part only. The completed versions of the regulation 29 reports were submitted to RQIA following the inspection. In addition training information and statistics which were cross referenced to individual staff records were not accurately completed: therefore accuracy of information which was presented could not be assured. A requirement has been made in respect of staff training. **This requirement has not been addressed and has been stated for the second time.**	

3	20 (1)(a)(b)(c)(i)(ii)(iii)(iv), (2), (3).	The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of patients – (a)ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients; (b)ensure that the employment of any persons on a temporary basis at the nursing home will not prevent patients from receiving such continuity of nursing as is reasonable to meet their needs; (c)ensure that the persons employed by the registered person to work at the nursing home receive – (i)appraisal, mandatory training and other training appropriate to the work they are to perform; and (ii)are supported to maintain their registration with the appropriate regulatory or occupational body; and (iii)are enabled from time to time to obtain training and/or further qualifications appropriate to the work they perform;	It was confirmed that following the previous inspection, recruitment has been ongoing. A number of staff have recently been appointed and a number of staff are waiting to commence employment on completion of the relevant recruitment checks. These appointments have resulted in the reduction of agency staff as evidenced when reviewing the staffing rotas. There was no evidence that the recently appointed staff have dementia care experience or have received dementia training and it was evident this was impacting on the delivery of patient care. A review of the induction records of two staff identified that a robust induction programme was in place. The completed induction records did not include information as to how the competency of the staff member was assessed and staff competency had been confirmed after day one and prior to completion mandatory training.	Moving Towards Compliance

		(iv) are provided with a job description outlining their responsibilities. (2) The registered person shall ensure that persons working at the nursing home are appropriately supervised. (3) The registered person shall ensure that at all times a nurse is working at the nursing home and that the registered manager carries out a competency and a capability assessment with any nurse who is given the responsibility of being in charge of the home for any period of time in his absence. • There should be sufficient numbers of suitably qualified, skilled and experienced persons employed to meet the needs of patients and residents with dementia. • The use of agency staff is significantly reduced. • All staff employed in the home must complete an induction programme and be assessed as competent by management upon successful completion of the programme. • All nursing staff in charge of the	There was no evidence that mentorships arrangements were in place for one recently registered nurse or that a competency and capability assessment had been completed. The competency and capability assessment for another registered nurse was reviewed. There was no evidence that this assessment was robust and the assessment documentation referred to English legislation. Two medication competency assessments were in place. One was well completed and indicated that the staff member had three supervised practices, had successfully answered questions in relation to medication management and had been assessed and deemed competent. The second record confirmed competency had been completed. There was evidence that the Trust specialist tissue viability nurse had provided training on wound care and further training sessions were scheduled for 22 January 2015.	

		home must have a competency and capability assessment completed by the manager. • All nursing staff should receive wound care training and all care staff should have pressure care training.	One registered nurse consulted demonstrated good knowledge of wound care. **This requirement has been partially addressed and the relevant section will be stated for a second time.**	
4	17 (1)	The registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and other service provision in or for the purposes of the nursing home and that any such review is undertaken not less than annually. • The registered person should ensure that an audit of all care records is undertaken to identify all areas for improvement. A re-audit should also be undertaken to ensure identified deficits have been addressed.	A review of the records confirmed audits of care records had been undertaken for a number of patients. The audits identified some deficits in recording: however, there was no evidence of the actions that had been taken to address the deficits. A review of the audit of accidents/incidents for December 2014 indicated that there were no incidents of unexplained bruising. However, accidents/incidents records reviewed confirmed that there had been recorded reports of unexplained bruising. The factual accuracy of audits was discussed with the regional care director. **This requirement has been partially addressed and the relevant section has been stated for a second time.**	Moving Towards Compliance

5	12 (4) (a)(b)(c)(d)	The registered person shall ensure that food and fluids – (a)are provided in adequate quantities and at appropriate intervals; (b)are properly prepared, wholesome and nutritious and meets their nutritional requirements; (c)are suitable for the needs of patients; (d)provide choice for the patients;	Significant improvement in the management of food and fluids for patients was evident. During mid-morning patients were offered a hot snack. Staff were observed consulting with patients, providing support and assisting them in selecting their lunch choice of meal. The dining tables were appropriately set with condiments in place and pictorial menus to reflect the daily menu were displayed on dining tables. Catering staff were involved in the meal service and could adjust portion sizes to suit individual needs. The meals served looked nutritious and were nicely presented. Nursing staff were available to support and direct staff and provide discreet support and assistance as needed. Staff identified a number of patients who had a reduced appetite and advised of the action being taken.	Compliant

			It was observed that patients had to wait for their lunch meal to be delivered as one instead of two Bain Marie's were in use. The regional care director had also identified this and provided an assurance that this was not usual practice. A recommendation has been made in this regard. **This requirement has been addressed.**	

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	5.2	The registered person should ensure that to avoid confusion for staff, there is one pressure risk assessment tool in use.	The records reviewed confirmed that the Braden pressure ulcer risk assessment was in place. **This recommendation has been addressed.**	Compliant
2	12.12	The registered person should ensure that fluid records include all drinks offered and recorded as either consumed or refused.	The fluids records sampled were completed appropriately and the total fluid intake for the 24 hour period was recorded in daily progress records. **This recommendation has been addressed.**	Compliant
3	30.7	The registered persons should ensure that worked staff duty rosters commencing 20 October to 23 November 2014 are submitted to RQIA for review.	The requested information was submitted to RQIA**.** **This recommendation has been addressed.**	Compliant

4	12.4	The registered persons should ensure that menu choices displayed are adhered to, and a daily menu which meets the needs of patients/residents with dementia related conditions is displayed.	The weekly menu on display was adhered to and a daily pictorial lunch menu was displayed**.** **This recommendation has been addressed.**	Compliant
5	36.4	The registered persons should ensure that all staff have fire training and are aware how to respond to the fire alarm.	A review of the training records confirmed that not all of the staff employed had received fire training. During this inspection the fire alarm sounded. The inspectors were not assured that staff knew what to do when the fire bell was ringing. **This recommendation has not been addressed and a requirement is now made in this regard.**	Not compliant
6	25.24	There are arrangements in place to enable international nurses to have a period of supervised practice experience to give safe and effective nursing care, until deemed competent in accordance with NMC procedures**.**	Since the previous care inspection, the compliment of nursing staff has been increased, to ensure that two registered nurses are on duty at all times during the period from 08.00 hours to 20.00 hours. As the manager for the home was not on duty, the inspectors were unable to determine the support measures which were in place. **This recommendation will be brought forward for review during the next care inspection.**	Brought forward for review

7	25.2	The registered persons should inform RQIA when admission to the nursing unit recommences.	The manager informed RQIA of the proposed date of admissions as agreed. **This recommendation has been addressed.**	Compliant

10.0 Areas Examined

10.1.1 Staffing

Three registered nurses and three care assistants were on duty in the nursing unit. One of the registered nurses had commenced work in the home on the day of inspection and was undertaking induction training from 08.00 – 14.00 hours. The nurse had previous nursing home experience and had some experience in dementia care. These numbers are in keeping with RQIA staffing guidance.

The designated nurse in charge of the nursing unit had previously worked in nursing home settings and also had experience of caring for persons with dementia.

One of the registered nurses had only recently qualified and this was their first registered nursing position. The regional care director confirmed that the nurse had been issued with a preceptorship pack for reading. The registered nurse was unaware of who their mentor was and there were no records to confirm this. The induction record for the registered nurse was reviewed and confirmed that their competency assessment had been signed off by the nurse manager over a one day period. The assessment was not sufficiently robust and there was no evidence that mandatory training had been completed. These issues were discussed with the regional care director and a requirement has been made. A requirement has been made to ensure that all nurses in charge of the home have an assessment of competency completed by the nurse manager before being left in charge of the home, and records of fully completed assessments are available for inspection.

A requirement has also been made to ensure that any newly qualified registrant receives a period of supervised practice and has a designated mentor before they are left in charge of the home.

In the residential unit there was a senior care assistant and two care assistants on duty. A fourth care assistant, on induction, commenced at 17:00 – 23:00 hours. The care assistant was rostered to work four days per week on this twilight shift. Staff informed the inspector they did not think there were enough staff on duty. Whilst the number of staff on duty in the residential unit was in accordance with RQIA's recommended staffing guidance, staffing arrangements should also take into account, for example; the category of care the home is registered for, competency of staff and the needs of patients. A recommendation has been made.

10.1.2 Staff Training

The review of staff training records evidenced a third of staff employed had not completed mandatory induction training. This included safeguarding vulnerable adults, fire safety and moving and handling training. The staff had been employed in the home for a period exceeding eight weeks. Staff training records also evidenced that a further 19 staff were 'overdue' training in the practical component of moving and handling.

These issues were discussed with the regional care director. Issues relating to mandatory training have been included in the requirement in respect of staff and staff training.

The inspectors met with staff on both the nursing and residential units. A care assistant in the nursing unit confirmed they had received induction training on the commencement of employment and did demonstrate some knowledge in continence care. The inspectors were informed by staff in the residential unit that some dementia awareness training had been provided and added they felt that the home lacked strong leadership.

However, the inspectors were unable to confirm that staff on duty had sufficient knowledge and understanding of patients' with dementia. The bedroom doors in the residential unit were locked. Staff confirmed that the reason for this was that two residents went into other residents bedrooms. In addition there was no evidence that staff had an understanding of promoting values such as respect at all times. Staff consulted referred to patients as "singles" and "doubles". These terms are institutional. This was discussed with the regional care director and a requirement has been made to ensure that dementia training is provided and includes principles such as the principles of care and human rights.

10.3 Care Practices

There was no evidence to confirm that the management of the nursing and residential dementia care was well organised or that there was effective leadership of staff at the time of the inspection. This impacted on the delivery of patient care.

Staff in the nursing unit were observed to be very busy and the majority of patients were observed isolated in their bedrooms including patients who were at high risk of falls.

One patient informed the inspectors that they disliked being left alone and wanted to go home. This was discussed with the nurse in charge who confirmed that the patient was initially admitted to the residential unit but as their mobility needs increased they had been transferred to the nursing unit. The inspectors were informed that the plan of care for the patient included transfer to the residential unit during the day for socialisation. There was no explanation for this deviation in planned care.

A number of patients were ill and were being nursed in bed, repositioning records were appropriately maintained and fluid records indicated a deteriorating fluid intake for two ill patients. The GP visited one patient in respect of reduced oral intake.

The remaining patients were observed sitting in the corridor area outside the designated nursing office, in one of the smaller lounges, or walking up and down the corridors. There was no sense of calm and some patients were presenting as challenging. Lounges were not being used by patients.

The activities programme was displayed on a board on the wall outside the main lounge. The format was pictorial, which was good practice however; the pictures were small and may be difficult for patients to see. It may also be more beneficial if instead of the week's activities it was displayed on a daily basis. This would be more informative and less confusing for patients.

The residential unit has two lounges and two dining rooms. Only one dining room and one lounge were being used. The curtains in the second lounge were closed and the room was cold. The second dining room had two dining tables and four chairs. Residents should have a choice of where they wish to sit and/or eat. The majority of residents were sitting in the lounge opposite the entrance door. Staff confirmed that this was because it was easier for the activities coordinator to do activities if everyone was in the one place. Again this is institutional practice and not in keeping with best practice in dementia care. Activities should be based on the known preferences of patients and evidence is available that small group activities can be more beneficial.

In addition there was no evidence of activity or stimulation being provided during the morning period and some patients many of whom were mobile had no recreational opportunities. The inspectors were informed that the activities coordinator works in the residential unit in the morning and the nursing unit in the afternoon. The regional care director confirmed that the home was trying to recruit a second activities coordinator so as to provide more recreational/social opportunities for patients/residents. A requirement has been made to ensure activities are planned and provided to meet the needs of patients.

Whilst the patients in the main were well presented with personal care needs appropriately attended to, one patient seated in a wheelchair had fingernails which were in need of cleaning and in addition the patient had no footrest on the wheelchair. This practice puts the patient‘s feet at potential risk of pressure damage. The inspector observed another patient in a wheelchair without footrests however the staff member realised footrests were not present, searched and found and attached footrests. A requirement in relation to personal care had been made previously and has been stated for a second time.

Life story booklets/information had not been completed for patients. This work should be commenced at the time of admission to assist to staff provide care in a person centred and meaningful manner. A recommendation to complete life story work has been made.

The area around the entrance door in the residential unit became quite congested as the day progressed with a number of patients walking up and down the corridor and were unsettled. Staff were busy and unable to offer patients any form of meaningful activity.

10.4 Care Records

The inspectors reviewed four care records. The review focused on continence management, the use of restrictive practice and the assessment and care planning process.

10.4.1 Continence Management

The review of patients care records evidenced the following:

- there was no consistent record of a bowel assessment referencing the Bristol Stool Chart;
- one residents continence assessment was incomplete;
- daily progress referred to “incontinence care attended to”. There was no consistent record of bowel monitoring referencing the Bristol Stool Chart;
- bowel files and weight files were maintained for patients. The individual patient care record is the legal record which must be maintained at all times;
- there was no link nurse for continence management; and
- nursing staff confirmed that they required update training in relation to male and female catheterisation and the management of stoma appliances.

These issues were discussed with the regional care director and a requirement has been made. A recommendation has been made to ensure that that all sections of patients’ assessment of need are completed.

10.4.2 Restrictive Practice including the management of behaviours that challenge

Care records did not evidence consultation with the multidisciplinary team regarding the use of restrictive practice i.e. sensor mats. The review of a risk assessment for the use of a sensor mat did not evidence the reason why a sensor mat was being considered. In this instance it was because of a behaviour management issue.

The care plan for the management of the behaviour indicated that staff were to complete a behaviour chart. There was no evidence of a behaviour chart being maintained. There was also no evidence that the patient and/or their representative had been consulted in relation to the planning of care. The care interventions detailed in the care plan were not person centred and did not inform staff of how to support the patient. The monthly evaluation of the care plan simply referenced the patient was on medication.

A reference was made in a patient’s care records that three staff were required to keep the patient in the building. This is a concerning statement as it did not indicate that staff were knowledgeable regarding diffusing situations and the deprivation of an individual’s liberty. These issues were discussed with the regional care director and requirements have been made that staff are trained in the management of behaviours that challenge, the use of restrictive practice and the deprivation of liberty safeguards.

Other areas for improvement included;

- one patient’s record indicated a weight loss during October – December 2014 and the care plan indicated that weekly weights were to be completed. However, there was no evidence that this was being completed;

- the care and treatment prescribed by the TVN for one patient on 20 January 2015 was not being fully adhered to;
- not all records examined were fully completed, as some sections such as likes and dislikes were not completed; and
- there was no evidence that patients and/or their representatives had been consulted regarding the planning of care.

There was some evidence that the care records had been audited by the nurse manager and deficits were identified and recorded. However, the inspectors were unable to evidence that a re- audit of these same records had been undertaken to determine that the required improvements were made. These areas were discussed with the regional care director and requirements have been made.

10.5 Meals and Nutrition

An improvement in the management of meals was evident. Patients were receiving hot and cold drinks and snacks during mid -morning and afternoon periods.

Staff were observed offering a menu choice to select for lunch during the morning period. The four weekly menu was displayed on the notice board in the dining room and a daily pictorial menu was now being displayed on the dining tables.

The dining tables were appropriately set and the meals served were appropriately presented by catering staff who had knowledge of the patients' likes and portion sizes required. Staff provided assistance and support to patients in a discreet and dignified manner and were observed to positively engage with patients.

One Bain Marie trolley was in use resulting in patients in the nursing unit having to wait unit after 13.00 before their meal was served. This was discussed with the regional care director who had also observed this practice and provided an assurance that the second Bain Marie would be used and patients in the nursing unit would not have to wait to be served their meal. A recommendation has been made.

10.6 Notification of Accidents/Incidents

A sample of accidents and incidents recorded in the designated accident records for the home were reviewed.

It was not evident that robust systems were in place for notifying RQIA and Trust commissioners of the required accidents and incidents. Some reports reviewed indicated "care manager is to be informed" though not all records were updated to indicate they had been informed.

In addition, the accident records did not make reference to The Nursing Homes Regulations in Northern Ireland but referred to legislation in other parts of the United Kingdom. This is confusing for staff and should be addressed.

A requirement has been made to ensure that notifications are submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

10.7 Safeguarding Vulnerable Adults

The accidents/incidents records reviewed provided information in respect of unexplained bruising of a patient. However, staff action taken was not in keeping with the regional protocol for safeguarding vulnerable adults. There was no information to indicate that a referral had been to the safeguarding team for screening, nor were RQIA or the regional care director for the company notified. Audit information indicated that there were no incidents of unexplained bruising reported during the same month the accident/incident report was recorded.

Regional guidelines and company policy in respect of vulnerable adults were not being robustly followed, nor were relevant notifications being reported to the commissioning Trust who has responsibility for safeguarding, RQIA and senior management of the company. There is additional concerns' regarding the accuracy of audit information being recorded and reported. This was discussed with the regional care director and a requirement has been made.

10.8 Environment

The home which was purpose built was registered in July 2014. The majority of patients' bedrooms, en-suites and toilet and shower and bathroom areas and communal areas were reviewed.

It was noted that the standards of cleanliness and infection prevention and control measures in some areas of the home were not to an acceptable standard.

This was evidenced by

- furniture was not clean;
- in a number of identified bedrooms odour management issues were evident. In one patient's bedroom, faeces were observed on the radiator and the room was malodourous. In addition the patient's bed had been stripped and had not been remade. This was addressed on prompting by an inspector;
- several bedrooms in the nursing unit were malodourous. These were identified to the regional care director during inspection feedback
- laundry which had been placed in bedrooms had not been put away in drawers and wardrobes and the bedrooms looked untidy;
- breakfast dishes were still in some patients bedrooms at 12.30pm. One relative was observed clearing the dishes away;
- equipment used in patient treatment was not kept clean. This included fall out mats and mattresses;
- some walls were damaged and cannot be effectively cleaned and in some areas holes in the plaster were observed;
- a number of bedrooms were overlooked and there was a lack of privacy for patients. This had also been raised as a complaint;
- a black plastic bag containing a pyjama top was observed behind the bath in the residential unit. The pyjama top was soiled and malodorous; and
- a number of areas were being used inappropriately for storage. The medication room in the residential unit contained zimmmer frames, continence products and three intravenous drip stands.

Privacy screening should be discussed and offered to patients and a record of the outcome of the discussions recorded. An infection control audit of the premises should be undertaken identifying areas for improvement.

The issues were discussed with the regional care director. A requirement has been made to ensure that a consistently high standard of cleanliness is in place at all times, and robust arrangements are in place to ensure the standard of cleanliness throughout the home is monitored**.**

10.9 Fire Safety

The fire alarm was activated during the inspection. A check to determine where the alarm was sounded was undertaken by the maintenance man. This determined that the fire alarm had been activated by a patient.

Patients were observed to be visibly upset and anxious about the noise of the fire alarm and of what was happening around them. Observation of both staff and management identified that they were unsure how to respond and that there was a lack of organisation.

The regional care director was unaware that a notification report required to be submitted to RQIA in respect of such incidences.

The review of the staff training records evidenced 29 staff had not completed the practical component of fire safety training. All staff, including agency staff, must receive fire training appropriate to their roles and responsibility upon appointment. In addition staff who have additional duties in relation to fire safety should receive additional training.

There must also be a robust and effective fire incident reporting system in place for managing fire safety including the reporting of false alarms.

10.10 Finance

During the review of care records an issue regarding the arrangements for patients attending hospital arose. The home does not have an escort policy. In addition there was no information in the patient guide regarding escorts for hospital appointments.

A review of the patient contract indicated that the weekly charges did not cover the cost of transport for hospital appointments. There is information advising that charges to accompany residents and patients for appointments can be obtained from the nurse manager. The regional care director was not clear what this charge was. There was no evidence that the contract in place was sufficiently transparent to inform patients and their nominated representatives of any additional charges. There was a procedure for staff to follow in the event of an emergency hospital admission, however, this required updating.

This was discussed with the regional care director. A requirement has been made to ensure that a transparent patient's contract is in place to inform of additional charges. A recommendation has also been made to modify the patients guide is to include escort arrangements for patients when required to attend hospital appointments including emergency appointments.

10.11 Complaints

The complaints protocol was on display on the entrance foyer of the home; however the name of the previous manager was still recorded. This was amended during the inspection.

A record was maintained of the complaints received; however, from the information presented the inspectors were unable to evidence the action taken. There was a record of a verbal complaint which was made by a person in the community regarding the use of the extractor fan keeping them awake at night. Discussion with the regional care director confirmed that the extractor fan had been left on all night in the kitchen and they had met with the complainant and offered an apology. However, this information was not recorded. In addition a response had been provided to one complainant who had submitted a written complaint in respect of a designated smoking area for their relative. Whilst a written response had been provided it did not determine if the complainant was satisfied with the outcome.

One complaint investigation was still ongoing at the time of inspection.

This was discussed with the regional care director. A requirement has been made to ensure that all complaints received are investigated in accordance with DHSSPS complaints guidance; and

- a record must be maintained of all complaints received and of the action taken
- implement a process to determine if the complainant is satisfied with the action taken in response to their complaint; and
- where the complainant remains dissatisfied, they should be informed of the next steps to be taken.

11.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Norma McAllister, regional care director, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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.

Enquiries relating to this report should be addressed to:

Heather Sleator
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Heather Sleator **Date**
Inspector/Quality Reviewer

The **Regulation** and
Quality Improvement
Authority

Quality Improvement Plan

Secondary Unannounced Care Inspection

Dunmurry Manor

21 January 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Norma McAllister, regional care director, at the conclusion of the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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.

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	12 (1) (a) and (b) 12 (2) (a) and (b)	The registered person must that the following issues are addressed: - all aids and equipment used must be clean - maintenance records for specialist equipment must be retained in accordance with the manufacturers guidance - observed personal care of identified residents and patients must be appropriately addressed, for example, some residents were observed with long nails which were not kept clean. **Ref: 5.0 and 6.3**	Twice	Aids and equipment are maintained and are in clean working order. Maintenance records for specialist equipment is in place. Equipment provided by the Trust is also tracked to ensure servicing of equipment Personal Care Record is completed daily and person in charge of the shift now to sign off and confirm care delivery. Nail Care is part of the personal care record.	Two months

2	20 (1) (a), (b) and (c) 20 (2) 20 (3)	The registered person must ensure that; • sufficient numbers of suitably qualified, skilled and experienced persons are employed to meet the needs of patients and residents with dementia; • all staff employed in the home must complete an induction programme and be assessed as competent by management upon completion; • staff must complete mandatory training at the required time intervals; and • all nursing staff in charge of the home must have a competency and capability assessment completed by the manager. **Ref: 5.0 and 6.1.1 and 6.1.2**	Twice	Deputy Manager is now in post and she is supporting and coaching staff. She continues to be supernumerary until the team is established and developed. Dementia training is being completed and the skill mix is appropriate in order to meet the needs of the residents. Staff have completed an induction programme and competencies are is place. Mandatory training is ongoing and the e-learning is being completed. The e-learning is being monitored and staff are being allocated to complete training. All nursing staff in charge of the home have nurse in charge competency in place. This has been reviewed by the Manager.	Two months

3	17 (1)	The registered person must ensure that robust systems are implemented and monitored regarding the quality of nursing and other services provided by the home. Audits of care records, infection prevention and control, cleanliness of the home and accidents/incidents should evidence that where a shortfall has been identified a system of re-audit has been established and verifies that remedial action has been taken. Audits should include the factual accuracy of recording and reporting. **Ref: 5.0 and 6.4**	Twice	Care records are being standardised and 1-1 coaching is being undertaken with both nurses and CTM so that there are clear guidelines on care file management. Care file audits are in place with SMART targets. Infection Control audit is being undertaken monthly. Housekeeper has been appointed to manage the domstic team.	Two months
4	19 (2) Schedule 4	The registered person must ensure that all records as specified in The Nursing Homes Regulations (Northern Ireland) 2005 are maintained in an up to date manner, are available for inspection and safely and securely stored. These include; • patient's guide • a record of the nursing home's charges to patients • regulation 29 reports **Ref: 5.0 and 6.10**	One	Service user guide is available in reception. A copy is on the relatives notice board. Charges for residents are also posted on the relatives notice board as well as being in the Statement of purpose. Regulation 29 reports are retained in the Managers Office and are available for Relatives to see on request.	Two months

5	27 (4) (e) and (f)	The registered person must ensure all staff receive fire safety and evacuation training in accordance with fire safety regulations. Evidence must be present that any staff member working in the home has completed fire safety training and that this is updated within the required timescales. **Ref: 6.9**	One	Practical fire training has been undertaken and further training is being planned. Fire safety is also being completed on e-learning. Practica fire drill to be arranged before the end of March	One month
6	13 (1) (a) and (b)	The registered person must ensure the proper provision for the nursing, health and welfare of patients. Dementia awareness training should be provided with updates at regular intervals. **Ref: section 6.1.2**	One	Dementia coach and lead has now been appointed in Northern Ireland. Dementia awareness training is being further developed and support and coaching is being given within the home to improve understanding of residents that have Dementia.	Two months
7	25 (a) and (b)	The registered person shall ensure that any newly qualified registrant receives a period of supervised practice and has a designated mentor before they are left in charge of the home. **Ref: 5.0 and 6.1.1**	One	Newly qualified staff have mentors and are undertaking a period of supervised practice. Coaching and support is also being provided at present by Deputy Manager and Manager.	Two months

8	18 (2) (n) (i)	The registered person must ensure activities are planned and provided with regard to the needs of persons with dementia. Additional training should be provided to activities coordinators for support **Ref: 6.3**	One	An activities co-ordinator post has been advertised. The activities co-ordinator currently works 25 hours a week and the needs of the home will require more.	Two months
9	13 (1) (b)	The registered person must ensure the proper provision for the nursing and where appropriate, treatment and supervision of patients. Evidence must be present to verify the delivery and review of care in patients care records. Evidence must be present of; - A record of patients weight - A record of patients continence needs, including bowel pattern - A record that the recommendations of other health professionals is being followed, for example; the tissue viability specialist **Ref: 6.4.1**		Weights are to be recorded in care file. Monthly and weekly weights are reviewed by management and action taken. Continence needs and bowel records are in the care files. The multidisciplinary team records are adhered to and care file updated to reflect the advice of other health professionals.	One month

10	14 (5)	The registered person must ensure that no patient is subject to restrictive practice without a robust risk assessment in place. Evidence must be present of the regular review of the need for restrictive practice and that evidence is present that staff adhere to best practice guidance. **Ref: 6.4.2**	One	Risk assessments are in place to ensure that best practice guidance is in place in relation to any restrictive intervention considered. Residents are encouraged to live in a safe environment with decisions taken as to what is in the residents best interest	One month
11	14 (4)	The registered person must ensure staff complete training to ensure the safety and wellbeing of patient. Staff should undertake training in; - The use of restrictive practice - Management of behaviours that challenge - Deprivation of liberty safeguards **Ref: 6.4.2**	One	Restrictive practice training has been attended by some of the staff and further training is being organised. Challenging behaviour training has also been delivered at Dunmurry. Futher training to be put in place. Deprivation of liberty safeguards also being addressed.	Three months

12	16 (1)	The registered person must ensure that evidence is present that the written care plan is prepared by staff in consultation with the patient and or a representative of how the patients' needs in respect of health and welfare are to be met. **Ref: 6.4**	One	Written care plans are being further developed and input is being sought from residents,relatives and care management. Outcomes of care reviews are reflected in the care plan.	Two months
13	30	The registered person must ensure that RQIA are notified, without delay, of any death, illness or other event which occurs in the home in accordance with this regulation. Records maintained by the home must be factually accurate. Evidence should be present that staff have received training/information as to what is reportable and to whom. **Ref: 6.6**	One	Notifiable events provider guidance is in place so that staff can reference what they need to report. Acccidents and incidents are being checked regularly and being signed off. Supervisions have been given as to how Regulation 30 is completed.All staff involved in reporting of event will have this supervision.	One month
14	30 (1) (d)	The registered person must ensure staff are aware of and adhere to regional guidance and company policy in respect of notifying the relevant professionals/agencies regarding possible safeguarding vulnerable adults' incidents/events. **Ref: 6.7**	One	Safeguarding processes are in place for guidance on what needs to happen if there is a need to notify professional agencies regarding possible safeguarding vulnerable adults incidents and events.	One month

15	27 (d) 13 (7)	27 (d) The registered person must ensure that all parts of the home are kept clean. Evidence must be present of the regular auditing and remedial action, if necessary, of the cleanliness of the home. and 13 (7) The registered person must ensure all staff are trained and adhere to regional procedures and company policy in respect of infection control. Evidence must be present of the regular auditing and remedial action, if necessary, of the infection control procedures operational in the home. **Ref: 6.8**	One	Infection Control audits are now being undertaken monthly. Daily walk throughout the home is undertaken to ensure that standards are being adered to. Cleaning schedules are being signed weekly. Infection Control training is being undertaken. Action is taken to address practice so that a clean environment is maintained. Allocation of responsibility and accountability has been given within the home so that the team effort is involved to address infection control issues.	One month
16	19 (2) Schedule 4 (8)	The registered person must ensure the transparency of the home's charges to patients/residents, including any extra amounts payable for additional services. Evidence must be present in patients/residents residency contract and Patients/residents Guide of charges incurred for accompanying patients/residents to hospital, appointments or other events. **Ref: 6.10**	One	Finance policy for Northern Ireland reflects charges that may occur for residents. This is with the residents contract. Charges for Escort are also posted on the Relatives board and are written in the Service User Guide.	One month

17	24	The registered person must ensure that all complaints received are investigated in accordance with DHSSPS complaints guidance: • A record must be maintained of all complaints received and of the action taken • The registered persons should implement a process to determine if the complainant is satisfied with the action taken in response to their complaint • Where the complainant remains dissatisfied, they should be informed of the next steps to be taken. **Ref: 6.11**	One	Log is in place of the complaints received. The details of the complaint and actiontaken are kept in a file. A follow up conversation with complaniants should occurr to ensure that they are satisfied with how the complaint has been addressed. Where a complainant is dissatisfied they are informed of further steps that they can take with their complaint. Also a copy of the complaint procedure and process is kept in reception area.	One month

Recommendations

These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	25.24	There are arrangements in place to enable international nurses to have a period of supervised practice experience to give safe and effective nursing care, until deemed competent in accordance with NMC procedures. **This recommendation has been brought forward from the previous inspection.**	One	The international nurses are supported in regard to policy and processes and standards in Northern Ireland. Their practice is observed and competency confirmed. The international nurses are encouraged to seek clarity and advice.Having preceptorship nurses is also of benefit as there is sharing of knowledge.	One month
2	30.1	A review of staffing should be undertaken to ensure that at all times the staff on duty meet the assessed need of patients, social and recreational needs of patients/residents, taking into account the size and layout of the home, the statement of purpose and fire safety requirements. **Ref: 6.1.1**	One	The skill mix of staffing is undertaken so that the needs of the residents are addressed. Staff are being made aware of the social and recreational needs that need to be addressed. Engagement with the residents and raising awareness with staff as to how they are able to engage more.	One month

3	5.5	The care and support provided to patients/residents is supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. In accordance with best practice in dementia care life story information should be gathered and made available on patients/residents to assist staff afford person centred care. **Ref: 6.3**	One	Life story and compiling meaningful information on our residents is ongoing. Relatives have been requested and encouraged to help with this. Some of our residents are able to give this information as well and the sharing of their stories with staff will help in providing person centred care.	Three months
4	5.7	Care records should be maintained in an accurate and factual manner. Evidence should be present of; - The accurate and complete assessment of continence needs, including a bowel assessment - The daily progress record should be specific and include information referencing the Bristol Stool Chart when recording bowel patterns **Ref: 6.4.1**	One	Care file records are being organised so that the assessments are available in the same place in each care file. Continence and bowel assessment are recorded in the files. Bowel stool chart is available for referencing.	Two months

5	19.4	Nursing staff should have up to date knowledge and expertise in urinary catheterisation and the management of stoma appliances. **Ref: 6.4.1**	One	Training has been attended by some of the nurses and places are being sought for further training	Three months
6	19.4	Consideration should be given to providing additional training to an identified registered nurse who will act as the link nurse for continence management in the home. **Ref: 6.4.1**	One	A registered nurse has been identified to act as the link nurse for continence management.This nurse has already attended catheterisation training. The representative for the pads being used within the home is being requested to do further training.	Three months
7	5.3	The auditing of care records should ensure that all sections of patients/residents assessment of need are completed. **Ref: 6.4**	One	Auditing is ongoing to improve the care records that are being written. Care plans are being updated.	One month
8	12.5	The second Bain Marie in the home should be used so as patients in the nursing unit do not have to wait until the residents in the residential unit have been served their meal. **Ref; 6.5**	One	Two Bain Marie are being used. One for residential and one for the nursing floor.	Two weeks

9	26.1	An escort policy should be developed and shared with staff to ensure clarity regarding accompanying patient/residents to hospital, appointments or other events. **Ref: 6.10**	One	Escort charges are now in Service User Guide, Statement of purpose . Finance policy Northern Ireland is in place and these charges are also recorded there.	One month

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Norma McAllister
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Logan. N. Logeswaran.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	X	Heather Sleator	18/03/15
Further information requested from provider			