Unannounced Follow Up Care Inspection Report
19 August 2017

Dunmurry Manor

Type of Service: Nursing Home
Address: Rowan Drive, Seymour Hill, Dunmurry, BT17 9PX
Tel No: 028 9061 0435
Inspector: Dermot Walsh

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home registered to provide nursing and residential care for up to 76 persons.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Gavin O'Hare-Connolly (acting)	**Registered Manager:** Julie McKearney
Person in charge at the time of inspection: Janine Curran (Nurse in Charge)	**Date manager registered:** 10 August 2017
Categories of care: Nursing Home (NH) DE – Dementia. Residential Care (RC) DE – Dementia.	**Number of registered places:** Total number of registered beds: 76 Comprising: 40 – NH-DE 36 – RC-DE

4.0 Inspection summary

An unannounced inspection took place on 19 August 2017 from 13.30 to 16.30 hours.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015.

As a result of serious concerns, in relation to the well-being of patients in a nursing home operated by Runwood Homes Ltd., a lay magistrate issued an order to cancel the registration of that home. This inspection was undertaken to provide an assurance that appropriate arrangements were in place for the safety and well-being of patients accommodated in Dunmurry Manor.

The following areas were examined during the inspection:

- management arrangements
- care delivery
- staffing arrangements
- equipment
- behaviours that challenge
- environment
- fire safety

Patients said that they were satisfied with the care and services provided and described living in the home, in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

The term 'patients' is used to describe those living in Dunmurry Manor which provides both nursing and residential care.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Janine Curran, Nurse in Charge, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent inspection

No further actions were required to be taken following the most recent inspection on 28 July 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report

During the inspection the inspector met with six patients and six staff.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

The following records were examined during the inspection:

- duty rota for all week commencing 13 August 2017
- incident and accident records
- eight patient care records
- most recent fire risk assessment
- personal emergency evacuation plans

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 28 July 2017

The most recent inspection of the home was an unannounced care inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 28 July 2017

There were no areas for improvement made as a result of the last care inspection.

6.3 Inspection findings

Management arrangements

A registered manager was employed in the home. To support the registered manager a deputy manager was employed in the nursing unit and a unit manager was employed in the residential unit. In the absence of the registered manager, a nurse in charge had been identified. Competency and capability assessments for the nurse in charge in the absence of the registered manager had been appropriately completed.

Discussion with the nurse in charge confirmed the home's on-call arrangements for out of hours and weekends. The nurse in charge was able to confirm the identity of the on-call person for the weekend and a notice on display within the nursing station confirmed the contact details for the person on-call.

The nurse in charge was able to describe the procedure for referring concerns to adult safeguarding. An adult safeguarding standard operating procedure (SOP) was displayed at the nursing station and included contact details of all Trust adult safeguarding teams including out of hours contact details.

Care delivery

The nurse in charge was able to identify patients who had a wound, were at high risk of falls and patients who required supplements to enhance dietary intake. There was evidence that patient's continence management records had been reviewed during the morning of 19 August 2017.

Discussion with staff in the nursing unit and in the residential unit identified no difficulties about the delivery of care. Patients were observed to present well in their appearance. Daily personal care records had been maintained in respect of areas such as bathing, hair care, oral hygiene, nail care, eye care and ear care.

Discussion with the unit manager in the residential unit confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends on falls in the home in order to prevent recurrence were possible. An SOP for the management of falls in the home was displayed in nursing stations in the home. A review of four patient care records, where the patient had a fall, evidenced that the appropriate actions had been taken following the fall and the appropriate people had been notified of the fall.

Food and fluid intake charts were completed when patients were identified as having weight loss recorded and/or where patients were receiving supplements to enhance nutritional requirements. A monthly weight chart was maintained for all patients accommodated in the home. The chart was colour coded; weight loss highlighted in red and weight gain highlighted in green. A review of four patient care records where weight loss had been identified confirmed that appropriate referrals had been made to health professionals such as dieticians, speech and language therapist and/or general practitioners. Nutritional risk assessments had been updated monthly or more often as required. Patients' care plans had been updated to reflect recommendations made by health professionals. There was evidence of regular dietetic review within patients' care records.

Staffing arrangements

The nurse in charge confirmed the planned daily staffing levels for the home. Observation and a review of staff allocation in the home confirmed that the planned staffing level had been adhered to. RQIA were aware from the previous inspection of 28 July 2017 that these staffing levels were subject to regular review to ensure the assessed needs of the patients were met and this continued.

Duty rotas were made available to staff for the incoming four weeks. A review of the staffing rota for the week commencing 13 August 2017 evidenced that the planned staffing levels were generally adhered to. Discussion with staff confirmed that where agency staff were used to fill gaps in the duty rota, the same agency staff had been employed to allow for consistency of care. Discussion with three agency staff confirmed that they had received an induction to the home prior to commencing on their first shift. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. There were no concerns raised by staff in respect of the staffing arrangements.

Equipment

A random sample of call bells were checked in identified rooms within each of the units in the home. The call bells tested were found to be in working order and wall panels identified the rooms in which the call bells were tested. Likewise, pressure mats in three identified areas within the home were in good working order and rooms identified on wall panels when tested. The nurse in charge was able to describe the arrangements to access equipment out of normal working hours.

Behaviours that challenge

Patients were observed to be relaxed and comfortable in their surroundings during the inspection. Staff engaged with patients in a calm and dignified manner. Staff, when asked, were able to describe the actions they would take to manage behaviours that challenge. A care plan on the management of distressed reactions was included in patients' care records where appropriate. A recent incident submitted to RQIA on managing patient behaviour evidenced that this had been managed appropriately and appropriate persons notified.

Information received by RQIA following the inspection confirmed that 90 percent of staff had received training on dementia management and 46 staff had received face to face training on the management of distressed reactions.

Environment

A review of the home's environment was undertaken and included observations of a number of bedrooms, bathrooms, lounges, dining rooms and storage areas. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Bedrooms and communal areas were clean and spacious. Compliance with infection prevention and control had been achieved. Personal protective equipment holders in the home were full. The home was warm and fresh smelling throughout.

Fire safety

Fire exits and corridors were observed to be clear of clutter and obstruction. Doors within the home had not been propped or wedged open. Personal emergency evacuation plans (PEEP) had been completed for all patients accommodated in the home and a list of the PEEPs were retained in an identified area should an emergency occur in the home. A recent fire risk assessment had been conducted in July 2017. Recommendations made in the assessment had been reviewed by the home's estate staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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