

Unannounced Follow Up Care Inspection Report 9 January 2018



Balmoral View Care Centre

Type of Service: Nursing Home
Address: 5 The Manor, Blacks Road, Dunmurry, BT10 0NB
Tel no: 028 9062 9331
Inspector: Heather Sleator

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 39 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare Responsible Individual: Dr Claire Royston	Registered Manager: Mr Rosendo Soriano
Person in charge at the time of inspection: Rosendo Soriano	Date manager registered: 5 May 2017
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	Number of registered places: Total number of registered beds: 39 Comprising of : 15 patients in category NH-DE 2 named residents in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 9 January 2018 from 10.00 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 DHSSPS Care Standards for Nursing Homes 2015.

This inspection was undertaken to determine what progress had been made in addressing the areas for improvement identified during the previous care inspection on 29 August 2017 and to re-assess the home's level of compliance with legislative requirements and the Care Standards for Nursing Homes. Following the receipt of a serious adverse incident (SAI) from the Northern Health and Social Care Trust and a Significant Event Audit (SEA) from South Eastern Health and Social Care Trust the organisation, Four Seasons Healthcare, had submitted action plans in response to the issues raised in the SAI and SEA. The inspection sought to assess the progress made as stated in the action plans.

It is not the remit of RQIA to investigate adverse or significant events made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, if RQIA is notified of a potential breach of regulations or minimum standards, it will review the matter and take appropriate action as required; this may include an inspection of the home.

The following areas were examined during the inspection:

- care records – including the management of weight loss, wound care and restrictive practice
- governance arrangements including the review of quality audits
- action plans submitted by the organisation in response to a serious adverse incident and a significant event audit

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.

Patients said they were happy living in the home. Comments included, "Staffs great and the food is great too." Further comments can be viewed in section 6.3 of the report.

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 Balmoral View Care Centre which provides both nursing and residential care.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2*	4*

*The total number of areas for improvement includes one regulation and two standards which have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Rosendo Soriano, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 29 August 2017. Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 29 August 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 returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with nine patients individually and others in small groups and six staff. There were no patients representatives who wished to meet with the inspector during the inspection

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- validation evidence linked to the previous care inspection QIP
- a review sample of staff duty rotas
- four patients care records
- supplementary care charts including repositioning records
- a review of quality audits including complaints, accidents, infection prevention and control and care records
- monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland (2005))
- actions plans in response to a serious adverse incident and a significant event audit

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 29 August 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. Refer to section 6.2 for further information.

6.2 Review of areas for improvement from the last care inspection dated 29 August 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 12 (1) (a) and (b) Stated: First time	The registered person shall ensure the delivery of care is in accordance with patients assessed needs, meets his needs and reflects current best practice.	Not met
	Action taken as confirmed during the inspection: The review of four patient care records did not evidence that the issues previously identified at the inspection of 29 August 2017 had been addressed in relation to the use of a restrictive practice and the management of weight loss.	
Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes 2015		Validation of compliance
Area for improvement 1 Ref: Standard 4.8 Stated: First time	The registered provider shall ensure care plans evidence the desired daily fluid intake for individual patients and the action to be taken, and at what stage, should the desired target not be met.	Partially met
	Action taken as confirmed during the inspection: The review of one patients care record did not evidence that the nutritional care plan due to weight loss had been updated to reflect the daily monitoring of the patients nutritional and fluid intake. However, the remaining three care records did not evidence shortfalls regarding hydration.	
Area for improvement 2 Ref: Standard 4.4 Stated: Second time	The registered provider shall ensure that the recommendations made by any other healthcare professional are adhered to.	Met
	Action taken as confirmed during the inspection: The review of four patient care records evidenced that recommendations made by other healthcare professionals including the tissue viability nurse specialist and the speech and language therapist had been adhered to.	

<p>Area for improvement 3</p> <p>Ref: Standard 48.7</p> <p>Stated: First time</p>	<p>The registered provider shall ensure the personal emergency evacuation plans (PEEP's) are maintained in an up to date manner and reflect the needs of patients' at any given time.</p> <p>Action taken as confirmed during the inspection: The personal emergency evacuation plans for the patients in the home were reviewed and evidenced that these were regularly monitored by the registered manager and reflected the number of patients in the home.</p>	<p>Met</p>
<p>Area for improvement 4</p> <p>Ref: Standard 4.9</p> <p>Stated: First time</p>	<p>The registered provider shall ensure that patient care records contain readily accessible and structured information in respect of patients assessed need, including risk assessments and care plans. Information that is no longer current or applicable to the patient should be 'closed' and or moved to another part of the file to lessen any confusion.</p> <p>Action taken as confirmed during the inspection: The review of four patient care records evidenced that the records were maintained in a systematic and comprehensive manner. Current information was readily accessible within the record.</p>	<p>Met</p>
<p>Area for improvement 5</p> <p>Ref: Standard 35.6</p> <p>Stated: First time</p>	<p>The registered provider shall ensure that the recommendations made by any other healthcare professional are adhered to.</p> <p>Action taken as confirmed during the inspection: The review of patient care records evidenced that the recommendations made by other healthcare professional were in evidence in patient care records. However, there was a lack of evidence that the recommendations were being monitored and evaluated by registered nurses.</p>	<p>Partially met</p>

6.3 Inspection findings

Staffing arrangements

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from week commencing 8 January 2018 evidenced that the planned staffing levels were adhered to.

Discussion with staff confirmed that they were satisfied with the staffing arrangements and deployment of staff in the home. Comments included, "I love it here," and "We all work well together."

There was no evidence in respect of patient care being unduly affected due to the staffing arrangements and the deployment of staff. There was a calm and organised atmosphere in the home. Patients were well groomed and expressed their satisfaction with the care afforded to them by staff. Staff were observed responding to requests for assistance from patients promptly and sensitively.

Areas of good practice

Areas of good practice were identified in relation to communication between staff and communication between staff and patients and staffing arrangements.

Areas for improvement

There were no areas identified for improvement.

	Regulations	Standards
Total number of areas for improvement	0	0

6.4 Quality of care delivery, care practices and care records

A review of four patient care records evidenced that the content of the care records had been reviewed and information that was no longer applicable to the patient had been archived. Information within the care records was current and organised in a systematic and readily available manner.

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), speech and language therapist (SALT), dietician and tissue viability nurse specialists (TVN).

Care plans for a patient's elimination needs were reviewed. Care plans detailed a continence management plan, including catheter care and patients' bowel movements were monitored by the registered nurses on a daily basis, using the Bristol Stool guidance as a reference, to ensure that any changes from the patients' usual bowel patterns were identified and timely action taken.

A review of the wound care for two patients evidenced that the management of wound care was in accordance with professional guidelines. Evidence was present of consultation with the relevant healthcare professional, for example; the podiatrist and care plans reflected the professional's recommendations. Wound assessment and treatment records were maintained in accordance with the prescribed dressing regime.

The management of percutaneous endoscopic gastrostomy (PEG) evidenced that the feeding regimes were clearly stated in patient care records and reflected the recommendations of healthcare professionals.

A review of two patients care records evidenced that shortfalls remained regarding the management of weight loss and the management of a restrictive practice. In relation to the management of patients' weight loss two care records were reviewed. The evaluation of patient care did not evidenced that the monthly assessment of need took account of continued weight loss and remained as being assessed as 'low'. The monthly evaluation of care and the patients' daily progress records did not reflect the specific needs of the individuals. Registered nurses were recording generalised statements, for example; "still needs assistance with eating and drinking to maintain adequate nutritional intake". The recording did not evidence the patients' response to planned care and/or the specific interventions to assist the patients or a meaningful evaluation of their nutritional intake on any given day. Both patients had been referred to the relevant health care professional for advice.

The review of a patient care record in respect of the use of a restrictive practice did not evidence that staff were implementing the interventions as stated in the care plan. These issues had been identified at the previous inspection of 29 August 2017 as an area for improvement under regulation. As there was insufficient evidence of compliance in respect of both of the areas discussed, these remain an area for improvement and has been stated for a second time in the quality improvement plan (QIP) of this report.

Personal or supplementary care records including repositioning records and nutritional and fluid intake records were maintained in accordance with best practice and care standards. The review of the records evidenced that; for example, staff were reporting on the condition of a patient's skin following repositioning and that there was no evidence of significant 'gaps' when recording on repositioning. There was evidence that care staff were reporting on patients' nutritional and fluid intake. Regarding the management of weight loss, evidence should be present that this information was being monitored by the registered nurses. This had been identified at the previous inspection of 29 August 2017 and identified as an area for improvement under the care standards. As there was insufficient evidence of compliance this remains an area for improvement and has been stated for a second time in the quality improvement plan (QIP) of this report.

Areas of good practice

Areas of good practice included the approach to and communication between patients and staff.

Areas for improvement

There were no new areas for improvement identified.

	Regulations	Standards
Total number of areas for improvement	0	0

Governance arrangements

Discussion with the registered manager and observation of patients evidenced that the home was not operating within their registered categories of care. The care of two patients was discussed and it was agreed that the home was not registered to meet the needs of one of the patients. This was also discussed with the regional manager, by telephone, following the inspection and it was agreed an application of variation to the registration of the home would be submitted for one named patient. This has been identified as an area for improvement under regulation.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. There was a system in place to identify the person in charge of the home, in the absence of the manager.

Discussions with the staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff described how they felt confident that the management would respond positively to any concerns/suggestions raised.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. However, as shortfalls remained in evidenced regarding patient care records, the registered manager should assure himself, through the auditing process, that the shortfalls identified had been addressed by the registered nurses. This has been identified as an area for improvement under the care standards.

As a further element of its Quality of Life Programme, Four Seasons Healthcare operate a Thematic Resident Care Audit ("TRaCA") which home managers can complete electronically. Nursing homes which have attained the DCF accreditation complete the 'TraCA D' Information such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This information was subject to checks by the regional manager once a month.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement; including areas for improvement identified as a result of RQIA inspections of the home. As areas for improvement have been stated for a second time the regional manager should assure themselves that all aspects of a quality improvement plan have been addressed and compliant. This has been identified as an area for improvement under the care standards

We reviewed the progress made in addressing the areas identified in an action plan following receipt of a serious adverse incident (SAI) from Northern Health and Social Care Trust and a Significant Event Audit (SEA) from South Eastern Health Social Care Trust. The organisation, Four Seasons Healthcare, had submitted the action plans in response to the issues raised in the SAI and SEA. In discussion with the registered manager in respect of the individual action points, it was confirmed that the majority of the areas identified had been addressed. However, as there was some ambiguity a revised and up to date action plan was requested from the regional manager. This was submitted to RQIA on 19 January 2018. The action plans developed will also be monitored by the relevant health and social care trusts for compliance.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and maintaining good working relationships within the home.

Areas for improvement

An area for improvement identified under regulation was in relation to the submission of an application of variation to the registration categories of the home.

Areas identified under the care standards were in relation to a more robust system of auditing patient care records and ensuring that the regulation 29 monthly monitoring report validates compliance with regulations and standards as stated as a result of an inspection

	Regulations	Standards
Total number of areas for improvement	1	2

Consultation with patients and staff

Staff interactions with patients were observed to be caring and positive. Staff were observed speaking to patients in a friendly and sensitive manner. Staff responded to patients' calls for assistance quickly and staff were observed assisting patients with their midday meal in a calm and helpful manner. The staffing arrangements and deployment of staff as observed during the inspection had a positive impact on the delivery of compassionate care experienced by patients. This included the dining experience, the appearance of patients and level of personal care afforded and the timely response, by staff, to patients either by attending to individuals needs in communal areas or responding to patient call bells.

We met with the chef and observed the serving of the midday meal. Tables in both units were attractively set with cutlery and napkins and a range of condiments and drinks were readily available. Lunch consisted of two main courses; it reflected the planned meal as identified in the weekly menu planner. Alternative meals were provided to patients who did not wish to have the planned meal. The meals were pleasantly presented, were of good quality and smelt appetising. Patients who required a modified diet were afforded a choice at mealtimes; this was verified when reviewing the patients' meal choice record. Staff were observed supervising and assisting patients with their meal and monitoring patients' nutritional intake. Hot meals were covered when transferred from the dining room to the patients' preferred dining area. In discussion with the chef it was explained how patients preferred meal choice was provided and the example was given of how one patient meets with him on a daily basis and states what their meal choice for the day was to be. This is generally not what is on the day's menu; however the patient's meal choice is prepared and enjoyed by the patient.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector met with nine patients, two care staff, three registered nurses and one housekeeper.

Staff

All staff spoken with indicated that the care and other services provided in the home were good. Staff advised that the staffing arrangements were adequate to meet the needs of the patients. Staff stated that the registered manager was supportive and approachable.

Comments received from staff included:

- “Good home.”
- “Staffing levels are ok.”
- “We all help each other out.”

Patients

All patients spoken with commented positively about the home; the care they received and that staff were kind and respectful. Patients were observed sitting in the lounges, dining rooms and/or their bedroom, as was their personal preference. Patients appeared well dressed and commented that they had enjoyed their lunch, were offered a choice at mealtimes and were happy in the home.

Comments from patients included:

- “Great wee home.”
- “Manager’s a friendly fella.”
- “Couldn’t say a bad word about them.”
- “Lovely place I would recommend it to anyone.”
- “Staff are wonderful, couldn’t wish for better.”
- “It’s a homely place, not like a care home at all.”

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Rosendo Soriano, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The DHSSPS Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

<p>Area for improvement 1</p> <p>Ref: Regulation 12 (1) (a) and (b)</p> <p>Stated: Second time</p> <p>To be completed by: 19 February 2018</p>	<p>The registered person shall ensure the delivery of care is in accordance with patients assessed needs, meets his needs and reflects current best practice.</p> <p>Ref: Sections 6.2 and 6.3</p>
	<p>Response by registered person detailing the actions taken:</p> <p>Patients care is based on their individualised needs assessments and reflects current best practice. The registered manager is monitoring the care being given during his daily walkabout around the home, and from feedback from the patients themselves.</p>

<p>Area for improvement 2</p> <p>Ref: Regulation 3 (1) (c) schedule 1 (8)</p> <p>Stated: First time</p> <p>To be completed by: 19 February 2018</p>	<p>The registered person shall submit an application of variation of the registered categories of care for the home in relation to one named person.</p> <p>Ref: Section 6.3</p>
	<p>Response by registered person detailing the actions taken:</p> <p>An application for variation of the registered categories of care for the home in relation to one named person has already been submitted to RQIA for approval.</p>

Action required to ensure compliance with The Care Standards for Nursing Homes 2015

<p>Area for improvement 1</p> <p>Ref: Standard 4.8</p> <p>Stated: Second time</p> <p>To be completed by: 19 February 2018</p>	<p>The registered provider shall ensure care plans evidence the desired daily fluid intake for individual patients and the action to be taken, and at what stage, should the desired target not be met.</p> <p>Ref: Section 6.2 and 6.3</p>
	<p>Response by registered person detailing the actions taken:</p> <p>The registered manager is monitoring care documentation closely to ensure that care plans all evidence the desired daily fluid intake for individual patients. Then, if and when the desired daily fluid target is not met, appropriate action is taken and relevant professionals informed.</p>

<p>Area for improvement 2</p> <p>Ref: Standard 35.6</p> <p>Stated: Second time</p> <p>To be completed by: 19 February 2018</p>	<p>The registered provider shall ensure that the recommendations made by any other healthcare professional are adhered to.</p> <p>Ref: Section 6.2 and 6.3</p> <hr/> <p>Response by registered person detailing the actions taken: All recommendations made from any healthcare professionals are being adhered to and is reflected on individual patients needs assessments and care plan. The registered manager is monitoring this closely on an ongoing basis while reviewing care documentation and daily shift reports.</p>
<p>Area for improvement 3</p> <p>Ref: Standard 35.6</p> <p>Stated: First time</p> <p>To be completed by: 19 February 2018</p>	<p>The registered person shall ensure that a robust system of the auditing of patient care records is established and completed audits are validated by the registered manager.</p> <p>Ref: Section 6.3</p> <hr/> <p>Response by registered person detailing the actions taken: There are system of robust auditing of patient care records which is validated by registered manager.</p>
<p>Area for improvement 4</p> <p>Ref: Standard 35.7</p> <p>Stated: First time</p> <p>To be completed by: 19 February 2018</p>	<p>The registered person shall ensure that the Regulation 29, monthly quality monitoring report evidences that areas for improvement stated in quality improvement plans (QIPS), following an inspection by RQIA, are addressed.</p> <p>Ref: Section 6.3</p> <hr/> <p>Response by registered person detailing the actions taken: Monthly quality monitoring (Reg. 29) report which stated areas for improvement plans were addressed and carried out.</p>

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



The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9051 7500

Email info@rqia.org.uk

Web www.rqia.org.uk

 @RQIANews