# Unannounced Care Inspection Report
# 3 April 2017

# Pond Park Care Home

**Type of Service: Nursing Home**
**Address: 2 Derriaghy Road, Lisburn, BT28 3SF**
**Tel no: 028 9267 2911**
**Inspector: Aveen Donnelly**

## 1.0 Summary

An unannounced inspection of Pond Park took place on 3 April 2017 from 09.30 to 18.30 hours.

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

Concerns were identified in relation to the standard of the physical environment, specifically in the pond park unit of the home; and to the lack of progress made, in achieving compliance against previously stated recommendations.

**Is care safe?**

The systems to ensure that care was safely delivered were reviewed. We examined recruitment practices; staffing levels and the duty rosters; and staff training and development. Staff were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding.

Weaknesses were identified in the delivery of safe care, specifically in relation to the staffs' registration status with their professional bodies; the standard of décor in the home; the system for monitoring pressure mattresses settings; the completion of falls risk assessments; and the system for reviewing the personal egress evacuation plans (PEEPS); Two requirements and three recommendations were made in this domain to secure compliance and drive improvement.

**Is care effective?**

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that that the outcome of care delivery was positive for patients. A review of care records confirmed that a range of risk assessments were completed. Care plans were created to prescribe care and there were arrangements in place to monitor and review the effectiveness of care delivery.

We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Patients and staff were of the opinion that the care delivered provided positive outcomes. One area for improvement was identified to ensure that the methods available for engagement with patients are reviewed to ensure they are effective. One recommendation was made in this domain.

**Is care compassionate?**

Patients were very praiseworthy of staff and a number of their comments are included in the report. Staff were observed responding to patients' needs and requests promptly and cheerfully. Weaknesses were identified in relation to the environment on the pond park unit, which impacted on the dignity of patients. One requirement was made in this domain.

**Is the service well led?**

There was a clear organisational structure evidenced within Pond Park and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide. Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty.

Despite matters being raised previously, four recommendations continued to be non-compliant. Weaknesses were also identified during this inspection, in relation to the notifications of serious injuries to RQIA; the auditing processes; the staffing rota; and the management of staff alerts for staff who had sanctions imposed on their employment by professional bodies. Two requirements and three recommendations were made in the well led domain during this inspection.

Following this inspection, the responsible individual was required to attend a meeting in RQIA on 7 April 2017, to discuss the findings and to provide RQIA with assurances as to how the home will return to compliance. The outcome of this meeting is detailed in section 1.1 below. A further inspection will be undertaken to evidence that the required improvements have been made.

Throughout the report the term, 'patients', is used to describe those living in Pond Park which provides both nursing and residential care.

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

## 1.1 Inspection outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 6 | *9 |

*The total number of requirements and recommendations above includes three recommendations that have been stated for the second time. Another recommendation which was not met resulted in a requirement being made during this inspection.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Suzanne Scott, registered manager; and Lorraine Thompson, regional manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Given the inspection findings, RQIA were concerned regarding the governance arrangements within Pond Park Care Home. The inspection findings were communicated in correspondence to the responsible individual, Dr Maureen Claire Royston and a meeting to discuss the concerns took place in RQIA on 7 April 2017.

Carol Cousins, managing director, Suzanne Scott, registered manager and Lorraine Thompson, regional manager attended the meeting.

During the meeting, management representatives acknowledged the failings identified and submitted a detailed and comprehensive action plan to address the identified concerns. RQIA were satisfied with the action plan and the assurances provided and a decision was made to give them a period of time to address the concerns raised. A further inspection will be undertaken to validate compliance and drive necessary improvements.

## 1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 13 September 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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

## 2.0 Service details

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| **Registered organisation/registered person:**<br>Four Seasons (Bamford) Ltd<br>Dr Maureen Royston | **Registered manager:**<br>Suzanne Scott |
| **Person in charge of the home at the time of inspection:**<br>Suzanne Scott | **Date manager registered:**<br>19 May 2014 |
| **Categories of care:**<br>RC-I, NH-I, NH-PH, NH-PH(E), NH-TI, NH-DE<br><br>A maximum of 11 patients in category NH-DE accommodated in the Wallace Suite.<br>Of the residents in category RC-I, a maximum of 4 residents shall be accommodated in single occupancy bedrooms 21, 22, 24 and 25 and a maximum of 3 residents in the Pond Park Unit. | **Number of registered places:**<br>58 |

## 3.0 Methods/processes

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

Prior to inspection we analysed the following information:

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

- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with six patients, four care staff, two registered nurses, six patients' representatives and one visiting professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- staff training records for 2016/2017
- accident and incident records
- audits in relation to infection prevention and control; and falls
- one staff recruitment and selection record
- complaints received since the previous care inspection
- staff induction records
- records pertaining to NMC and NISCC registration checks
- minutes of staff' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures

## 4.0 The inspection

### 4.1 Review of requirements and recommendations from the most recent inspection dated 13 September 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

## 4.2 Review of requirements and recommendations from the last care inspection dated 9 May 2016

| Last care inspection recommendations | | Validation of compliance |
|---|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 19<br><br>**Stated:** Second time | Staff should receive training/ supervision on the content of the new palliative care and end of life manual once completed to ensure they are knowledgeable regarding best practice in this aspect of care. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>Although the training content was available, the list of attendees was not maintained. Consultation with staff evidenced that only three of the ten staff spoken with, had received the training. This recommendation was not met. A requirement has now been made in this regard. | |
| **Recommendation 2**<br><br>**Ref**: Standards 19 and 32<br><br>**Stated:** Second time | Best practice guidelines including the regional guidelines on breaking bad news (2003) and the GAIN palliative care guidelines, should be made available to staff for reference. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The above guidance documents were available for staff to reference. | |
| **Recommendation 3**<br><br>**Ref**: Standard 32 criterion 8<br><br>**Stated:** Second time | The cultural, religious and spiritual needs of patients should be discussed and incorporated into the care plans for the end of life. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>A review of patient care records confirmed that cultural, spiritual and religious needs were included in the care plan for end of life care. | |

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| **Recommendation 4**<br><br>**Ref**: Standard 41<br><br>**Stated:** First time | The registered persons should ensure that the staff on duty at all times meets the needs of the patients. The roles and responsibilities of staff should be reviewed in relation to the transport of tea trolleys to and from Wallace unit. The deployment of staff in pond park unit should also be reviewed to ensure that patients receive adequate supervision at all times. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Discussion with the registered manager and staff confirmed that patients were supervised appropriately and that there were no concerns regarding the staffing levels. Two staff members informed the inspector that at times the care staff continued to transport the tea trolleys to and from the kitchen. This was communicated to the registered manager who agreed to monitor this practice. | |
| **Recommendation 5**<br><br>**Ref**: Standard 4<br><br>**Stated:** First time | The registered person should ensure that entries in care records are meaningful, contemporaneous, dated, timed and signed and accompanied by the name and designation of the signatory. The language used should reflect person-centred principles. Action should be taken to address any staff management issues in this regard. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>A review of care records confirmed that records were maintained in accordance with best practice guidance, care standards and legislative requirements. | |
| **Recommendation 6**<br><br>**Ref**: Standard 34<br><br>**Stated:** First time | The registered person should arrange a care review to discuss the suitability of the placement of one specified patient and how best their needs can be met in accordance with the home's statement of purpose. Confirmation of the date of this meeting is to be sent to RQIA with the return of the QIP. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The specified patient referred to was no longer residing in the home. Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. | |

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| **Recommendation 7**<br><br>**Ref**: Standard 12<br><br>**Stated:** First time | The registered person should ensure that the menu is displayed in a suitable format and in a suitable location to show what is available at each mealtime. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The menu was displayed appropriately in each dining room. | |
| **Recommendation 8**<br><br>**Ref**: Standard 12<br><br>**Stated:** First time | The registered person should address the concerns raised regarding the timing of the evening meal and the choices available. Patients' level of satisfaction should be assessed and any concerns addressed accordingly. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>Discussion with patients and staff confirmed that the evening meal continued to be served at 16.30 hours. Patients also stated that although their opinions had been sought, no changes had been made in response to their comments/suggestions. We were also not assured that fresh fruit was consistently offered to patients. This recommendation was not met and has been stated for the second time. Refer to section 4.5 for further detail. | |
| **Recommendation 9**<br><br>**Ref**: Standard 16<br><br>**Stated:** First time | The registered persons should ensure that records of complaints are maintained to include details of the complaint, the result of any investigation, the action taken; whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>A review of the minutes of the most recent staff' meeting evidenced that a concern which had been raised by a relative had been discussed. Although discussion with the registered manager confirmed how this complaint had been managed, this was not recorded in line with the home's policies and procedures. This recommendation was not met and has been stated for the second time. | |

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| **Recommendation 10**<br><br>**Ref**: Standard 35<br><br>**Stated:** First time | The registered person should ensure that when audits identify any shortfalls there is clear evidence of the action taken to address these. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>Although a range of audits were conducted on a regular basis, there was no evidence of any action taken in response to identified shortfalls. Refer to section 4.6 for further detail. This recommendation was not met and has been stated for the second time. | |

## 4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 27 March 2017 evidenced that the planned staffing levels were generally adhered to. Discussion with patients, relatives and staff evidenced that there were no concerns regarding the staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

The registered manager explained there were currently three registered nurse vacancies and two care staff vacancies. These vacancies were being filled by agency staff or permanent staff working additional hours.

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

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly quality monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and staff confirmed that there was a system in place to monitor staff performance and to ensure that staff received support and guidance. Staff were mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals. Discussion with staff confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home.

A review of personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed.

The review of recruitment records evidenced that enhanced criminal records checks were completed with AccessNI and a register was maintained which included the reference number and date received. Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with the Nursing and Midwifery Council (NMC).

Similar checks were carried out for care staff' registrations with the Northern Ireland Social Care Council (NISCC); however, two care staff members had not applied for registration, within the required timeframe after commencing employment. Although the review of the monthly monitoring checks confirmed that this matter had been identified by the registered manager, the system to ensure care staff applied for registration with the NISCC, within the required timeframe was not sufficiently robust. A recommendation has been made in this regard.

All staff consulted with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report any concerns. The registered manager confirmed that there had been no actual or potential adult safeguarding issues since the previous care inspection. The arrangements in place to implement the new regional safeguarding procedures were not clear on the day of the inspection; however; following the inspection correspondence was received from the managing director, which confirmed the organisation's arrangements to support the home to comply with the regional policy. The organisation's safeguarding adults policy had been reviewed in June 2016 and is due to be revised again in June 2017, to ensure that it reflects the 'Adult Safeguarding and Prevention and Protection in Partnership' policy (July 2015) and the 'Adult Safeguarding Operational Procedures' (2016).

A range of validated risk assessments were completed as part of the admission process and were generally reviewed on a regular basis. However, patients' risk assessments and care plans were not always updated when patients' needs changed. For example, although risk assessments and care plans had been completed for patients who were at risk of falling, these had not been revised when a patient had fallen. A recommendation has been made in this regard. Refer to section 4.6 for further detail.

One identified patient required a pressure relieving mattress on their bed. Observation of the specific pressure relieving mattress evidenced that staff had to 'set' the pressure according to the patient's weight. We found that the patient, whose weight was 55.1 kgs was using a mattress that was set for a patient of more than 110 kgs which would not effectively relieve pressure and could potentially be detrimental. Discussion with staff confirmed that there was no process in place to monitor or record pressure mattress settings. This was discussed with the registered manager. A requirement has been made in this regard.

A review of the home's environment was undertaken which included a sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy and warm throughout. However, a number of areas within the pond park unit were not well decorated and required refurbishing.

The concerns identified included but were not limited to:

- woodwork under sink required repairing
- carpet on stairs and landing stained and in need of cleaning/replacement
- flooring in one ensuite bathroom separated from the wall
- architrave to a number of doors damaged
- carpets in two bedrooms stained and in need of replacement
- carpet in one identified bedroom malodorous and in need of cleaning or replacement
- the legs on a linen trolley were broken
- a wall in one identified bedroom was stained and had a hole in the wall which needed repaired

The management team advised that refurbishment work has been scheduled for completion within the next six months and provided assurances that the identified areas would be prioritised for refurbishment. RQIA acknowledges that some of the above issues had been previously identified in the monthly quality monitoring visits; however many of the issues identified in the action plan had not been followed up in a timely manner. Following the inspection, the registered manager confirmed to RQIA by email on 4 April 2017, that one identified patient had been temporarily moved to another bedroom, to enable redecoration to commence. These matters were discussed with the registered manager at the meeting held in RQIA on 7 April 2017. RQIA will continue to monitor the progress of the planned improvements in accordance with the timescales provided during subsequent inspections.

Incontinence odours were observed in one identified patient's bedroom. This was discussed with the registered manager. A requirement has been made that the floor covering in this bedroom is replaced to ensure that the malodours are effectively eliminated.

Infection prevention and control measures were adhered to and equipment was stored appropriately.

Fire exits and corridors were maintained clear from clutter and obstruction. Each patient had a Personal Emergency Egress Plan (PEEP) completed taking into account their mobility, assistance level and any equipment needed to evacuate them safely. However, the PEEPS had not been consistently reviewed when patients' needs had changed. This was discussed with the registered manager. A recommendation has been made in this regard.

**Areas for improvement**

A requirement has been made that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use.

A requirement has been made that the floor covering in the identified patient's bedroom is replaced to ensure that the malodours are effectively eliminated.

A recommendation has been made that a robust system is implemented to ensure that care staff register with the Northern Ireland and Social Care Council (NISCC), in line with the home's policy and procedure.

A recommendation has been made that risk assessments are completed following patients' falls.

A recommendation has been made that the patients' Personal Emergency Egress Plans (PEEPs) are consistently reviewed, to ensure that they reflect current need in terms of mobility and assistance level; and any equipment required for safe evacuation from the home. The location of the PEEPs should be discussed with the home's fire risk assessor and the outcome of this discussion communicated to RQIA with the returned QIP.

| Number of requirements | 2 | Number of recommendations | 3 |
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## 4.4 Is care effective?

A review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process. Care records accurately reflected that the assessed needs of patients' were kept under review and where appropriate they adhered to recommendations prescribed by other healthcare professionals such as the tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

The review of care records evidenced that registered nurses assessed, planned and evaluated care in accordance with NMC guidelines.

Staff demonstrated an awareness of the importance of contemporaneous record keeping. A review of personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition.

Staff also confirmed that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. All those consulted with confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Discussion with the registered manager and review of records evidenced that relatives' meetings were held on a regular basis and records were maintained. Patients consulted with all knew who the manager was and stated that she they saw them on a regular basis. However, meetings with patients were not formalised and discussion with the registered manager confirmed that these had not taken place in some time. All patients consulted with stated that they would like to have the opportunity to put their views forward. A recommendation has been

made that the management should review the methods available for engagement with patients to ensure they are effective.

**Areas for improvement**

A recommendation has been made that the management should review the methods available for engagement with patients to ensure they are effective.

| Number of requirements | 0 | Number of recommendations | 1 |
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## 4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients consulted with stated that they felt that they were afforded choice, privacy, dignity and respect; and described the staff and management in positive terms.

The majority of patients' bedrooms were personalised with photographs, pictures and personal items. However, an area of the Pond Park unit was observed to be in need of redecoration, particularly in two patient's bedrooms. Refer to section 4.3 for further detail regarding the environment. The bedrooms identified had not been personalised, bed linen was observed to be worn and faded; and there was no attention to detail in the way staff dressed the beds. For example, one patient did not have a bedside locker and their lamp was placed on the floor beside the bed. Many of the beds were made with only duvet covers and no top sheets. Despite this all patients consulted with stated that they were comfortable and that the home was never cold. This was discussed with the management team on the day of the inspection, who agreed to address the matter. A requirement has been made in this regard.

Although patients confirmed that they were offered a choice of meals, snacks and drinks throughout the day, two patients stated that their feedback in relation to the types of food offered had not been acted upon. The most recent dining audit also did not ascertain patients' opinions in relation to the food being served. We had mixed responses from patients and staff in relation to the availability of fresh fruit. Staff consulted with stated that it was sometimes available in the afternoon. Comments from patients included 'you may get fruit the odd time' and 'you wouldn't see fresh fruit here'. As discussed in section 4.2, a recommendation made in relation to meal times and food choices has been stated for the second time.

We observed the lunch time meal in two dining rooms. The menus were displayed clearly on each table in the dining rooms and were correct on the day of inspection. The food served at lunch looked well-balanced and portion sizes were adequate. Tables were set attractively and were well-spaced so that people could move about freely and choose where they sat. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. A variety of condiments were available in sachets on each table. Discussion with staff confirmed that they provided assistance to the patients who had difficulty opening the sachets. This was discussed with the registered manager, who provided assurances that this matter would be addressed.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home.

There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. There were various photographs displayed near the front entrance of the home of patients' participation in recent activities.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met. At the time of the inspection no one was receiving end of life care.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the manager, staff, relatives and a review of the compliments received, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

During the inspection, we met with six patients, four care staff, two registered nurses, six patients' representatives and one visiting professional. Some comments received are detailed below:

**Staff**

"I have no concerns"
"The care is good, but we could do with new furniture, curtains in the bedrooms"
"I am very proud of the care given by the care staff"
"All the staff are very good, the patients are well looked after"
"The care is very good, the staff are good and the patients get what they need"
"All is good here, the staff are good and management runs a tight ship"

Two staff commented that they would like more staff on duty, to enable them to do extra little things for patients. These comments were relayed to the registered manager to address. Consultation with staff and observation on the day of the inspection confirmed that patients' needs were being met by the number and skill mix of staff on duty.

**Patients**

"It is all very good, I get what I need"
"The staff are very polite"
"I am getting on fine, I like it here"
"I have no dispute about nothing, they are all very nice and I am treated fairly"
"You couldn't say better about them, they are very considerate"
"I have no issues, it is first class"

**Patients' representatives**

"'I have no concerns in the least"
"No problems here, I am happy enough"
"They are all very helpful, despite up and down days"
"I am very impressed with the staff, we really appreciate how lucky we are here"

"It seems to be very good, I can't complain"
"My (relative) is treated very well here"

**Visiting Professionals**

"No concerns here, everything is fine"

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Two staff, five patients and six relatives returned their questionnaires within the timeframe for inclusion in this report. With the exception of one staff questionnaire, all respondents indicated that they were either 'satisfied' or 'very satisfied' that the care was safe, effective and compassionate; and that the home was well-led. Written comments received on one staff questionnaire related to dissatisfaction with staffing levels between 14.00 and 16.00 hours; and to the lack of information available for planning the care for patients who are newly admitted to the home. Following the inspection these comments were relayed to the registered manager, to address.

**Areas for improvement**

A requirement has been made that the environment is reviewed to ensure that this respects the dignity of patients at all times. Staff must also have an awareness of the potential negative impact this may have on patients' dignity.

| **Number of requirements** | 1 | **Number of recommendations** | 0 |
|---|---|---|---|

## 4.6 Is the service well led?

Although there was some evidence that action had been taken to improve the effectiveness of care, the total number of requirements and recommendations made during this inspection included three recommendations that have been stated for the second time.

The recommendation made in relation to staff training on the palliative and end of life care manual was also not met and has now been stated as a requirement. Given the lack of progress in meeting all the previously stated recommendations and the number of requirements and recommendations made during this inspection, we were concerned regarding the management and governance arrangements in the home.

The organisational structure of the home was discussed with the registered manager during feedback on the day of the inspection. The registered manager explained that there was one deputy manager and three clinical lead nurses in post; however, the deputy manager had not consistently been given supernumerary hours, which may potentially have supported the registered manager to take action to improve the effectiveness of the care. The registered manager had also recently been without administrative support and was fulfilling administrative duties on the day of the inspection. This was addressed in the action plan submitted at the meeting held in RQIA on 7 April 2017. Assurance were provided that supernumerary hours would be allocated to the deputy manager and where this were not possible, additional support would be provided by the regional manager, as required.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

All those consulted with knew who the registered manager and other members of the senior management team were and stated that they were available at any time if the need arose. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff described the registered manager in positive terms. Comments included 'she is very approachable' and 'she deals with things very confidentially'.

Discussion with the registered manager and review of the home's complaints record evidenced that where complaints were recorded, they were managed appropriately. However, a review of the minutes of a staff meeting identified that one complaint had been discussed. This complaint had not been reflected in the complaints record. As discussed in section 4.2, a recommendation that was previously stated has been stated for the second time in this regard.

Discussion with the registered manager confirmed that a range of audits were conducted on a regular basis. However, we were not assured of the effectiveness of the audits due to the lack of analysis and follow up action taken in response to identified issues. For example, the infection prevention and control audits evidenced deficits with staff compliance with hand hygiene and wearing personal protective equipment; and there was no evidence of the action taken to address the shortfalls. Similarly, the falls audit, which was used to reduce the risk of further patient' falls did not identify the patients who had fallen most frequently. As discussed in section 4.2 a recommendation that was previously stated was stated for the second time.

The falls audit also did not identify a serious injury which was reportable under Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been made in this regard.

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. The monthly quality monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. Although an action plan was generated to address any areas for improvement, the review of the quality monitoring reports identified that a number of areas for improvement had not been addressed and had been repeated on successive action plans. A requirement has been made in this regard.

A review of the staffing rotas evidenced that amendments had been were made using address labels. The registered manager explained that a permanent photocopy of the staffing rota would normally have been made by the administrator. However, this had not been done. This was discussed with the registered manager. A recommendation has been made in this regard.

The registered manager discussed the processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts. However, we were unable to evidence that the system for managing alerts regarding staff with sanctions imposed on their employment by professional bodies, was sufficiently robust. This was discussed with the registered manager. A recommendation has been made in this regard.

**Areas for improvement**

A requirement has been made that RQIA notifiable events are reported to RQIA.

A requirement has been made that the person identified with the responsibility for undertaking the monthly quality monitoring visits, maintains a robust oversight of the audits maintained in the home. Where identified areas for improvement are identified, follow up action must be taken with specified timescales clarified.

A recommendation has been made that a permanent record is maintained of the staffing rotas; and the practice of amending duty rotas, as described above, must cease.

A recommendation has been made that the robust arrangements are put in place to manage alerts received, in relation to staff with sanctions imposed on their employment by professional bodies.

| Number of requirements | 2 | Number of recommendations | 2 |
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## 5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Suzanne Scott, registered manager and Lorraine Thompson, regional manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing 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.

## 5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

## 5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

## 5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

## Quality Improvement Plan

**Statutory requirements**

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| **Requirement 1**<br><br>**Ref**: Regulation 20 (1)(c)(i)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>1 June 2017 | The registered persons must ensure that staff receive training/ supervision on the content of the palliative care and end of life manual to ensure they are knowledgeable regarding best practice in this aspect of care.<br><br>**Previously stated on two occasions as recommendations.**<br><br>**Ref: Section 4.2 and 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>To date 41 out of 53 staff have attended face to face palliative care and end of life training. Supervisions have taken place to ensure that staff fully understand the content of the training delivered. The remaining staff will have completed this training by 30 May 17 |
| **Requirement 2**<br><br>**Ref:** Regulation 13 (1) (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>1 May 2017 | The registered persons must ensure that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use.<br><br>**Ref: Section 4.3** |
| | **Response by registered provider detailing the actions taken:**<br>The settings of the pressure relieving mattresses have been accurately recorded on the repositioning charts and are checked and signed when care is delivered. Any resident who requires an airwave mattress has an individual care plan in place stating the required make, model and setting. This will also be reviewed by trained staff in relation to any weight changes that may occur. |
| **Requirement 3**<br><br>**Ref:** Regulation 18 (2) (j)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>1 June 2017 | The registered persons must ensure that the floor covering in one identified bedroom is replaced to ensure that the malodours are effectively eliminated.<br><br>**Ref: Section 4.3** |
| | **Response by registered provider detailing the actions taken:**<br>In relation to the identified room the floor covering has been replaced, in addition to this all other identified flooring has been replaced as needed. |
| **Requirement 4**<br><br>**Ref:** Regulation 13 (8) (a)<br><br>**Stated:** First time | The registered persons must review the environment to ensure this respects the dignity of patients at all times. Staff must also have an awareness of the potential negative impact this may have on patients' dignity.<br><br>**Ref: Section 4.5** |

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| **To be completed by:**<br>1 June 2017 | **Response by registered provider detailing the actions taken:**<br>A review of bed linen has been undertaken and items replenished as needed Bedrooms on Pond Park unit have been repainted. Bedrooms that appeared to be lacking in individuality have now been personalised accordingly and made homely. |

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| **Requirement 5**<br><br>**Ref:** Regulation 30 (1) (c)<br><br>**Stated:** First time<br><br>**To be completed by:** Immediately from date of inspection | The registered persons must ensure that RQIA is notified of all notifiable events.<br><br>**Ref: Section 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>———RQIA will be notified off all notifiable events to include any injury above the neck which requires CNS observation..This will also include any accidents requiring medical attention. The Home Manager and Deputy Manager are aware of the need to monitor all incident to ensure reporting as needed, supervision has been undertaken with the HM and DM in this regard. |
| **Requirement 6**<br><br>**Ref:** Regulation 10 (1)<br><br>**Stated:** First time<br><br>**To be completed by:** 1 June 2017 | The registered persons must ensure that the person identified with the responsibility for undertaking the monthly quality monitoring visits, maintains a robust oversight of the audits maintained in the home. Where identified areas for improvement are identified, follow up action must be taken with specified timescales clarified.<br><br>**Ref: Section 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>———Regulation 29 report action points have been reviewed and clear dates set for compeltion. Supervisions have been completed with the Home Manager and Deputy Manager on the need to address actions in a timely manner and within timescales. The Regional Manager will monitor the progress of action fortnighly. |
| **Recommendations** | |
| **Recommendation 1**<br><br>**Ref**: Standard 12<br><br>**Stated:** Second time<br><br>**To be completed by:** 1 June 2017 | The registered persons should address the concerns raised regarding the timing of the evening meal and the choices available. Patients' level of satisfaction should be assessed and any concerns addressed accordingly.<br><br>**Ref Section 4.2 and 4.5** |
| | **Response by registered provider detailing the actions taken:**<br>———A dining audit has been completed on all three units, followed by an action plan with agreed dates when actions will be addressed. This has been shared with the cook. Food questionnaires have been completed and feedback discussed with the cook. Spot checks are carried out regarding the times of meals served by the Home Manager and/or Deputy Manager, which is recorded on the shift report. QOL feedback has been reviewed and 15 relative questionnaires and 43 resident questionnaires have been completed with no identified issues regarding meals or meal times. Fresh fruit is available on a daily basis and on request. Condiments on tables have now been changed back to containeres rather than sachets and are readily available on all tables and trays. There is a choice of meals at each meal time and individual requests are met. |

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| **Recommendation 2**<br><br>**Ref**: Standard 16<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>Immediately from date of inspection | The registered persons should ensure that records of complaints are maintained to include details of the complaint, the result of any investigation, the action taken; whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined.<br><br>**Ref Section 4.2 and 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>The Regional Manager has completed supervision sesssion with the Home Manager and Deputy Manager on the management of complaints. All complaints/concerns have been entered onto datix with an investigation, outcome and lessons learnt recorded |

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| **Recommendation 3**<br><br>**Ref**: Standard 35<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>1 June 2017 | The registered person should ensure that when audits identify any shortfalls there is clear evidence of the action taken to address these.<br><br>**Ref Section 4.2 and 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>———Action plans have been developed following all audits to ensure that any shortfalls are addressed. Supervision has been completed with Home Manager and Deputy manager on the completion and follow through of action plans. These will be monitored by the Regional Manager during monitoring visits. |
| **Recommendation 4**<br><br>**Ref**: Standard 39<br><br>**Stated:** First time<br><br>**To be completed by:**<br>1 June 2017 | The registered persons should ensure that a robust system is implemented, to ensure that care staff' register with the Northern Ireland and Social Care Council (NISCC), in line with the home's policy and procedure.<br><br>**Ref: Section 4.3** |
| | **Response by registered provider detailing the actions taken:**<br>———NISCC checks are completed on a monthly basis to ensure staff are registered. The one outstanding staff member's documentation has been verified and awaiting final registration. All new staff will not be permitted to pass their probationary period without having applied to NISCC |
| **Recommendation 5**<br><br>**Ref**: Standard 22.4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediately from date of inspection | The registered persons should ensure that risk assessments are completed following patients' falls.<br><br>**Ref: Section 4.3** |
| | **Response by registered provider detailing the actions taken:**<br>———Supervision has been completed with all trained staff on the need to complete/update risk assessments following a fall. This will be monitored by the Home Manager and Deputy Manager on completion of datix report. Fall TRaCA will be completed by Regional Manager during the monitoring visit as appropriate. |
| **Recommendation 6**<br><br>**Ref**: Standard 7.1<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With the return of the QIP | The registered persons should ensure that the patients' Personal Emergency Egress Plans (PEEPs) are consistently reviewed, to ensure that they reflect current need in terms of mobility and assistance level; and any equipment required for safe evacuation from the home.<br><br>The location of the PEEPs should be discussed with the home's fire risk assessor and the outcome of this discussion communicated to RQIA with the returned QIP.<br><br>**Ref: Section 4.3** |
| | **Response by registered provider detailing the actions taken:**<br>———The Personal Evacuation Egress Plans have all been reviewed |

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| | and updated as needed. These will be monitored monthly by the named nurse when competing monthly reviews of care documentation. On discussion with the fire risk assessor PEEP's will be retained in individal care file and in the residents bedroom. |

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| **Recommendation 7**<br><br>**Ref**: Standard 7.1<br><br>**Stated:** First time<br><br>**To be completed by:**<br>1 June 2017 | The registered persons should review the methods available for engagement with patients and relatives to ensure they are effective.<br><br>**Ref: Section 4.4** |
| | **Response by registered provider detailing the actions taken:**<br>———The Home Manager held a resident meeting on 18 April 2017 and minutes are available. Meetings will take place a minimum of quarterly. Relative meeting has been scheduled for 16 May 2017, any concerns raised will be entered on datix and investigated accordingly. |
| **Recommendation 8**<br><br>**Ref**: Standard 41<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediately from date of inspection | The registered persons should ensure that that a permanent record is maintained of the staffing rotas; and the practice of amending duty rotas, as described in section 4.6, should cease.<br><br>**Ref: Section 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>———The maintenance and up keep of the rota and any changes has been allocated to the Clinical Lead Nurse. Home Manager and Deputy Manager have been undertaking spot checks and signing that the rota is legible. |
| **Recommendation 9**<br><br>**Ref**: Standard 35.17<br><br>**Stated:** First time<br><br>**To be completed by:**<br>1 June 2017 | The registered persons should ensure that robust arrangements are put in place to manage alerts received, in relation to staff that have sanctions imposed on their employment by professional bodies.<br><br>**Ref: Section 4.6** |
| | **Response by registered provider detailing the actions taken:**<br>———All staff alerts from NISCC and NMC have been printed and retained on file. Going forward all alerts will be retained on file. Regional Manager to be monitor same during monitoring visit. |

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