Unannounced Secondary Care Inspection

Name of Establishment:	**Pond Park Care Home**
Establishment ID No:	**1282**
Date of Inspection:	**12 June 2014**
Inspector's Name:	**Loretto Fegan**
Inspection ID:	**IN018355**

The Regulation And Quality Improvement Authority
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General Information

Name of Home:	Pond Park Care Home
Address:	2 Derriaghy Road Lisburn BT28 3SF
Telephone Number:	028 92672911
E mail Address:	pond.park.m@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons (Bamford) Ltd Mr James McCall
Registered Manager:	Ms Suzanne Scott
Person in Charge of the Home at the Time of Inspection:	Ms R Waring, Team Lead was present at the commencement and conclusion of the inspection. Ms S Scott, Registered Manager was available for a period during the inspection.
Categories of Care:	NH-I, NH-PH, NH-PH(E), NH-TI, RC-I
Number of Registered Places:	58
Number of Patients Accommodated on Day of Inspection:	50 nursing patients 3 residential clients
Scale of Charges (per week):	Residential £461 - £476 per week Nursing:£ 581 per week
Date and Type of Previous Inspection:	23 and 24 January 2014 Primary and Pre- registration inspection.
Date and Time of Inspection:	12 June 2014 12.45 – 19.15
Name of Inspector:	Loretto Fegan (bank inspector)

1.0 Introduction

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

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

1.1 Purpose of the Inspection

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

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

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

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

1.2 Methods/Process

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

- discussion with the registered manager
- discussion with staff
- discussion with patients individually and with others in groups
- review of a sample of care plans
- review of the complaints records
- observation during a tour of the premises
- evaluation and feedback

1.3 Inspection Focus

The main focus of the inspection was to follow-up the progress made in relation to requirements and recommendations made during the previous inspection of 23 and 24 January 2014 and to establish the level of compliance being achieved.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

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

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

2.0 Profile of Service

Pond Park Care Home is situated in the semi-rural area of Pond Park, Lisburn at the junction of the Antrim Road and Derriaghy Road, Belfast.

The nursing home is owned and operated by Four Seasons (Bamford) Ltd.

The registered manager is Ms Suzanne Scott.

Accommodation for patients/residents is provided in three separate units across three floors.

Access to all floors is via a passenger lift and stairs.

Communal lounge and dining areas are provided in the three units.

The home also provides for catering and laundry services.

A number of communal sanitary facilities are available throughout the home.

The home has an enclosed garden leading from the dementia unit.

There are parking facilities within the grounds of the home and public transport facilities are located directly outside the home.

The home is registered to provide care for a maximum of 58 persons under the following categories of care:

Nursing Care

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment
PH (E)	Physical disability other than sensory impairment over 65 years
TI	Terminally ill
DE	dementia care for 11 patients

Residential Care (3 residents)

I	Old age not falling into any other category

3.0 Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection to Pond Park Care Home. The inspection was undertaken by Loretto Fegan on 12 June 2014 from 12.45 to 19.15 hours.

The inspector was welcomed into the home by registered nurse R Waring, team lead who was available for the beginning and conclusion of the inspection, Ms S Scott, registered manager was present for a period during the inspection. Verbal feedback of the issues identified during the inspection was given in part to Ms Scott prior to her leaving the home at 16.30 hours and as Ms Scott was not available for the remainder of the inspection, she arranged that registered nurse R Waring; team lead would receive full feedback at the conclusion of the inspection.

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

As a result of the previous inspection conducted on 23 and 24 January 2014, eight requirements and seven recommendations were issued. These were reviewed during this inspection. Details can be viewed in the section immediately following this summary.

The inspector observed care practices including the serving of the lunch-time meal. Appropriate assistance was offered to patients as required and the meal was observed to be well presented.

Communication between staff and patients evidenced that patients were treated courteously and with dignity and respect. Those patients who were unable to verbally express their views were observed to be well groomed, appropriately dressed and appeared relaxed and comfortable in their surroundings.

Patients/residents commented positively in regard to staff and were satisfied with the care received. One patient advised that they had raised a concern which was addressed by management. However, there was no record of this complaint or written evidence that it had been referred to the designated officer for safeguarding in accordance with Safeguarding Vulnerable Adults (SOVA) regional guidance. Requirements are made in this regard.

Relatives spoken with praised the staff and were generally content with the care provided. An issue raised by one relative regarding previous concerns was followed up by the inspector with the team lead. It was determined that no record was made of these complaints in the home. An analysis of notifiable events reported to RQIA identified that an unusually low number of notifications had been received since the inspection of 23 and 24 January 2014. It is required that the person identified with responsibility for monitoring the quality assurance processes and outcomes in the home should maintain a robust oversight of all governance arrangements including the audits undertaken.

The inspector examined specific aspects in relation to the care records. In the main, these were well recorded; however issues were raised in relation to aspects of patient assessment, care planning, and in relation to documentation pertaining to pain management, the use of restrictive practices and maintaining contemporaneous records. Requirements were made in relation to these issues and in respect of referral to the multi professional team and medicine management.

Requirements were also made in relation to training, availability of records for inspection and in relation to updating the competency and capability assessment of registered nurses taking charge of the home in the absence of the registered manager.

As part of the inspection process, the inspector observed the general environment in the nursing home. The home was warm and comfortable and with the exception of one area where a mal-odour was evident, all other areas of the home were maintained to a high standard of hygiene. A requirement has been made in relation to a mal-odour in an identified area. A requirement was also made in relation to fire safety.

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients/residents was evidenced to be generally of a good standard.

However, there were also areas of concern identified which were discussed with Ms S Scott, registered manager while present during the inspection and with Ms R Waring, team lead at the conclusion and post inspection. Ms Waring accepted the findings of the inspection as accurate. At the conclusion of the inspection, the home was issued with written confirmation of urgent actions which required to be addressed without delay.

Due to the serious concerns highlighted as a result of the inspection in relation to the governance arrangements in the home, a meeting was convened on 1 July 2004 by RQIA, to discuss with the registered manager and senior management in the company, the areas of non- compliance, agree actions and discuss timescales in line with RQIA's enforcement procedures.

The main concerns related to the management of complaints, incidents and safeguarding of vulnerable adults. Prior to the meeting taking place, RQIA was contacted by a representative of the safeguarding team of the local health and social care trust. This contact raised further concern regarding the management of safeguarding of vulnerable adults (SOVA) and the reporting of notifiable events to RQIA in accordance with legislation. As a result, the responsible individual was contacted by telephone prior to the meeting and advised that RQIA intended to escalate their enforcement procedures and the meeting would discuss the intention of RQIA to issue a failure to comply notice.

After discussion with senior management of Four Seasons (Bamford) Ltd, two Failure to Comply notices were issued in relation to the home in terms of notification of incidents and safeguarding of vulnerable adults.

Twenty requirements were made, four of which are stated for a second time, and one recommendation was also stated for the second time. One recommendation was carried forward for review at the next inspection.

The inspector would like to thank the patients / residents, visiting relatives, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

4.0 Follow-Up on Previous Issues from previous care inspection on 23 and 24 January 2014

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1.	25(a)	The registered person must ensure that management and nursing staff are completing documentation in accordance with evidence based practice.	The inspector reviewed specific aspects relating to five patients' care records. The review evidenced that in the main, documentation in relation to care records was completed in accordance with evidence based practice. Concerns were raised regarding the management of pain assessment. This matter is raised as a separate requirement. A validated pain assessment tool was not in use when patients were prescribed analgesia.	Substantially compliant

2.	16(1) and (2)	The registered person must ensure that shortfalls identified in care records are addressed to reflect patients', and residents' individual needs. The specific records reviewed contained the following shortfalls : • Care records should be person centred and fully reflective of individual care needs • Information was incomplete in two care records reviewed. • Care plan audits should identify shortfalls.	The inspector reviewed specific aspects relating to five patients' care records. The review evidenced that care records mainly reflected a person centred approach and were responsive to individual care needs. The inspector raised concern regarding the management of the care record audit. This matter is addressed in a separate requirement. The most recent care plan audit was completed on 31 January 2014. The registered manager confirmed that the audit sample size comprised three care records. Shortfalls were identified; however they did not reflect the issues relating to the care records which were highlighted during the inspection.	Substantially compliant

3.	16(1) and (2)	The registered person must ensure that outcomes of audits are monitored to ensure appropriate action has been taken to address shortfalls in record keeping.	The most recent care plan audit was completed on 31 January 2014. The registered manager confirmed that the audit sample size comprised three care records. A summative evaluation was provided in response to each audit question in the form of yes/no. Discussion took place with the registered manager regarding the audit process as there was no evidence available that the outcome of the audit was monitored to ensure appropriate action was taken to address shortfalls. Re-audit should have taken place on a more timely basis as the registered manager stated that the next audit was not planned to take place until July 2014. The inspector can confirm that whilst the outcomes of audits undertaken were found to be recorded, concern is raised in respect of the quality of the care record audit process. The audit process should include the following; • the audit should be undertaken on a regular and frequent basis, at least every 1-2 months • the audit should include at least 10% of care records on each	Substantially complaint

			occasion • action plans with timescales and person/s responsible should be developed in response to findings / learning from audits carried out, re-audit should be undertaken in a timely manner This matter is raised as a separate requirement in the quality improvement plan (QIP).	
4.	24	The registered person must ensure that the recording of complaints is fully completed in accordance with DHSSPS complaint guidance for complaint investigation.	The registered manager provided the inspector with information pertaining to complaints received since the previous care inspection on 23 & 24 January 2014. These were on-going and completed in accordance with DHSSPS complaint guidance for complaint investigation. During the inspection, a relative and a patient informed the inspector regarding additional complaints made during this timeframe. However these complaints were not recorded in accordance with legislation or DHSSPS guidance (see section 5.2 for further detail). This requirement will be stated for a second time and compliance followed up during the next care inspection.	Moving towards compliance

5.	13 (1)(a)(b),	The registered person must ensure that where there is any restrictive practice, robust and effective protocols are in place to evidence: • Who was involved in the decision making? This must be recorded in sufficient detail • information on the identified risks with recorded information of other options which had been tried and why they were ineffective • the monitoring and review process	The inspector reviewed the records of three patients in this regard. One patient had a lap-strap in use. This patient's care record clearly indicated the professional and family involvement in the decision making process. A monitoring chart was in place and documented when the lap strap was released during the preceding days. However on the day of inspection at 13.00 hours, no entries had been made for that morning. The inspector was assured that the strap was released hourly for five minutes each time. This should be recorded contemporaneously and the frequency of releasing the lap strap should also be included in the care plan. One patient had bedrails in place and the records reflected best practice with regard to this restrictive practice. The inspector observed an alarm mat in one patient's bedroom. However, there was no evidence in the patient's care records regarding this restrictive practice being in place or who was involved in the decision making process regarding this. This requirement will be stated for a	Substantially compliant

			second time and compliance followed up during the next care inspection.	
6.	16 (1)(2)(a)-(d),	The registered person must ensure that • a pain assessment and care plan is completed for patients/residents receiving analgesia. • in addition care plans must consistently evidence the involvement of patients/residents and their representatives in planning and agreeing care. • wound care and treatment is delivered as prescribed. • there is effective management of hydration for patients to reflect the action taken to address fluid deficits	The inspector reviewed three care records pertaining to patients who were prescribed analgesia. None of the records examined had a pain assessment or care plan in place to guide staff in the management of pain. The team lead, registered nurse advised the inspector that this was work in progress. The need for use of an appropriate pain assessment tool is raised as a separate requirement as a consequence of this inspection. The records examined evidenced the involvement of patients/residents and their representatives in planning and agreeing care. However, specific examples of when this was not evidenced is contained elsewhere in this report (see section 5.3). One patient's care plan reflected that a specific wound dressing was in place, however, this dressing was not prescribed by the GP or an appropriate wound care specialist.	Moving towards compliance

			The management of hydration in relation to three patients was reviewed. Fluid intake charts were in place which evidenced that in the main this aspect of care was well managed. However, one patient's recommended daily fluid intake should be adjusted in response to a change in body weight. Part of this requirement will be stated for a second time and compliance followed up during the next care inspection.	

7.	30 (a) (e)	The registered person must ensure that the legislation and procedures from RQIA and FSHC in respect of notifications is adhered to and notifications are submitted to RQIA without delay.	During the inspection visit, the inspector was informed by a patient that they had reported a complaint, in respect of staff attitude when delivering care. The patient advised that the issue had been addressed by management. The inspector then sought clarification from the registered manager regarding the complaint. The registered manager advised that the issue had been referred to the trust care manager; however, this had not been identified as a potential safeguarding matter and was not referred to the designated officer or reported to RQIA in accordance with legislation. RQIA records indicate that notification in respect of one specific accident recorded in a patient's care record observed during inspection was not received by RQIA. Further concerns are raised in respect of the notification of events in the home. Analysis of submissions of notifiable events to RQIA evidence that an exceptionally low number of events have been received since the last inspection. This highlighted the need for further	Not compliant

			development or training for all staff with regard to the recognition and reporting of incidents. **This requirement has been subsumed into the failure to comply notice issued on 4 July 2014.**	
8.	20(1)(a)(c)(i)(iii)	The registered person must ensure that any nurse providing wound care to patients has been assesed and deemed competently in undertaking wound care safely. In addition **all** staff designated to work in the proposed dementia unit must receive dementia training and training on restrictive practices. Records of this process must be maintained	The inspector sought to examine staff records in respect of competency assessment for wound care for registered nurses, and dementia training for all staff working in the dementia care unit. Competency and capability assessments for two registered nurses were examined, however these did not reflect competency in respect of wound care. No other written form of evidence was available to verify compliance with this aspect of the requirement. However, the team lead registered nurse informed the inspector that she has been assessed by the company's wound care nurse with regard to undertaking wound care and that this is an on-going process with other registered nurses. Records pertaining to dementia training and training on restrictive practices were	Moving towards compliance

			not available for inspection. However, the care assistant working in the dementia unit confirmed that he had received this training. The team lead registered nurse also informed the inspector that all staff designated to work in the dementia unit have received this training, with the exception of 2-3 staff members who have recently moved from another area of the home to the dementia unit. This requirement will be stated for a second time and compliance followed up during the next care inspection.	

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1.	28.1	The nurse manager should ensure that each employee has a record of induction which is available for inspection at all times and provides the following information; • final statement of competency signed off by the registered manager.	The registered manager informed the inspector that there were no new employees since November 2013. Therefore this recommendation was not validated on this occasion and will be followed up during the next care inspection **Carried forward for validation at the next inspection.**	Not validated on this occasion
2.	25.12	The registered person must ensure that there is effective action taken when action plans are not addressed in a timely manner.	Regulation 29 reports dated February and March 2014 were examined in this regard. Reference was made to the previous action plan, however there were a number of actions outstanding and a comment was made such as “not addressed yet” or “trying to source”. The timescales for the planned actions was not clear. As the most recent Regulation 29 visit report available for inspection was dated March 2014, the inspector could not ascertain if the outstanding actions were subsequently addressed. This recommendation will be raised as a requirement as a consequence of this inspection.	Moving towards compliance

3.	25.2	The registered person should implement a system to inform patients/residents and or their representatives of the availability of both the monthly and annual report and how they can be accessed. Report formats should be presented in a user friendly format. In addition reports of visits should be discussed at staff meetings.	The registered manager informed the inspector that patients/residents and or their representatives are informed of the availability of both the monthly and annual report at joint patient/resident meetings. However, Ms Scott confirmed that these meetings were poorly attended and that no other system was in place to disseminate this information. The team lead registered nurse informed the inspector that the outcome of Regulation 29 visits are discussed with staff. However, the only minutes from staff meetings over the past four months available for inspection were dated 26 May 2014. No mention of Regulation 29 visits was made on the minutes of this meeting which took place with the Heads of Department. This recommendation will be raised as a requirement as a consequence of this inspection.	Substantially compliant

4.	16.1	The registered manager should ensure the following guidance documents were available to staff, Safeguarding Vulnerable Adults Regional Adult Policy and Procedural Guidance, Safeguarding Vulnerable Adults A Shared Responsibility (1st edition 2010) and Regional and Local Partnership arrangements (March 2010). Raising and escalating concerns NMC and The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007.	The team lead registered nurse informed the inspector that she was not familiar with these documents and was unable to source them on the day of inspection. This recommendation will be included in a requirement made pertaining to safeguarding of vulnerable adults as a consequence of this inspection.	Not compliant

5.	16.2	The registered person should ensure that staff receives training on the role and function of the safeguarding team including their investigatory responsibility.	During the inspection, the team lead registered nurse reviewed the content of the e-learning programme available to staff with regard to safeguarding and confirmed that the role and function of the safeguarding team including their investigatory responsibility does not form part of this training. The team lead registered nurse also confirmed that there is no additional training provided which includes this aspect of safeguarding. **This recommendation has been subsumed into the failure to comply notice issued on 4 July 2014.**	Not compliant
6.	5.2	The registered person must ensure that all sections of the assessment information are completed in full.	The inspector can confirm that in the main assessment of need documentation was fully completed. The exception to this has been raised previously in relation to pain assessment. However, the inspector identified that one record examined did not have a re-assessment undertaken for two years. This matter is raised as a separate requirement.	Substantially compliant

7.	11.6	The nurse manager should provide information leaflets on skin care and prevention to patients/residents and their representatives.	The registered manager and team lead registered nurse confirmed that information leaflets on skin care and pressure ulcer prevention were sourced for patients/residents and their representatives. However, on the day of inspection, there were none available. This recommendation will be stated for a second time and compliance followed up during the next care inspection.	Moving towards compliance

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

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

RQIA have been informed by the adult safeguarding team from a HSC Trust of an ongoing investigation in relation to a serious adverse incident. RQIA are not part of the investigatory process, however RQIA will be kept informed at all stages of the investigation.

Due to the serious concerns highlighted as a result of the inspection in relation to the governance arrangements in the home, a meeting was convened on 1 July 2004 by RQIA, to discuss with the registered manager and senior management in the company, the areas of non- compliance, agree actions and discuss timescales in line with RQIA's enforcement procedures.

The main concerns related to the management of complaints, incidents and safeguarding of vulnerable adults. Prior to the meeting taking place, RQIA was contacted by a representative of the safeguarding team of the local health and social care trust. This contact raised further concern regarding the management of safeguarding of vulnerable adults (SOVA) and the reporting of notifiable events to RQIA in accordance with legislation. As a result, the responsible individual was contacted by telephone prior to the meeting and advised that RQIA intended to escalate their enforcement procedures and the meeting would discuss the intention of RQIA to issue a failure to comply notice.

After discussion with senior management of Four Seasons (Bamford) Ltd, two failure to comply notices were issued in relation to the home in terms of notification of incidents and safeguarding of vulnerable adults.

5.0 Additional Areas Examined

5.1 Care practices

The inspector observed care practices including the serving of the lunch-time meal. The meal was well presented in suitable portion sizes and in a way and consistency that met the patients' needs. Staff were in attendance to provide appropriate support and assistance with meals.

Communication between staff and patients evidenced that patients were treated courteously and with dignity and respect. Those patients who were unable to verbally express their views were observed to be well groomed, appropriately dressed and appeared relaxed and comfortable in their surroundings.

5.2 Patients/residents' and relatives' views

The inspector spoke with thirteen patients individually. In the main, patient/residents commented positively in regard to staff and were satisfied with the care they receive. Comments included:

- "well looked after"
- "marvellous", "food and company good"
- "food very bad, get gravy with most dishes including fish" (no other sauces available)
- "couldn't complain, food good"
- "like most of the food"

The comments regarding the food were passed on to the team lead post inspection who clarified that alternatives sauces were available on request.

The inspector during the inspection visit was informed by a patient that they had reported a complaint, in respect of staff attitude when delivering care. The patient advised that the issue had been addressed by management. The inspector then sought clarification from the registered manager regarding the complaint. The registered manager advised that the issue had been referred to the trust care manager and that it was agreed with the care manager that an internal investigation into the matter would take place.

The patient's progress notes relating to the date of the complaint were not available for inspection and there was no other written evidence that the complaint was assessed to identify any safeguarding issue contained therein or that it had been referred to the designated officer for safeguarding in accordance with Safeguarding Vulnerable Adults (SOVA) regional guidance. RQIA should also have received notification regarding this matter. Requirements have been made regarding these matters.

No record was made in relation to this complaint in the home's complaints file. The registered person must ensure that the recording of complaints is fully completed in accordance with DHSSPS complaint guidance for complaint investigation.

The inspector spoke with the relatives of two patients who were visiting at the time of inspection. The relatives praised the staff and were in the main content with the care provided. One relative advised the inspector that they had raised concerns with the registered manager on two occasions. It was verified by the team lead, post inspection that the registered manager confirmed receipt of the two complaints received by telephone; however no record was made of

them. It is required that a record is made of all complaints received either verbally or in writing in accordance with legislation.

5.3 Care Records

The inspector examined specific aspects in relation to the care records of five patients and the following issues were identified for improvement as follows and should be addressed in partnership with the patient and/or their representative:

- One patient's assessment details should be reviewed as the records indicate that a re-assessment was last undertaken in September 2012.
- The record of patients' weights should be transcribed contemporaneously from the "weight book" to the individual patients' care records.
- A care plan should be put in place with regard to the prevention of pressure ulcers for one identified patient.
- The recommended daily fluid intake should be adjusted in response to one patient's change in body weight.
- One patient's care plan should incorporate advice from the speech and language therapist.
- One patient's care plan should include the action to take when the patient refuses their main meal/s.
- A referral to the dietician should be considered in respect of two identified patients.
- The care records made reference to tablets being crushed or chewed in relation to one patient, the GP should be consulted with regard to this practice and discuss the prescribing of liquid medicines in accordance with the speech and language therapist's recommendations. This matter has been referred to the aligned RQIA pharmacy inspector.
- All fluid balance charts should be totalled over the 24 hour period and the daily progress evaluations should include the patients' daily fluid intake (and output if monitored) - the inspector acknowledged that this was completed correctly in most cases.
- Monthly evaluations should be carried out in relation to the outcome of the care provided (2 months had lapsed since one patient's evaluation was completed in relation to diet and this was a significant part of that patient's care.
- The care manager should be informed in relation to one patient's fall and subsequent injury. A record should be made of this contact in the patient's care records.

Ms Waring, team lead was in agreement with the issues identified in relation to the care records examined during the inspection. Requirements are made to address the issues identified above.

5.4 Staffing

Discussion took place with the registered manager regarding the staffing levels on the day of inspection. The information provided indicated that the staffing arrangements met the DHSSPS's recommended minimum staffing guidance for nursing homes. Ms Waring, team lead advised the inspector that an additional staff member has been recently deployed to work in the home during the twilight period (Monday – Thursday).

5.5 General Environment

As part of the inspection process, the inspector observed the general environment in the nursing home. This included viewing twenty-six bedrooms, lounges, dining rooms and bathroom/toilet facilities. The home was warm and comfortable and with the exception of one area where a mal-odour was evident, all other areas of the home were maintained to a high standard of hygiene. A requirement has been made in relation to the mal-odour.

The inspector observed that two identified bedroom doors were wedged open. Fire doors should not be wedged open as this will compromise the safety of the patients. If the doors to these bedrooms need to be kept open, appropriate hold open devices linked to the fire detection and alarm system should be installed. Advice should be sought from the Fire Risk Assessor for the home. The matter has been referred to the RQIA estates inspector aligned to the home. A requirement has been made in this regard.

5.6 Competency and Capability Assessments

The registered manager provided the inspector with the competency and capability assessments pertaining to two registered nurses who take charge of the home in the absence of the registered manager. One assessment had been reviewed in November 2013; however the other assessment was last updated in July 2012. It is required that competency and capability assessments in this regard are undertaken on an annual basis or more frequently if deemed necessary. A requirement is raised in this regard.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Scott registered manager and Ms Waring team lead either during or after the inspection visit.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Secondary Inspection

Pond Park Care Home

12 June 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Scott registered manager and Ms Waring team lead either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	24	The registered person must ensure that the recording of complaints is fully completed in accordance with DHSSPS complaint guidance for complaint investigation. **Ref sections 4.0 & 5.2**	Two	All complaints both verbal and written will be dealt with in accordance with DHSSPS guidance and requirements. Complaints will be logged and an analysis completed monthly by Home Manager. This will also be reviewed by RM monthly.	From date of inspection and ongoing
2	13 (1)(a)(b),	The registered person must ensure that where there is any restrictive practice, robust and effective protocols are in place to evidence: • Who was involved in the decision making? This must be recorded in sufficient detail. • Information on the identified risks with recorded information of other options which had been tried and why they were ineffective. • The monitoring and review process. **Ref section 4.0**	Two	A restraint log is in place in the Home which will be updated as required and reviewed monthly by Home Manager. All residents who require any form of restrictive practice will have a risk assesment, consent or best interest decisions and care plans in place, as agreed by a multi-disciplinary team, which will be reviewed monthly or sooner as required. This process is currently on-going.	From the date of inspection and on going

3	16 (1)(2)(a)-(d),	The registered person must ensure that • A pain care plan is completed for patients/residents receiving analgesia. • In addition care plans must consistently evidence the involvement of patients/residents and their representatives in planning and agreeing care. • Wound care and treatment is delivered as prescribed. **Ref section 4.0 & 5.3**	Two	All residents who receive analgesia have a pain care plan in place. Care plans have been discussed with the resident/relative and representatives. For those not agreed in writing relatives will be advised to speak to the nursing staff regarding same. Any resident requiring wound care will have their case discussed with the TVN and GP. A wound analysis will be completed monthly by the wound link nurse and HM.	From the date of inspection and on going
4	20(1)(a)(c)(i)(iii)	The registered person must ensure that any nurse providing wound care to patients has been assesed and deemed competently in undertaking wound care safely. In addition **all** staff designated to work in the proposed dementia unit must receive dementia training and training on restrictive practices. Records of this process must be maintained **Ref section 4.0 & 5.6**	Two	The home has a designated wound care link nurse who will complete wound care competencies with all trained nurses. This will be updated on a yearly basis. All staff currently working in the dementia unit have received dementia training. Records are maintained on training matrix.	From the date of inspection and on going
5	15(1)(a)	The registered person must ensure that an appropriate pain assessment tool is used for	One	An appropriate pain assessment tool is in place for	By end July 2014

		all patients receiving regular or occasional analgesia. The outcome of the pain assessment should then be used to influence the development of an individualised pain management care plan. **Ref section 4.0**		all residents as a base line and will be updated as required for those residents receiving analgesia or who express pain. A care plan is in place for any individual requiring pain management which will incorporate analgesia as required.	
6	17(1)	The registered person must ensure that a robust system of audit is established and maintained for patient care records. The audit process should include the following; • The audit should be undertaken on a regular and frequent basis, at least every 1-2 months. • The audit should include at least 10% of care records on each occasion. • Action plans with timescales and person/s responsible should be developed in response to findings / learning from audits carried out, re-audit should be undertaken in a timely manner. **Ref section 4.0**	One	All care records in Pond Park Care Centre have been audited and an action plan devisied with actions required. Time scales have been agreed with individual nurses according to the date of receipt of the audit, but the completeion date will be no later than end of August. These will then be reauidted to ensure compliance.	by end of July 2014

7	30 (1) and (2)	(1) The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of – (a) the death of any patient, in the nursing home, including the circumstances of his death; (b) the outbreak in the nursing home of any infectious disease which in the opinion of any medical practitioner attending persons in the home is sufficiently serious to be so notified; (c) any serious injury to a patient in the nursing home; (d) any event in the nursing home which adversely affects the wellbeing or safety of any patient; (e) any theft or burgulary in the nursing home; (f) any accident in the nursing home; (g) any allegation of misconduct by the registered person or any person who works at the nursing home. (2) Any notification made in accordance with this regulation which is given orally shall be confirmed in writing within 3 days of the oral report.	One	All acccident and incidents will be reported as required by the Nursing Home Regulations. All trained staff have been reminded of all incidents which require to be reported. A new log has been devised for both the trained staff and the Home Manager to record all incidents logged. Any incident which is reported verbally will be confirmed in writing within 3 days	From date of inspection and on going

		An analysis of all reportable incidents which have occurred in the nursing home in the past six months should be forwarded to RQIA with the return of the QIP. **Ref section 4.0 and 5.2**		An analysis of reportable incidents in the last 6 months from February to July is attached.	
8	20(3)	The registered person must ensure that any registered nurse who takes charge of the home in the absence of the registered manager should have a competency and capability assessment undertaken on an annual basis or more frequently if deemed necessary. **Ref section 5.6**	One	All registered nurses who take charge of the home in the Home Managers absence have an annual competency and capablility assessment completed. This is currently being reviewed with all trained nurses.	31 July 2014
9	19	The registered person must ensure that the records required are available for inspection at all times **Ref section 4.0 and 5.2**	One	All records required will be availbale for insoection at all times.	From date of inspection and on going

10	29 (3) & (5)a-d	The registered person must ensure that; • Inspection visits in keeping with regulation 29 shall take place at least once a month or as agreed with the Regulation and Improvement Authority and shall be unannounced. • A copy of the Regulation 29 visit report should be available on request in the home in accordance with legislation. • Actions identified during regulation 29 visits should have identified time scales for completion. **Ref section 4.0**	One	All regulation 29 visits are conducted on an unannounced basis and a report made available following the visit. There is an action plan attached to the report with time frames for addressing each action. The report will be printed and maintained at home level for viewing at all times.	By end July 2014
11	17(1)	The registered person shall ensure that the person identified with the responsibility for quality assuring the management of the home, maintains a robust over sight of the audits maintained in the home. Action plans to correct deficits identified from audits should be evidenced to be actioned as required. **Ref section 4.0**	One	The regulation 29 visit will incoporate an over view of records within the home on a monthly basis. Evidence to ensure actions required have been addressed will be included in the report.	By July 2014

12	29(5)(c)	The registered person must ensure that all patients / residents and their representatives are made aware of the availability of the most recent unannounced regulation 29 report and/or the annual report. **Ref section 4.0**	One	A notice is displayed informing all residents/relatives and visitors of the availablilty of the regulation 29 report. This report and the annual report are discussed at resident and relative meetings.	By end July 2014
13	14(4)	The registered person must make arrangements, by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse by: • Ensuring that all suspected, alleged or actual incidents of abuse are reported to the relevant persons and agencies in accordance with legislation. • Ensuring all staff receive training on the role and function of the safeguarding team including their investigatory responsibility. • Ensuring all staff have access to the following documents; Safeguarding Vulnerable Adults Regional Adult Policy and Procedural Guidance Safeguarding Vulnerable Adults A Shared Responsibility (1st edition 2010) and Regional and Local Partnership arrangements (March	One	All suspected, alleged or actual incidents of abuse are reported by telephone to the appropriate care manager who will advise if there is further action to be completed. A VA form will be completed by Trust personel if needed. As off 11th August all Reg30 reports will be copied to the designated care manager. This will be followed up in one week by HM if no response from Trust as to whether screened in or out. SOVA training was completed on 28th July, 1st August and 15th August - further dates to be arranged within the next month to capture those on leave.. Trust officer to complete training session on 19th August for trained staff and Home Manager on reporting of incidents and the role of the	From date of inspection and ongoing

		2010). Raising and escalating concerns NMC The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007. **Ref sections 4.0 & 5.2**		safeguarding team.Further dates to be arranged following same for other grades of staff. All documents as listed are available in each unit in a SOVA file and a copy also retained in Home Managers office	
14	15(2)(b)	The registered person must ensure that the assessment of the patient's need is revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. **Ref section 5.3**	One	This has been addressed and will be monitored through regular care documentation reviews/audits	From date of inspection and on going
15	19(1)(a) Schedule 3 (3)(k)	The registered person must ensure that contemporaneous records are maintained in each individual patient care record. • Fluid intake and output if applicable are totalled over the 24 hour period and the totals achieved are evaluated daily in progress notes against the target assessed need. • Monthly weight checks must be recorded in the patient's individual care record. **Ref section 5.3**	One	All staff have been advised of the need to complete these correctly. This will be monitored by DM and Team Leaders of each unit and overseen by HM. All trained staff have been advised that they must transcribe weights into care files when completed either weekly or monthly.	From date of inspection and on going

16	14(1)(b)	The registered person must ensure that patients are referred to the appropriate multi professional team member when required. • The identified patient with a non-prescribed wound dressing should be referred to the GP or appropriate wound care specialist. • The identified patients should be referred to GP for onward referral to the dietician. • The care manager should be informed in relation to one patient's fall and subsequent injury. **Ref section 5.3**	One	The identified residents wound has healed and therefore did not require referral to GP. RN's have been advised that all dressing must be prescribed. All residents have had a diet review completed over the last month and referred to dietician as required. The care manager has been informed of the identified patients fall and injury.	From date of inspection and on going
17	13(4)(b)	The registered person must ensure that medicines are administered as prescribed. Medicines must not be crushed or chewed without written authorization from the aligned GP. **Ref section 5.3**	One	The identified residents medication had been reviewed by the GP and changed to liquid form.	From date of inspection and on going
18	16(2)(b)	The registered manager must ensure that patients care plans are reviewed in light of the issues raised in section 5.3 of the report. **Ref section 5.3**	One	All care files have been audited and action plans devised as required to address issues.	From date of inspection and on going

19	18 (2)(j)	The registered person must ensure that the identified corridor with a notable malodor is addressed with urgency. **Ref section 5.5**	One	This is monitored on a daily basis and a new floor covering has been approved. Fitters arrived 14th August to fit new carpet but resident has refused to allow same to be fitted. Following negotiation, involving GP and Care Manager the resident has agreed to allow carpet to be fitted in 6 weeks time. On-going discussions with Care Manager and GP regarding same.	From date of inspection

20	27(4)(b) &(c)&(d)(1)	The registered person must ensure: • Fire doors should not be wedged open. • Needs assessments should be carried out to establish if the doors to the two identified bed rooms require to be kept open. • Appropriate hold open devices linked to the fire detection and alarm system should be installed based on the outcome of the needs assessment. • Advice should be sought from the fire risk assessor for the home. **Ref section 5.5**	One	All staff, residents and visitors have been reminded of the importance of not wedging doors open. The fire risk assessor has visited the home and hold open devises to be installed as per residents assessed need.	From date of inspection and going

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	28.1	The nurse manager should ensure that each employee has a record of induction which is available for inspection at all times and provides the following information; • Final statement of competency signed off by the registered manager. **Ref section 4.0** **This recommendation has been carried forward from the previous inspection**	Three	All staff have an induction on file and this is signed off by the Home Manager.	From date of inspection and on going
2.	11.6	The nurse manager should provide information leaflets on skin care and prevention to patients/residents and their representatives. **Ref section 4.0**	Two	Leaflets are available in the front foyer as needed.	By end July 2014

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and return to nursing.team@rqia.org.uk

Name of Registered Manager Completing Qip	Suzanne Scott
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall DIRECTOR OF OPERATIONS 19/8/2014

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

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	x	L Fegan	28/10/14
Further information requested from provider			