The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
25 May 2017

Seaview House

Type of Service: Nursing Home
Address: 276 Seacliff Road, Ballyholme, Bangor, BT20 5HS
Tel no: 028 9146 0833
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Seaview House took place on 25 May 2017 from 10:00 to 15:00.

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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment. Observation of the delivery of care and discussion with patents and staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

A review of the home's environment was undertaken and the home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. Infection prevention and control measures were adhered to. Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no areas for improvement identified in this domain.

Is care effective?

A review of three patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting and that staff were aware of the importance of handover reports in ensuring effective communication.

There were no areas for improvement identified in this domain.

Is care compassionate?

We arrived in the home at 10:00. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were in their bedrooms or seated in the lounge in keeping with their personal preference.

Staff interaction with patients was observed to be compassionate, caring and timely. Consultation with eight patients individually and with others in small groups confirmed that patients were afforded choice, privacy, dignity and respect. Patients stated they were involved in making choices about their own care. Patients were consulted with regarding what time they got up at and retired to bed at and where they spent their day. Patients were offered choices throughout the day with meals and drinks and snacks. Staff demonstrated a detailed knowledge of patients' wishes, likes and dislikes.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Discussion with patients individually and with others in smaller groups, confirmed that living in Seaview House was a positive experience.

There were no areas for improvement identified in this domain.

Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home. Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required. Over the past few months the registered manager has been working the majority of her contracted hours as a registered nurse. It was recommended that the registered manager's working arrangements should be kept under review to ensure they have sufficient time to undertake the day to day operational management of the home.

We reviewed the reports of the unannounced quality monitoring visits and made a requirement that these visits must be completed at least once a month.

One requirement and recommendation were made. Compliance with these areas for improvement further enhance the domain of well led.

The term 'patients' is used to describe those living in Seaview House which provides nursing care and residential care to two named patients.

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	1	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Clair O'Connor, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 23 November 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

Registered organisation/registered person: Seaview House Private Nursing Home Ms. Fiona Gilmore	**Registered manager:** Mrs Clair O'Connor
Person in charge of the home at the time of inspection: Mrs Clair O'Connor	**Date manager registered:** 21 April 2015
Categories of care: RC-I, NH-I, NH-PH, NH-PH(E), NH-TI Category RC-I for 2 identified residents only.	**Number of registered places:** 22

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with eight patients individually and with the majority in small groups, two care staff, one domestic and two resident's visitors/representative.

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

Questionnaires were also left in the home to facilitate feedback from relatives and staff not on duty. Ten staff and relative questionnaires were left for completion.

The following information was examined during the inspection:

- duty rota for all staff for the week of the inspection
- Records confirming registration of staff with the Nursing and Midwifery Council (NMC)and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment files
- competency and capability assessments of nurses
- staff register
- three patient care records
- record of staff meetings
- patient register
- complaints record
- record of audits
- RQIA registration certificate
- certificate of public liability
- monthly monitoring reports

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 23 November 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned, approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 23 November 2016

Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 35.7 **Stated:** Second time	It is recommended that the content of the report prepared in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 should be reviewed and extended to include the detail of any issues identified. Issues identified should be reviewed at the next monthly visit and a comment of the actions taken recorded.	**Met**

	Action taken as confirmed during the inspection: A review of the reports completed from January 2017 include the detail of any issues identified. The issues were reviewed at the next monthly visit and a comment of the actions taken recorded. This recommendation has been met. Visits required in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 are further discussed in section 4.6 of this report.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 22 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Observation of the delivery of care and discussion with patients evidenced that their needs were met by the levels and skill mix of staff on duty. At the time of the inspection the registered manager was generally rostered to work as a registered nurse; this is further discussed in section 4.6.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; two were returned following the inspection. Both staff answered ‘yes’ to the question “Are there sufficient staff to meet the needs of the patients?”.

Patients and two relative spoken with during the inspection commented positively regarding the staff and care delivery. One relative commented on the number of staff who have left the home over the past few months but had confidence that the registered manager was managing the situation. Patients were satisfied that when they required assistance staff attended to them in timely manner. We sought relatives’ opinion on staffing via questionnaires; three were returned in time for inclusion in the report. The relatives were very satisfied that there was sufficient staff to meet the needs of their loved one.

The registered manager confirmed that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in their absence. We reviewed one completed assessment; the assessment was signed by registered nurse and the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

Staff recruitment records were available for inspection and were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager. A review of the records of NMC registration evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The record of the checks of care staff registration included the expiry date of their registration with NISCC.

The registered manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe. The induction programmes were signed by the inductor, the member of staff who was being inducted and the registered manager.

We discussed the provision of mandatory training and the registered manager explained that training delivered via the e learning system in the home was ongoing. The registered manager had systems in place to monitor compliance. The registered manager had identified that provision of face to face mandatory training in 2017 required improvement. They confirmed that they were currently working to secure dates for training in fire, manual handling, first aid and adult safeguarding. It was agreed that we would review compliance at the next scheduled inspection to ensure improvement has been achieved.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. They confirmed that they had attended training on the role of the safeguarding champion in February 2017. Following discussion we were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

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. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since January 2017 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. No issues were identified with infection prevention and control measures. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

No areas for improvement were identified with the delivery of safe care.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

A review of three patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

We reviewed the management of falls and observed that care records contained a falls risk assessment. Care plans were in place for patients assessed as at high risk of falls. Care plan were evaluated after each fall to ensure the care plan continued to meet the needs of the patient. Records evidenced that appropriate clinical observations were monitored and recorded for patients who sustained a head injury.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Care management reviews for patients were arranged by the relevant health and social care trust. These reviews could be held in response to a change to patient need and as a minimum annually. They could also be requested at any time by the patient, their family or the home. There was evidence within the care records of regular, ongoing communication with relatives.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

The registered manager and staff confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting held was on 7 April 2017.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

We arrived in the home at 10:00. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were in their bedrooms as was their personal preferences or seated in the lounge again in keeping with their personal preference.

Staff interaction with patients was observed to be compassionate, caring and timely. Consultation with eight patients individually and with others in small groups confirmed that patients were afforded choice, privacy, dignity and respect. Patients stated they were involved in making choices about their own care. Patients were consulted with regarding what time they got up at and retired to bed at and where they spent their day. Patients were offered choices throughout the day with meals and drinks and snacks. Staff demonstrated a detailed knowledge of patients' wishes, likes and dislikes.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Discussion with patients individually and with others in smaller groups, confirmed that living in Seaview House was a positive experience.

All of the patients spoke highly of the staff. The following are examples of comments provided:

"I love it here, the staff are wonderful….they can't do enough for you."
"Staff are great, nothing is a problem."
"I'm very happy with the care."

Patients and staff were confident that if they raised a concern or query with management, they were taken seriously and their concern/query was responded to appropriately.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. The following are examples of comments received on thank you cards:

"…you couldn't have been more kind nor more loving nor more helpful." (January 2017)
"Thank you so much for taking such good care of … You have such a wonderful generous attitude." (October 2016)
"Thank you for all the extra care you provided for … on Sunday. We are delighted to be part of the Seaview family."

As previously discussed ten relative questionnaires were issued; three were returned within the timescale for inclusion in this report. The relatives were very satisfied with care provided across the four domains.

We issued ten questionnaires to nursing, care and ancillary staff; two were returned prior to the issue of this report. Staff were very satisfied with the care provided across the four domains.

Any comments from relatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas for improvement

No areas for improvement were identified with the delivery of compassionate care.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.

Previously the registered manager's hours were divided between her management role and her role as a registered nurse. Over the past few months the registered manager has been working the majority of her contracted hours as a registered nurse. They explained that whilst recruitment was ongoing for registered nurses there has been a poor response. We were concerned that the registered manager, undertaking the role of a registered nurse on an almost full time basis, has the potential to impact negatively on the time they have to provide effective management and sustain the governance arrangements in the home. It is therefore recommended that the working arrangements of the registered manager are kept under review to ensure they have sufficient time to undertake the day to day operational management of the home effectively.

Discussion with the registered manager and review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The registered manager confirmed that monthly audits were completed, for example trend analysis of accidents, monthly patient weights and medication.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

There were systems and 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.

We reviewed the reports of the unannounced quality monitoring visits required to be completed in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. The reports evidenced that a visit was completed in January, March and May 2017. A copy of the reports was available in the home. Unannounced visits to monitor the quality of care delivered must be completed at least once a month. A requirement has been made.

Areas for improvement

The working arrangements of the registered manager should be kept under review to ensure they have sufficient time to undertake the day to day operational management of the home effectively.

Unannounced visits in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 must be completed monthly.

Number of requirements	1	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Clair O'Connor, registered 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 nursing.team@rqia.org.uk 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	
Requirement 1 **Ref:** Regulation 29(3) **Stated:** First time **To be completed by:** 23 June 2017	The registered provider must ensure that unannounced visits are completed monthly. **Ref section 4.6**
	Response by registered provider detailing the actions taken: The registered provider is aware two reports overlapped this year and will be carrying out monthly visits.The registered provider,although not rostered on the rota,does visit the home on a regular basis outside of nursing shifts enabling her to be aware of day to day issues within the home which may need actioned..
Recommendations	
Recommendation 1 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 23 June 2017	The registered provider should ensure that the working arrangements of the registered manager are kept under review to ensure they have sufficient time to undertake the day to day operational management of the home effectively. **Ref section 4.6**
	Response by registered provider detailing the actions taken: The home is actively trying to recruit nursing staff to enable the manager to have required time for managerial duties.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

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