Unannounced Care Inspection Report
21 July 2017

Tennent Street

Type of Service: Nursing Home
Address: Sandringham Suite, 1 Tennent Street, Belfast, BT13 3GD
Tel No: 028 9031 2318
Inspector: Heather Sleator

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

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 17 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual(s):** Dr Claire Royston	**Registered Manager:** See below
Person in charge at the time of inspection: Violet Graham	**Date manager registered:** Ms Violet Graham – registration pending
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of registered places:** 17 This home also provides care on a day basis to 1 person.

4.0 Inspection summary

An unannounced inspection took place on 21 July 2017 from 10.00 to 15.30 hours.

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

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to staffing and the empathy displayed to patients, adult safeguarding, infection prevention and control and fire safety. The home's environment was fresh smelling and clean throughout and the level of attention to personalising patients' bedrooms was commended. We observed good practice in communication between staff and between patients and staff. Our observations confirmed that staff were knowledgeable of patients' wishes and preferences. There were good working relationships between staff and good support from management.

Areas requiring improvement were identified under the standards: improving the standard of décor in the lounge and dining room; eliminating the malodour in an identified bathroom and ensuring the supplementary care records template, for example, repositioning recording and patients' food and fluid intake recording provide the necessary information regarding patients' health and wellbeing.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Violet Graham, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 15 February 2017

The most recent inspection of the home was an unannounced premises inspection undertaken on 15 February 2017.

There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

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

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing.
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with 17 patients and five staff. There were no patients' visitors/representatives available at the time of the inspection. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution

The following records were examined during the inspection:

- duty rota for all staff for week commencing 17 July 2017
- 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
- three staff recruitment and induction file
- two patient care records
- two patient care charts including food and fluid intake charts and reposition charts

- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

There were no areas for improvement identified at the last care inspection of 28 July 2016.

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 15 February 2017

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

6.2 Review of areas for improvement from the last care inspection dated 28 and 29 July 2017

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

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The 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 17 July 2017 evidenced that the planned staffing levels were adhered to. The planned staffing levels were based on the patients' dependency levels, which were assessed using the Care Home Equation for Safe Staffing (CHESS) assessment tool, developed by Four Seasons Healthcare. The manager explained that this was reviewed on a regular basis and that the staffing levels could be adjusted as required. A member of staff was employed to deliver activities. Observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Patients spoken with were satisfied that there were sufficient staff to meet the needs of the patients.

A nurse was identified on the staffing rota to take charge of the home when the manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. The assessments were signed by the 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.

Discussion with the manager and a review of three personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their registrations were checked with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC), to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and satisfactory references had been sought and received, prior to the staff member starting their employment.

The manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of three completed induction programmes evidenced that these were completed within a meaningful timeframe. We spoke with two staff who confirmed that they had been provided with a period of induction. Both staff commented positively on the induction they had received.

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 manager. A review of the records evidenced that a robust system was in place to monitor the registration status of nursing and care staff.

Discussion with the manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals. Staff also confirmed that individual supervision was on-going.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were 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. The records reviewed confirmed that the training statistics to evidence completion were between 90 to 100 percent in all areas.

Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. The relevant contact details were available in a folder for all staff to access.

Discussion with the manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified within the organisation and all registered managers/managers attended regional training on the new procedures on 16 June 2017. Discussion also evidenced that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures

Review of two 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. Care records are further discussed in section 6.5.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since July 2016 confirmed that these were appropriately managed.

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. The areas reviewed were found to be clean, tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home had a welcoming and very pleasant atmosphere.

An area for improvement was identified in relation to a bathroom where there was a malodour; the malodour appeared to be in keeping with drainage problems. Areas of the home would benefit from redecoration, for example; the lounge and dining room, as the décor evidenced signs of wear and tear. There was evidenced of the availability of and adequately stocked personal protection equipment (PPE).

We discussed the management of fire safety with the manager who confirmed that fire checks were completed weekly. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control and risk management.

Areas for improvement

The following areas were identified for improvement in relation to the need to improve the standard of décor in the lounge and dining room and explore the reason for the malodour in the identified bathroom.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

A review of two patients care records evidenced that a comprehensive assessment and a range of validated risk assessments were completed for each patient; these assessments informed the care planning process.

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and language therapist (SALT), dietician and Tissue Viability Nurse Specialists (TVN). Discussion with registered nurses 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 plans for a patient's elimination needs were reviewed. The care plan detailed a continence management plan and information regarding when catheter care was provided, including serial numbers of any catheter used.

Patients' bowel movements were monitored by the registered nurses on a daily basis, using the Bristol Stool guidance as a reference, to ensure that any changes from the patients' usual bowel patterns were identified and timely action taken.

Personal or supplementary care records evidenced that records were maintained on a computerised record. The review of the records did not evidence that; for example, staff were reporting on the condition of a patient's skin following repositioning. This was discussed with the manager and it was agreed that it was the recording template in use as opposed to staff not diligently reporting on individual's wellbeing. This was identified as an area for improvement and the manager agreed to review the supplementary care recording templates to ensure all required information was being captured.

Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005; the manager confirmed that the patient register was checked on a regular basis.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Observations of staff interactions evidenced that communication was good within the home and that there was effective team work. Staff confirmed that they were provided with the relevant information in response to patients' daily needs and changing needs. Staff also confirmed that they enjoyed working in the home and with colleagues and if they had any concerns, they could raise these with the manager or the regional manager who was in the home regularly. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent meeting with the clinical leads of each unit was held on 7 June 2017. Staff stated that there was effective teamwork with each staff member knew their role, function and responsibilities.

The serving of the midday meal was observed. Tables were attractively set with cutlery, condiments and napkins. Those patients who had their lunch in the lounge, or their own bedroom, were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. The meals were nicely presented and smelled appetising. All of the patients spoken with enjoyed the meals provided in the home.

The day's menu was displayed in the dining room. Registered nurses were observed supervising and assisting patients with their meals and monitoring patients' nutritional intake. Following the observation of the serving of the mid-morning tea and snack to patients and discussion with the manager it was agreed that the tea service would be reviewed and new crockery/equipment purchased as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping; the care planning process and communication between residents, staff and patient representatives.

Areas for improvement

The following area identified for improvement was in relation to reviewing the supplementary care recording templates, for example, repositioning recording and patients' food and fluid intake recording.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with 17 patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect

Patients and or their representatives were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients and/or patient representatives 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 a personal activities leader (PAL) responsible for the provision of activities in the home. There was evidence of a variety of activities in the home and discussion with staff confirmed that patients were given a choice with regards to what they wanted to participate in. One patient was very excited about going to a concert of her favourite artist and, in discussion, stated that one of the staff had organised it for her and would be accompanying her to the concert. The patient was truly delighted. There were various photographs displayed around the home of patients' participation in recent activities. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided.

An electronic feedback system was also situated in the reception area. This was available to relatives and other visitors to give general feedback on an ongoing basis or answer specific questions on the theme of the month. The feedback was summarised automatically by the system and the results were available to the manager and the regional manager.

Staff and patient 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, patients and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner. Comments from the compliments record included, "We could not have managed without your help and support," and "Thank you all very much for the care and attention you gave to my (relative), it was greatly appreciated."

During the inspection, we met with 17 patients; three care staff and two registered nurses, there were no patients' representatives available at the time of the inspection.

Some comments received are detailed below.

Staff

"We love it here. It's a great place to work."
"I love coming to work."

Patients

"Great staff, the nurses are brilliant."
"Couldn't say a bad word about them (staff)."
"I would recommend this home to anyone."
"Very friendly staff."
"Staff are very attentive."
"Couldn't get better staff."

Patients' representatives' comments as per electronic feedback to the home

"She's alright here and everything is perfect."
"Everything is perfect here, I can see that all residents are being well looked after."
"No concerns at all."
"Everything is great."

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. There were no questionnaires returned within the timeframe for inclusion in this report.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with the 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.

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

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

Discussion with the manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015. Staff and patients spoken with confirmed that they were aware of the home's complaints procedure.

Discussion with the manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

As a further element of its Quality of Life Programme, Four Seasons Healthcare operate a Thematic Resident Care Audit ("TRaCA") which home managers can complete electronically.

Information such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This information was subject to checks by the regional manager once a month.

A review of the patient falls audit evidenced that this was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

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. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement; discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships within the home.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

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

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

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

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

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

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 43 **Stated:** First time **To be completed by:** 31 October 2017	The registered person shall ensure that the standard of décor in the lounge and dining room is improved and rectify the malodour in the identified bathroom Ref: Section 6.4
	Response by registered person detailing the actions taken: The lounge and dining room in Sandringham is going to be redecorated. The malodour in the bathoom has been addressed.
Area for improvement 2 **Ref:** Standard 4.8 **Stated:** First time **To be completed by:** 31 August 2017	The registered person shall ensure that the supplementary care recording templates, for example, repositioning recording and patients' food and fluid intake recording provide the necessary information regarding patients' health and wellbeing. Ref: Section 6.5
	Response by registered person detailing the actions taken: The care records are on epic care, after discussion with the Inspector and the Clinical Lead on the day of inspection,we are now implementing Four Seasons Health Care booklets for repositioning ,food and fluid intake and recording the health and well being of the patient when their condition deteroriates.

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

The Regulation and Quality Improvement Authority

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews