Unannounced Follow-up Care Inspection Report 6 January2020

Tennent Street

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

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.

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.

1.0 What we look for

2.0 Profile of service

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

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager and date registered:** Methyl Dagooc 7 December 2018
Person in charge at the time of inspection: Methyl Dagooc	**Number of registered places:** 17
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 patients accommodated in the nursing home on the day of this inspection:** 16

4.0 Inspection summary

An unannounced inspection took place on 06 January 2020 from 09.30 hours to 16.30 hours.

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

The inspection sought to assess progress with issues raised from the last care inspection. The following areas were examined during the inspection:

- staffing
- environment
- meals and mealtimes
- provision of activities
- care records

Patients said:

- “Staff are very good.”
- “Not a bad spot.”
- “Dead on no complaints.”
- “Do alright.”
- “Really good, no complaints.”

- "Quick to come to buzzer."

Areas of good practice were found in the presentation of the patients, the dining experience staff interaction with patients and the environment in the home.

Areas for improvement were identified in relation to the documentation of the ongoing wound evaluation and bowel management

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

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Methyl Dagooc, manager, and Lorraine Kirkpatrick, regional 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 3 October 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 3 October 2019. Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 3 October 2019.

5.0 How we inspect

"RQIA involves service users and members of the public as volunteer lay assessors. A lay assessor is a member of the public who will bring their own experience, fresh insight and a public focus to our inspections. A lay assessor was present during this inspection and their comments are included within this report."

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

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

During the inspection the inspector met with six patients, one patient's relatives and one staff member. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line no responses were returned.

A lay assessor was present during the inspection and their comments are included within this report.

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

The following records were examined during the inspection:

- training records
- three patients' care records
- two patients' supplementary care records
- monthly monitoring reports
- governance audits

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

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

6.0 The inspection

6.1 Review of areas for improvement from previous inspections

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure the infection prevention and control issues identified in this inspection are addressed.	**Met**
	Action taken as confirmed during the inspection: A review of the environment identified that this area for improvement was met.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that fluid intake records in relation to enteral feeding are fully completed and include an accurate total daily fluid intake.	**Met**
	Action taken as confirmed during the inspection: After discussion with the manager and evidence reviewed post inspection this area for improvement was met.	

Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that prescribed thickening agents and food supplements are securely stored at all times.	**Met**
	Action taken as confirmed during the inspection: Thickening agents were securely stored at the time of inspection.	
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered person shall review the existing fluid management arrangements in the home so to ensure that daily fluid targets are reflective of individualised assessed need. Assessed fluid targets should be recorded in the patients individual care records and fluid intake reviewed daily by a registered nurse.	**Met**
	Action taken as confirmed during the inspection: Records reviewed evidenced assessed fluid targets are reflected in the care plans and reviewed by the registered nurses.	
Area for improvement 4 **Ref**: Standard 11 **Stated:** First time	The registered person shall ensure that the pressure relieving equipment used is appropriately set in regards to manufacturer's guidance and patients' weight. The settings required should be appropriately recorded in care plans and reviewed accordingly.	**Met**
	Action taken as confirmed during the inspection: Records reviewed evidenced settings were recorded in the care plan and reviewed accordingly.	
Area for improvement 5 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that meals are stored in an appropriate manner prior to serving to maintain the temperature of the food.	**Met**
	Action taken as confirmed during the inspection: Observation of the mealtime evidenced that meals were stored in an appropriate manner.	

Area for improvement 6 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that action plans are developed to address the shortfalls identified within auditing records and that these action plans are reviewed to ensure completion.	**Met**
	Action taken as confirmed during the inspection: Records reviewed evidenced shortfalls were identified and action plans reviewed to ensure completion.	
Area for improvement 7 **Ref**: Standard 2.8 **Stated:** First time	The registered person shall ensure that patients' written agreements are updated to show the current fee paid by, or on behalf of, patients.	**Met**
	Action taken as confirmed during the inspection: Agreements reviewed showed current fee paid by, or on behalf of, patients.	

6.2 Inspection findings

Environment

We reviewed the home's environment including store rooms, bathrooms, shower rooms, sluices and a selection of patients' bedrooms. We observed an improvement in the general environment in the home and some good examples of personalisation of patients' bedrooms. We observed there was improvement in the storage areas in the home and the snack kitchen was tidy and no inappropriate storage was observed. A side-board in the dining room had been replaced. Music was playing in the lounge as requested by the patients. Fire exits and corridors were observed to be clear of obstruction

Care Records

We reviewed two patients' care records and these evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patients. Care records reviewed also evidenced regular evaluation of the care provided in order to assess the effectiveness of this and to determine if reassessment of planned care was required. The evaluations reviewed were meaningful and patient centred.

We reviewed a care plan for pressure relief. It was documented that a pressure relieving device was in use the mattress type and setting for the device recorded; this area for improvement identified in the last inspection was assessed as met.

We reviewed the documentation for a patient who had a wound. We identified that the care plan was reflective of the care required to manage the wound and relevant wound care documentation was in place. We did, however, identify some gaps in wound care evaluation but all other relevant documentation was completed. We discussed this with the nurse and an area for improvement was identified.

We reviewed the supplementary care records and we observed that fluid monitoring, for those patients who required a prescribed fluid target, were evaluated by the nurses. An area for improvement on the previous inspection was met. However we did identify "gaps" in the recording of the bowel monitoring. This had not been identified in the daily evaluation of care and evaluation and an area for improvement was identified.

Dining Experience

We reviewed the lunch time experience for patients and it was observed to be a relaxed and calm experience. Food was served to the patients straight from the "hot trolley" and staff were observed interacting with patients and offering choice. The tables were set and condiments were available for patients to use.

Various drinks were available and offered to patients and food delivered to the patients in their bedrooms was covered.

The lay assessor observed that nine patients were seated at four tables and were assisted or supervised by three care staff.

Those patients who required assistance were helped sensitively and appropriately.

All of the patients seemed to be enjoying the experience.

Three meals were served to patients in their room.

Unlike on the previous visit the heated trolley was plugged in in the snack kitchen. An area for improvement identified on the previous inspection was met.

Governance

Patients and staff had no complaints about the staffing levels in the home unless there was short notice absence. They did advise that there were systems in place to manage this. Staffing levels on the day of inspection were seen to meet the needs of the patients.

Records reviewed evidenced that various governance audits undertaken by the manager, for example, training, infection prevention and control and care records showed that any areas that were identified as requiring improvement had an action plan and completion date. An area for improvement from the previous inspection was met.

Areas for improvement

Areas for improvement were identified in relation to documentation of wound care evaluation and recording of bowel monitoring.

	Regulations	Standards
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Methyl Dagooc, manager, and Lorraine Kirkpatrick, regional 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.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 March 2020	The registered person shall ensure wound care evaluation is recorded at each wound dressing change. Ref: 6.3
	Response by registered person detailing the actions taken: Supervison was completed with all nurses with regards to wound management. A wound care traca is competed every month to monitor wounds and review care plan and its evaluation. Compliance will be montiored by the RM or nominated person as part of the monthly Reg 29 visits
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 March 2020	The registered person shall ensure accurate recording of bowel management documentation and this care is evaluated by the registered nurses. Ref: 6.3
	Response by registered person detailing the actions taken: Supervision was completed with all registered nurses in regards to bowel management. Bowel records will be monitored on daily basis and action taken if required. This will be documented in resident's daily progress notes and care plan evaluation monthly. Compliance will be monitored by the RM or nominated person as part of the monthly Reg 29 visits

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

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