Unannounced Care Inspection Report
24 January 2017

Three Islands

Type of Service: Nursing Home
Address: 62-66 Main Street, Toomebridge, BT41 3NJ
Tel no: 028 7965 0650
Inspector: Bridget Dougan

1.0 Summary

An unannounced inspection of Three Islands took place on 24 January 2017 from 11.00 to 15.00 hours. On this occasion the inspector was accompanied by a Lay Assessor. Please refer to section 4.5 for further detail.

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

The focus of the inspection was meals and mealtimes.

On the day of inspection the majority of patients, relatives and staff spoken with commented positively in regard to the care in the home. The comments received from one patient require consideration and follow up by the registered manager. A review of records, discussion with the registered manager and staff and observations of care delivery evidenced that all of the requirements and recommendations made as a result of the previous inspection have been complied with.

No requirements or recommendations were made as a result of this inspection

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	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mr. David Joseph McAteer, registered manager, as part of the inspection process and can be found in the main body of the report.

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 01 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: Mr D McAteer & Mrs A McAteer	**Registered manager:** Mr David Joseph McAteer
Person in charge of the home at the time of inspection: Mr David Joseph McAteer	**Date manager registered:** 07 May 2009
Categories of care: NH-LD, NH-LD (E)	**Number of registered places:** 40

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre-inspection assessment audit.

During the inspection we met with 25 patients, three relatives, two registered nurses, six care staff, one catering and one domestic staff.

Eight patients, eight staff, and six relatives' questionnaires were left for distribution. Eight patients and one staff completed and returned questionnaires within the allocated timeframe.

The following information was examined during the inspection:

- staffing arrangements in the home
- two patient care records
- staff training records
- accident and incident records
- notifiable events records
- complaints and compliments records
- policy on meals and mealtimes

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 01 November 2016

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

4.2 Review of requirements and recommendations from the last care inspection dated 01 November 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39 **Stated:** First time	The registered manager should countersign all completed induction records. **Reference: Section 4.3**	**Met**
	Action taken as confirmed during the inspection: Review of three staff induction records evidenced that this recommendation had been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rotas for the weeks commencing 08, 15 and 22 January 2017 evidenced that the planned staffing levels were adhered to.

Discussion with patients and staff evidenced that there were no concerns regarding staffing levels.

Review of the training matrix/schedule for 2016/17 indicated that staff had completed mandatory training to date. Additional training in nutrition, hydration, dysphagia, subcutaneous fluids and enteral feeding had been completed by all relevant staff in 2015/16. Further training had been planned in the management of swallowing difficulties and nutrition in January 2017.

There was a policy on meals and mealtimes dated 10 March 2015 and the registered manager confirmed that it was kept under review and was in line with current best practice guidance. A system was in place to ensure all relevant staff had read and understood the policy.

Up to date nutritional guidelines were available and used by staff on a daily basis.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

Review of two patients' 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 care had been assessed, planned, evaluated and reviewed in accordance with NMC guidelines. Risk assessments informed the care planning process.

Care records reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

Patients and their representatives expressed their confidence in raising concerns with the home's staff/management.

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?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Observation of the lunch time meal confirmed that patients were given a choice in regards to, food and fluid choices and the level of help and support requested. The daily menu was displayed in the dining rooms and offered patients a choice of two meals for lunch and dinner. A choice was also available for those on therapeutic diets. Alternatives were available for those patients who did not like either option. Modified meals were served with food elements portioned separately. A discussion with catering staff demonstrated that they were knowledgeable regarding the patients dietary needs. This included; patients who required modified diets; diabetic diets and food fortification. Where patients required assistance with meals, staff were observed to offer patients reassurance and assistance in a discreet, unhurried and sensitive manner.

During the inspection we met with 25 patients, three relatives and ten staff. We also issued questionnaires as outlined in section 3.0 to gain additional feedback from patients, staff and patients representatives. Eight patients and one staff member completed and returned questionnaires within the required time frame.

The majority of patients spoken with were complimentary regarding the care they received and life in the home. One patient raised a number of issues which were discussed with the registered manager for follow up as appropriate. Those 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. Three relatives spoken with were complimentary regarding the care, staff and management.

Some staff comments from patients, relatives and staff are detailed below:

Patients

- "I like it here, the food is good"
- "the minister comes in to see me"
- "everybody is good to me"
- "I would like more privacy when I am in the toilet/bathroom"
- "I am happy and contented. It's a nice, easy place to live"
- "If you don't like a meal, just tell the staff and you can have something else"
- "I like to play my computer"

Relatives

"we're very happy with this home. Staff are brilliant"

Staff

- "I like working here"
- "our patients are very well cared for. I have no concerns"

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities. Staff also confirmed that there were good working relationships and staff stated that the registered manager was responsive to any concerns raised.

The certificate of registration issued by RQIA was displayed in the home. A certificate of public liability insurance was current and displayed. Discussion with the registered manager, a review of care records and observations confirmed that the home was operating within its registered categories of care.

Review of the home's complaints records and discussion with the registered manager evidenced 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.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies in a timely manner.

There was evidence that a range of audits had been completed on a monthly basis, including accidents/incidents and complaints. There was also evidence of regular monthly audits of care records, patients' weights, referral and follow up as necessary.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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