



Unannounced Care Inspection Report 30 July 2019



Three Islands

Type of Service: Nursing Home
Address: 62-66 Main Street, Toomebridge, BT41 3NJ
Tel No: 028 7965 0650
Inspector: Michael Lavelle

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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.

1.0 What we look for



2.0 Profile of service

This is a registered nursing home which provides care for up to 40 patients.

3.0 Service details

Organisation/Registered Providers: Mr Donal McAteer Mrs Ann McAteer	Registered Manager and date registered: David Joseph McAteer – 7 May 2009
Person in charge at the time of inspection:	Number of registered places: 40 With associated physical disabilities.
Categories of care: Nursing Home (NH) LD – Learning disability. LD (E) – Learning disability – over 65 years.	Number of patients accommodated in the nursing home on the day of this inspection: 39

4.0 Inspection summary

An unannounced inspection took place on 30 July 2019 from 09.30 hours to 16.40 hours.

This inspection was undertaken by the care inspector.

The inspection assessed progress with all areas for improvement identified in the home 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 staff recruitment and induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management, communication between residents, staff and other key stakeholders, the culture and ethos of the home, dignity and privacy, listening to and valuing patients, governance arrangements and maintaining good working relationships.

Areas requiring improvement were identified in relation to maintaining skin integrity and updating care plans post falls.

Patients described living in the home as being a good experience. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from patients and staff during the inspection, are included in the main body of this report.

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	2	0

Details of the Quality Improvement Plan (QIP) were discussed with David Joseph McAteer, 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.

4.2 Action/enforcement taken following the most recent inspection dated 6 February 2019

The most recent inspection of the home was an unannounced enforcement care inspection undertaken on 6 February 2019. Evidence was available to validate compliance with the Failure to Comply Notices which were issued on 11 December 2018.

No further actions were required to be taken following this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including) registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept.

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from weeks commencing 29 July 2019 and 5 August 2019
- 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
- one staff recruitment and induction file
- three patient care records
- a selection patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records
- complaints record
- compliments received
- a sample of reports of visits by the registered provider
- RQIA registration certificate.

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as either 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 inspection(s)

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 30 (1) (d) Stated: First time	The registered person shall give notice to RQIA without delay of the occurrence of all head injuries and injuries to patients that require medical intervention. All relevant notifications identified in this report should be submitted retrospectively.	Met
	Action taken as confirmed during the inspection: Review of accidents and incidents since the last care inspection confirmed that these were reported in a timely manner. All relevant notifications identified in the previous care inspection report were submitted retrospectively.	

<p>Area for improvement 2</p> <p>Ref: Regulation 10 (1)</p> <p>Stated: First time</p>	<p>The registered persons must ensure that robust governance arrangements are put in place to ensure that the deficits identified in the report are appropriately actioned.</p> <hr/> <p>Action taken as confirmed during the inspection: Review of audits and discussion with the registered manager confirmed robust governance arrangements are in place.</p>	<p>Met</p>
<p>Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</p>		<p>Validation of compliance</p>
<p>Area for improvement 1</p> <p>Ref: Standard 12</p> <p>Stated: Third time</p>	<p>The registered person shall review the dining experience to ensure that meal times are delivered in accordance with best practice guidance, for example, Nutritional Guidelines and menu checklist, March 2014.</p> <hr/> <p>Action taken as confirmed during the inspection: Review of the environment and observation of the dining experience evidenced this area for improvement has been met. This is discussed further in section 6.4.</p>	<p>Met</p>
<p>Area for improvement 2</p> <p>Ref: Standard 11</p> <p>Stated: Second time</p>	<p>The registered person shall ensure that meaningful activities for all patients are provided and the duties of the activities manager are reviewed.</p> <hr/> <p>Action taken as confirmed during the inspection: Review of the activities and discussion with the registered manager evidenced this area for improvement has been met. This is discussed further in section 6.5.</p>	<p>Met</p>

Area for improvement 3 Ref: Standard 43 Stated: First time	The registered person shall review the general nursing home environment to ensure that patient areas are appropriately personalised and that appropriate signage and information is displayed in a suitable format for the patients accommodated.	Met
	Action taken as confirmed during the inspection: During review of the environment we confirmed that patient areas are appropriately personalised and that appropriate signage and information is displayed in a suitable format for the patients accommodated.	

6.2 Inspection findings

6.3 Is care safe?

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

We arrived at the home at 09.30 hours and were greeted by the nurse in charge who was friendly and welcoming. They 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 rota for weeks commencing 29 July 2019 and 5 August 2019 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff. The manager should clearly identify which hours are worked by the activity co-ordinator in the home on the staffing rota.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patient's needs. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Patients spoken with indicated that the care they received was good and that they felt safe and happy living in Three Islands.

Review of one staff recruitment file confirmed staff were recruited in accordance with relevant statutory employment legislation and mandatory requirements. Appropriate pre-employment checks are completed and recruitment processes included the vetting of applicants to ensure they were suitable to work with the patients in the home.

Staff spoken with said they completed a period of induction alongside a mentor and they would actively support new staff during their induction to the home. Review of records confirmed that a comprehensive induction was given to one recently recruited employee. Review of records evidenced the registered manager had a robust system in place to monitor staffs' registrations with their relevant professional bodies.

Review of records and discussion with staff and the manager confirmed that staff training, supervision and appraisal was well maintained and actively managed.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice.

We reviewed accidents/incidents records since February 2019 in comparison with the notifications submitted by the home to RQIA. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. If required, an action plan was devised to address any identified deficits. This information was also reviewed as part of the monthly monitoring visits.

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control measures were generally well adhered to. Staff were knowledgeable in relation to best practice guidance with regards to hand hygiene and use of personal protective equipment (PPE) and were observed to wash their hands/use alcohol gels and use PPE at appropriate times.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices. There was also evidence of consultation with relevant persons. Care plans were in place for the management of restrictive practices including bedrails, lap belts and alarm mats. It was pleasing to note the manager was finalising the use of a best interest decision making tool with regards to the use of restrictive practices within the home in preparation for the introduction of the Mental Capacity Act (Northern Ireland) 2016.

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 and well decorated.

Fire exits and corridors were observed to be clear of clutter and obstruction. Records evidenced that systems were in place to manage and record fire drills and fire alarm tests within the home. We encouraged the registered manager to consider incorporating a fire drill into the six monthly fire training delivered to staff.

Areas of good practice

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

Areas for improvement

No new areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total numb of areas for improvement	0	0

6.4 Is care effective?

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

Review of three patient care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process. Care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of infection, weight loss, falls and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Review of wound management for one patient evidenced that when a wound was identified, an initial wound assessment was completed and a wound care plan developed to direct the care in managing the wound. Body maps were completed identifying the location of the wound and wound observation charts completed to monitor the progress of the wound at the time of wound dressing. However, wound evaluations were not always well completed. This was discussed with the registered manager who agreed to address this with registered nurses. This will be reviewed at a future care inspection.

We reviewed the management of skin integrity. Patients identified at risk of developing pressure damage were repositioned regularly for comfort, although, staff did not review or record the condition of the patients' skin at this time. Review of one record confirmed the condition of the patient's skin was checked twice daily and recorded, however, the patient required four hourly repositioning and this was not evidenced within repositioning/patient care records. This was discussed with the registered manager and an area for improvement under the regulations was made.

It was positive to note that the care record for one patient who had recently experienced an unwitnessed fall evidenced relevant and accurate information concerning the patient's assessed needs in relation to being at risk of falling, including onward referral to the falls nurse. The fall was managed in keeping with best practice guidance, however, there was no evidence that the patient's care plan was reviewed or updated post fall. This was discussed with the registered manager who agreed to highlight this with the registered nurses. An area for improvement under the regulations was made.

Minor deficits were identified in relation to record keeping in some care records and supplementary care records. Specifically staff did not always replace paperwork and were writing on the margins, 24 hour fluid intake was not consistently recorded in the daily progress notes and dates and times were not always accurately recorded. This was discussed with the registered manager for action as required. This will be reviewed at a future care inspection.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as general practitioners (GPs), physiotherapist, dietician, optician and speech and language therapists (SALT). There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals.

We observed the serving of the mid-morning snacks and midday meal. Patients were assisted to the dining room and staff were observed assisting patients with their meal appropriately. Patients appeared to enjoy the mealtime experience and were offered a choice of meals and drinks. The decor in the dining rooms had been updated since the previous care inspection and patients had

personalised placements. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Review of the menu evidenced that planned meals had been adhered to.

Discussion with staff evidenced they 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.

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 would raise these with the registered manager or the nurse in charge. When we spoke with staff they had a good knowledge of patients' abilities and level of decision making; staff knew how and when to provide comfort to patients because they knew their needs well.

All grades of staff consulted with demonstrated the ability to communicate effectively with their colleagues and other health care professionals. Discussion with registered manager and review of records confirmed that staff meetings were held regularly and records maintained. We encouraged the registered manager to review action points identified during staff meeting at the subsequent staff meeting to ensure all outstanding actions had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between residents, staff and other key stakeholders.

Areas for improvement

Two areas for improvement under the regulations were identified in relation to maintaining skin integrity and updating care plans post fall.

	Regulations	Standards
Total number of areas for improvement	2	0

6.5 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 demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff and review of the activity programme displayed in the home evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. We observed patients painting clay picture frames they had made previously. Patients reported they enjoyed this activity and the external visitors who come to the home to provide other activities such as arts and crafts and music. There was evidence new equipment has also been purchased for activities. The registered manager confirmed a care assistant is allocated in the absence of the activity co-ordinator to lead on activities. We asked the registered manager to review the type of music played in the sensory room to ensure it was appropriate for a therapeutic environment. This will be reviewed at a future care inspection.

Review of records confirmed contemporaneous records were kept by the activity co-ordinator of all activities that took place, with the names of the person leading them and the patients who participated. We discussed the activity planners and the need for registered nurses to review activities as an integral part of the care process with the registered manager. They agreed to review this with staff. This will be reviewed at a future care inspection.

The environment in the home had been adapted to promote positive outcomes for the patients. Many of the bedrooms were personalised with possessions that were meaningful to the patients and reflected their life experiences. However, we did observe a number of bedrooms that appeared to be quite sparse. This was discussed with the registered manager who agreed to discuss this with patients' families with a view to addressing this. This will be reviewed at a future care inspection.

The dining room was attractively set with table cloths and we saw clocks within the home along with prompts for the date and weather.

We reviewed the compliments file within the home. Some of the comments recorded included:

- "I really appreciate the care (my relative) receive and he looks so happy."

Consultation with 12 patients individually, and with others in smaller groups, confirmed they were happy and content living in Three Islands. Some of the patient's comments included:

- "I am happy this morning."
- "I have been here since Christmas and so far so good."
- "I like it here. You get good food and do different things like arts and crafts and different things over the month."
- "I'm getting on great, love it here."
- "I am going to stay. It's lovely."
- "It's good here. There is a man who comes in and gives me fags and money. The staff are all kind to me and try to help me. This is my home. Seven people come to see me."
- "I'm spoiled. I really enjoy it. Anne, Donal and DJ and everyone have me ruined."
- "I like all the staff. You have your own nice room and stuff and you can have your own peace and quiet."

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.

Five relative questionnaires were provided; we had no responses within the timescale specified.

Staff were asked to complete an online survey; we received no responses within the expected timeframe. Six members of staff were spoken with during the inspection. Some of the comments received included the following:

- “It’s a nice place to work. I have no complaints.”
- “We have a proper menu for patients now and management are more strict since the last inspection, asking for infection prevention and control protocol to be maintained. The dining areas are nicer for patients.”

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Review of records confirmed a patient forum is held each month and minutes are maintained. The registered manager confirmed the home operated an open door policy and relatives are invited to speak with staff every Sunday.

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 and listening to and valuing patients.

Areas for improvement

No new areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 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.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been no change in management arrangements. 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 staff evidenced that the manager’s working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

There was evidence of good management oversight of the day to day working in the home. A number of audits were completed to assure the quality of care and services; areas audited included pressure ulcers, care plans, infection prevention and control, medications, complaints and

accidents and incidents. Audits generated action plans that highlighted areas for improvement and there was evidence that the deficits identified were actioned as required.

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 appropriately. Review of records evidenced that quality monitoring visits were completed on a monthly basis on behalf of the responsible individual in accordance with the relevant regulations and standards.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed appropriately in line with best practice guidance. Patients spoken with said they would be confident if they raised a complaint that it would be dealt with accordingly. We asked the registered manager to ensure staff are aware that expressions of dissatisfaction from patients and relatives should be managed as a complaint.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

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

Areas for improvement

No new areas for improvement were identified during the inspection in this domain.

	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 David Joseph McAteer, registered 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 Nursing Homes Regulations (Northern Ireland) 2005

<p>Area for improvement 1</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: First time</p> <p>To be completed by: Immediate action required</p>	<p>The registered person shall ensure that patients at risk of developing pressure damage have a robust repositioning schedule in place. This should be appropriately care planned for, direct staff as to the frequency of repositioning/skin checks and reviewed as required in keeping with the patient's needs.</p> <p>Ref: 6.4</p> <p>Response by registered person detailing the actions taken: The Manager has recently redesigned the documentation for pressure care. Staff have been provided with training in the area, and the manager will ensure that best practice and correct documentation is adhered to.</p>
<p>Area for improvement 2</p> <p>Ref: Regulation 16 (2) (b)</p> <p>Stated: First time</p> <p>To be completed by: Immediate action required</p>	<p>The registered person shall ensure patient care plans are kept under review.</p> <p>This area for improvement is made in reference to management of falls.</p> <p>Ref: 6.4</p> <p>Response by registered person detailing the actions taken: The Manager has clarified this with Staff and they now update the care plans correctly. The Manager will monitor this as part of the care planning audit.</p>

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



The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9536 1111

Email info@rqia.org.uk

Web www.rqia.org.uk

Twitter @RQIANews

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