Unannounced Care Inspection Report
1 December 2016

Queenscourt

Address: 36 Doagh Road, Ballyclare, BT39 9BG
Tel No: 02893341472
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Queenscourt took place on 1 December 2016 from 10:45 hours to 15:00 hours.

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.

On the day of inspection patients and staff spoken with commented positively in regard to the care in the home. A review of records and discussion with the manager and staff evidenced that a significant amount of work had been undertaken to improve the standard of care records in the home. One requirement and five recommendations made as a result of the previous inspection have been complied with. Whilst acknowledging the improvements made to date, further improvements are required to ensure all of the care records are maintained in accordance with regulatory requirements and professional standards. One requirement and three recommendations were assessed as partially met and have been stated for a second time.

There was a busy atmosphere in the home which was nicely decorated for Christmas. Those patients spoken with were excited about the planned activities and looking forward to Christmas period.

There were no areas for improvement identified 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	1*	3*

*The requirement and recommendations were made as a result of the previous inspection and are now stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Eoghain King, responsible person, and Ms Stella Law, 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 care inspection.

The most recent inspection of the home was an unannounced care inspection undertaken on 24 May 2016. Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent 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.

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

2.0 Service details

Registered organisation/registered person: Manor Healthcare Ltd Eoghain King	**Registered manager:** The registration process is ongoing for Ms Law.
Person in charge of the home at the time of inspection: Ms Stella Price	**Date manager registered:** Ms Law's application for registered manager has been received by RQIA and is pending.
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 43

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 the majority of patients, one registered nurse, five care staff and one visiting healthcare professional.

The following information was examined during the inspection:

- three patient care records
- accident and incident reports
- records of audit.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 May 2016.

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

4.2 Review of requirements and recommendations from the last care inspection dated 24 May 2016.

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15(2)(b) **Stated:** First time	The registered person must ensure that the assessment of patient need is kept under review and revised no less than annually.	**Met**
	Action taken as confirmed during the inspection: In the three care records reviewed the assessments of patient need had been reviewed and updated within the past 12 months. This requirement has been met.	
Requirement 2 **Ref:** Regulation 16(1)&(2)(b) **Stated:** First time	The registered person must ensure that care plans are in place to detail how the patients' needs in respect of health and welfare are to be met. Care plans must be kept under review	**Partially Met**
	Action taken as confirmed during the inspection: Two of the three care records reviewed had a range of care plans in place to meet the assessed needs of the patients. The manager explained that work was ongoing with the care records to ensure that they met professional and regulatory standards. This requirement is assessed as partially met and is stated for a second time.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 4.8 **Stated:** First time	Care records should be updated following an accident to reflect any identified risks.	**Partially Met**
	Action taken as confirmed during the inspection: We reviewed the accidents and incident records completed since the previous inspection. Three incidents, with identified risks, were recorded. Two of the three care records reviewed had been updated to reflect the identified risks. This recommendation has been assessed as partially met and is stated for a second time.	
Recommendation 2 **Ref**: Standard 18.3 **Stated:** First time	It is recommended that any decision to use restrictive practice should be discussed, and agreed, with the relevant health care professionals and, where appropriate, the patient and their representatives/relatives. Records should be maintained of these discussions.	**Met**
	Action taken as confirmed during the inspection: In the care records reviewed there was robust evidence of discussion and agreement with patients, where possible, relatives and relevant healthcare professionals with regard to the management of restrictive practice. The records included the nature of the restrictive practice, the rationale for it and what discussions had taken place and with who. Where appropriate the patients had signed to evidence their consent. The restrictive practices included the management of mobile phones, assistance to manage personal monies and the storage and access to toiletries. This recommendation has been assessed as met.	

Recommendation 3 **Ref**: Standard 44.1 **Stated:** First time	It is recommended that a further phase of refurbishment is implemented to replace the fitted furniture which cannot be repaired to an acceptable standard.	**Met**
	Action taken as confirmed during the inspection: The manager confirmed that a programme of refurbishment had been commenced. We observed one bedroom which had been redecorated and new furniture provided. The manager identified a number of bedrooms as we walked around the home which were due to be refurbished as part of the current plan. We observed a number of rolls of carpet to be fitted in identified bedrooms. Following discussion with the manager and observations made we were assured that a plan, which included the replacement of the fitted furniture, was in place. This recommendation is as met.	
Recommendation 4 **Ref**: Standard 47.3 **Stated:** First time	It is recommended that the unsupervised operation of the laundry should be discussed with the fire risk assessor and advice sought how to best manage the laundry with regard to fire safety. RQIA should be informed of the outcome of this discussion.	**Met**
	Action taken as confirmed during the inspection: The responsible person confirmed that the unsupervised use of the laundry was discussed with the fire risk assessor following the previous inspection. The manager explained that the operation of the laundry in the evenings had been reviewed. Further discussion evidenced that the laundry did operate unsupervised at time throughout the day. We were informed that the annual fire risk assessment had been completed the week prior to the inspection. A copy had not been received by the home at the time of the inspection. The responsible person confirmed by e mail that the fire risk assessor had been made aware of the unsupervised use of the laundry during the recent assessment and that this would be reflected in the assessment. This recommendation has been met.	

Recommendation 5 **Ref**: Standard 4 **Stated:** First time	Risk assessments to meet individual needs should be completed. **Action taken as confirmed during the inspection**: A review of three care records evidenced that a range of risk assessments were completed for each patient. We noted that two patients received medication for the management of pain on an "as required" basis. There were no pain assessments completed for these patients. This recommendation is assessed as partially met and is stated for a second time.	**Partially Met**
Recommendation 6 **Ref**: Standard 4 **Stated:** First time	It is recommended that risk assessments are reviewed regularly, and following any change in the patient's condition **Action taken as confirmed during the inspection**: In two of the three care records reviewed there was evidence that risk assessments were reviewed regularly and following any changes to the patients' condition. This recommendation is assessed as partially met and is stated for a second time.	**Partially Met**
Recommendation 7 **Ref**: Standard 35.16 **Stated:** First time	It is recommended that the frequency with which care records are audited is increased. The audit process should include a re-audit of the areas for improvement to check compliance has been achieved. **Action taken as confirmed during the inspection**: A review of audit records evidenced that audits of care records were being undertaken. Areas for improvement were identified and shared with the relevant named nurse. A date was recorded when the re-audit, to check that the required improvements were made, would be completed. This recommendation has been assessed as met.	**Met**

Recommendation 8 **Ref**: Standard 12 **Stated:** First time	The dining experience is reviewed to ensure that individual needs and preferences are considered and that meal times are delivered in accordance with best practice guidance, for example, Nutritional Guidelines and menu checklist, March 2014. This review should include the environment of the dining room which must be decluttered and defined as a dining area.	**Met**
	Action taken as confirmed during the inspection: The manager explained that a review of the dining experience had been completed following the previous inspection. We observed that dining tables were set with cutlery prior to the meals being served. Meals were served in two stages; those patients who required assistance with their meals were served first followed by those patients who ate independently. The dining room had recently been repainted and the manager informed us that new flooring had been ordered. The manager explained that further improvements were planned for the dining room environment. We discussed if any consideration had been given to encouraging patients of similar ability to sit together to create a more social experience at mealtimes. The manager confirmed that work was ongoing to improve the dining experience for patients. Improvements were observed to the dining experience and environment. It was encouraging to hear that further work is planned. This recommendation was assessed as met.	

4.3 Inspection findings

4.3.1 Care delivery

We arrived in the home at 11 00 hours. There was a busy atmosphere in the home and staff were quietly attending to the patients' needs. Patients were observed to be sitting in the lounge, or in their bedroom, as was their personal preference. The staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day. Staff were observed responding to patients'

needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time.

The home was nicely decorated for Christmas and those patients spoken with were excited about the planned activities and looking forward to the Christmas period.

We did not have the opportunity to speak with any relatives during the inspection. Ten questionnaires were issued for relatives; none were returned.

We spoke with one healthcare professional who visited the home regularly. They commented positively on the outcome of care for patients and the good communication between the staff and the healthcare trust.

Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences. Staff stated they were satisfied that they were well supported in their role; there were good training opportunities and that management were approachable. Staff were of the opinion that they delivered a good standard of care to the patients. Ten questionnaires were issued for staff; none were returned.

No areas for improvement were identified during the inspection.

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Eoghain King, responsible person, and Ms Stella Law, 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 16(1)&(2)(b) **Stated:** Second time **To be completed by:** 24 January 2017	The registered person must ensure that care plans are in place to detail how the patients' needs in respect of health and welfare are to be met. Care plans must be kept under review **Ref section 4.2**
	Response by registered provider detailing the actions taken: All care plans have been reviewed and records are currently up to date. New auditing system has been implemented for RN staff to complete, on-going monitoring system is in place for all care records to be updated at all times.
Recommendations	
Recommendation 1 **Ref**: Standard 4.8 **Stated:** Second time **To be completed by:** 24 January 2017	Care records should be updated following an accident to reflect any identified risks. **Ref section 4.2**
	Response by registered provider detailing the actions taken: The Home Manager has introduced a daily monitoring system where all accidents/incidences are recorded, reported and monitored appropriately. RN staff will complete accident/incident report and the Home Manager will monitor as appropriate.
Recommendation 2 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 24 January 2017	Risk assessments to meet individual needs should be completed. **Ref section 4.2**
	Response by registered provider detailing the actions taken: Home Manager will audit care profile for RN to complete all risk assessment monthly or as when needed. The Home Manager will review on monthly basis to ensure resident's needs identified are met as appropriate.
Recommendation 3 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 24 January 2017	It is recommended that risk assessments are reviewed regularly, and following any change in the patient's condition **Ref section 4.2**
	Response by registered provider detailing the actions taken: Home manager will conduct audits of care records and review risk assessments. Corrective actions identified will be completed by the RN and monitored by Home Manager.

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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