

Unannounced Care Inspection Report 18 July 2016



Jordanstown

Type of Service: Nursing Home
Address: 1a Old Manse Road, Jordanstown, BT37 0RU
Tel No: 028 9085 2258
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Jordanstown took place on 18 July from 9.45 to 18.15 hours.

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.

Is care safe?

Staff were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. Training had been provided in all mandatory areas and this was kept up to date. The home was clean, infection prevention and control measures were adhered to and fire exits and corridors were maintained clear from clutter and obstruction. However, three requirements have been made in regards to staffing arrangements; availability of recruitment and selection records; and the reporting of serious injuries sustained in the home to RQIA. Three recommendations have also been made in regards to the completion of staff induction programmes; and the completion of falls risk assessments.

Is care effective?

There was evidence of regular communication with patient representatives regarding any changes in the patients' condition. Patients were repositioned in line with their care plans; and patients' fluid intake had been monitored, as required. However, weaknesses were identified in the review of patient care records and in the delivery of personal care and hourly supervision checks. Two recommendations that were previously stated were not met and have now been stated as requirements to ensure compliance and drive improvements in this area.

Is care compassionate?

Patients stated that they were involved in decision making about their own care and confirmed that they were able to maintain contact with their families and friends. There were opportunities for patients to partake in activities in the home. There were systems in place to obtain the views of patients and their representatives on the quality of the service provided. Although some positive comments were made regarding individual staff members, consultation with patients also confirmed that they were not always, afforded dignity and respect; and patients reported long delays in having their needs met. Comments from patients and their representatives were variable and have been included in the report. Two recommendations have been made in regards to patient/representative engagement; and staff training in the principles of choice, dignity and respect which underpin the care standards for nursing homes, 2015.

Is the service well led?

There was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities. The home was operating within its registered categories of care. Complaints were managed appropriately and there were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed in a timely manner.

Monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and there were systems in place to monitor and report on the quality of nursing and other services provided; however we were unable to assess the effectiveness of the audits as they could not be accessed on the day of the inspection.

There was a system in place to identify the person in charge of the home, in the absence of the registered manager; however the management support arrangements over the weekends were not responsive to reports of staff shortages. Staff also stated that they felt unable to raise their concerns about staffing arrangements and the standard of personal care delivery to the management.

One recommendation has been made that audits completed on the 'Quality of Life' (QOL) system are available in print format, to enable evaluation and inspection. Given that two recommendations were not met and that requirements and recommendations have been made in the three other domains, improvements are required to meet the required standards and to demonstrate a well-led service.

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	5	6

Details of the QIP within this report were discussed with the registered manager. Following the inspection, the inspection findings were discussed with senior management in RQIA and a decision was made to discuss the inspection findings with the regional manager of the home. This discussion took place by telephone on 19 July 2016. 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 inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 12 November 2015. Other than those actions detailed in the previous QIP there were no further actions required. 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 provider: Four Seasons Healthcare Dr. Maureen Claire Royston	Registered manager: Jean Elizabeth Steele
Person in charge of the home at the time of inspection: Jean Elizabeth Steele	Date manager registered: 1 April 2005
Categories of care: NH-PH, NH-I Category NH-PH for 1 identified patient only.	Number of registered places: 53

3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

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, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with four patients, three care staff, two registered nurses and four patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records for 2015/2016
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 November 2015

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. The QIP will be validated at this inspection. Please refer to section 4.2.

4.2 Review of requirements and recommendations from the last care inspection dated 12 November 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 20.2 Stated: First time	The registered person should ensure that patients religious preferences/spiritual needs are documented in end of life care plans.	Met
	Action taken as confirmed during the inspection: A review of care records confirmed that patients' religious preferences and spiritual care needs were documented in their care plans, as appropriate.	
Recommendation 2 Ref: Standard 4.7 Stated: First time	The registered person should ensure that, with regard to care records – <ul style="list-style-type: none"> • the assessment of the patient's needs is kept under review, and • revised at any time when it is necessary to do so having regard to any change of circumstances • the patient's care plan is kept under review and reflects the current assessment of needs and care delivery. 	Not Met
	Action taken as confirmed during the inspection: A review of care records evidenced that risk assessments and care plans were not consistently reviewed on a regular basis. This recommendation was not met. A requirement has been made in this regard. Refer to section 4.4 for further detail.	

<p>Recommendation 3</p> <p>Ref: Standard 6.14</p> <p>Stated: First time</p>	<p>It is recommended that patients personal care needs are regularly assessed and met to include (but is not limited to) oral health care. Records should be completed to evidence care delivered or not delivered. Training should be provided for all care staff to further enhance the delivery of care in this regard.</p> <p>Action taken as confirmed during the inspection: A review of personal care records evidenced inconsistencies in the completion of personal care records, particularly in relation to the provision of showers/baths to patients.</p> <p>This recommendation was not met. A requirement has been made in this regard. Refer to section 4.4 for further detail.</p>	<p>Not Met</p>
<p>Recommendation 4</p> <p>Ref: Standard 37.5</p> <p>Stated: First time</p>	<p>The registered person should review the system of placing Do Not Attempt Resuscitation notices on the covers of care records. An alternative method of communicating this information is recommended to ensure confidentiality is maintained.</p> <p>Action taken as confirmed during the inspection: The Do Not Resuscitate notices had been removed from the covers of the care records.</p>	<p>Met</p>
<p>Recommendation 5</p> <p>Ref: Standard 6.3</p> <p>Stated: First time</p>	<p>The registered person should ensure that patients are enabled to exercise choices and give their consent regarding the provision of intimate care, including, but not limited to the gender of the staff providing the care where possible and practical.</p> <p>Action taken as confirmed during the inspection: Discussion with patients confirmed that their preferences were respected in regards to the gender of the staff member, providing assistance with intimate care.</p>	<p>Met</p>

Recommendation 6 Ref: Standard 11.1 Stated: First time	The registered person should review the provision of activities to ensure the programme of events and activities provide positive and meaningful outcomes for patients and are based on their identified needs, life experiences and interests.	Met
	Action taken as confirmed during the inspection: Discussion with patients evidenced that a range of activities were available for patients to participate in.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were in the process of being reviewed to ensure the assessed needs of the patients were met, taking into account the patients' dependency levels.

The planned staffing levels for the home were as follows:

08.00 to 14.00 – 3 registered nurses and 6 care staff
 14.00 to 20.00 – 2 registered nurses and 5 care staff
 20.00 to 08.00 – 2 registered nurse and 3 care staff.

The patients were accommodated over three floors. This meant that one staff member each from the ground and first floors were allocated to provide care to patients on the second floor. This resulted in insufficient staff in place on the ground and first floors during the periods that the staff were deployed to the second floor. Discussion took place with the registered manager regarding the staffing levels, skill mix and deployment of staff. The registered manager stated that the staffing levels had been reviewed by the regional manager, the previous week and that a new staffing tool was being trialled, taking the patients' dependency levels and the layout of the building into account. There was no information available on the assessment tool used.

A review of the staffing rota commencing 11 July 2016 evidenced that the planned staffing levels were not adhered to on three consecutive days due to absenteeism. There was no evidence that the staff had made any efforts to address the staff shortages on two of the three days. Further detail on support arrangements is discussed in section 4.6. Observations on the day of the inspection evidenced that the staff were under pressure in regards to meeting the patients' needs. For example, the medication round in the morning was prolonged and did not finish until 12pm. A registered nurse was also observed serving afternoon refreshments to the patients, which took over one hour to complete. This duty could have been more appropriately delegated.

Patients, staff and relatives consulted with stated that there have been staffing difficulties particularly over the weekends due to staff absenteeism. Patients consulted with described to the inspector how they had to wait for long periods to get assistance from staff.

Other comments received from patients included:

“The staff are polite. I am reasonably well looked after. There are not enough staff”.

“They are not too fast at coming when I call the bell”.

“I am treated fantastic and I couldn't think of a better accolade”.

“I am ok. Could do with more staff”.

“It's all good but they are under pressure”.

We also sought patients' opinion on staffing via questionnaires. Three completed questionnaires were returned. All of the patients expressed a high level of satisfaction within the domain of safe care; however one patient responded 'no' to the question 'are you satisfied that there are enough staff available to care for you?' and commented that the “staff are very good but always busy.”

Relatives spoken with were concerned that their relative's needs were not being met as the home was frequently short staffed. One relative informed the inspector that a patient's call bell had not been responded to for 12 minutes on one occasion. Other comments received included:

“The weekend staffing is bad. The staff are being 'murdered' but it's not their fault. There is just not enough staff, it is desperate here, especially at weekends.”

We also sought relatives' opinion on staffing via questionnaires. One completed questionnaire was returned which expressed satisfaction within the domain of safe care.

Staff consulted with described concerns regarding the staffing levels. Comments received included:

“We are so short staffed, the patients are not being washed properly”.

“Sometimes it can be hard when we are short staffed. The care is good”.

“We need more staff on. I cannot do my own job we are so stretched”.

We also sought staff's opinion via questionnaires. Five completed questionnaires were returned. All the staff expressed satisfaction within the domain of safe care. No comments were provided regarding staffing.

A requirement has been made to ensure that the staffing levels are reviewed in keeping with the dependency levels of patients to ensure patients' needs are being met in a timely way and taking into account the layout of the building. The routine in the home and the deployment of staff should also be reviewed to ensure that the needs of patients are being met and records of the necessary action taken to address staff shortages should also be maintained. The impact of staffing on care delivery is further discussed under the domain of effective care.

The inspection findings were discussed with senior management in RQIA and a decision was made that the concerns would be communicated to senior management within Four Seasons Healthcare. Discussion took place by telephone with the regional manager on 19 July 2016 who advised that an additional care staff member had been authorised from 08.00 to 20.00 hours each day.

Although the staff consulted stated that they only commenced employment once all the relevant checks had been completed, a review of one personnel file evidenced that the recruitment processes were not in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. For example, there was no evidence that an enhanced criminal records check had been completed for one staff member and only one reference pertaining to the staff member's most recent employer had been obtained. This was discussed with the registered manager who stated that an enhanced criminal check with AccessNI would have been completed prior to commencement of employment; however, this was not evidenced on the day of inspection. Following the inspection, the registered manager provided confirmation that the enhanced criminal records check had been completed, prior to the staff member's start date. A requirement has been made that records pertaining to enhanced criminal records checks with AccessNI are available in the home at all times. A recommendation has also been made that two written references linked to the requirements of the job are obtained before commencement of employment.

Discussion with the registered manager confirmed that there were systems in place for the recruitment and selection of staff. Where nurses and carers were employed, their PIN numbers were checked on a regular basis, with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that their registrations were valid.

Discussion with the registered manager confirmed that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. However, staff consulted with stated that they felt that the induction process was not sufficient to give them the basic knowledge to begin work and that new staff were often 'thrown in at the deep end'. One completed induction programme was reviewed. Although the induction programme included a written record of the areas completed and the signature of the person supporting the new employee, the review identified that the record had been completed in one day. The induction records of one agency nurse were also not available when requested. A recommendation has been made that all staff, including those who are newly appointed and agency staff, complete a structured orientation and induction; and records are retained.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was 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. Overall compliance with training was monitored by the manager and this information informed the responsible persons' monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. There were no recent records pertaining to safeguarding incidents. Discussion with the manager confirmed that there was a process in place to manage potential safeguarding incidents, in accordance with the regional safeguarding protocols and the home's policies and procedures.

A range of risk assessments were completed as part of the admission process; however these were not reviewed on a regular basis and did not consistently inform the care planning process. Refer to section 4.4 for further detail.

A review of the accident and incident records confirmed that appropriate action had been taken; care management and patients' representatives were notified appropriately. However, a review of one patient's care record did not evidence the date that the falls risk assessment had been completed and as such we were not assured that this had been completed in response to the accident having occurred. A recommendation has also been made in this regard.

Discussion with the registered manager and a review of the notifiable events forms submitted to RQIA also evidenced that an incident which resulted in a patient sustaining a head injury, had not been reported to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been made in this regard.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean and reasonably tidy. The temperature on the first and second floors was 30 degrees Celsius from 12.00 to 16.00 hours and although the patients were not observed to be in any discomfort, the staff were observed to be having difficulty delivering care to patients due to the heat. When we made the registered manager aware of this issue, adjustments were made by the maintenance staff member to address this. Following the inspection, this issue was communicated to the RQIA estates inspector.

Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

A requirement has been made that the provision of staffing in the home is reviewed, to ensure that there are adequate staff on duty to meet the needs of the patients. This review must include the monitoring of care delivery and the response time to the nurse call system. The registered persons must inform RQIA of the outcome of the review. Records of the necessary action taken to address staff shortages should also be maintained.

A requirement has been made that records pertaining to enhanced criminal records checks with AccessNI are available in the home at all times.

A recommendation has been made that two written references linked to the requirements of the job are obtained before commencement of employment.

A recommendation has been made that all staff, including those who are newly appointed and agency staff, complete a structured orientation and induction; and records are retained.

A recommendation has been made that the falls risk assessment is reviewed in response to patients' falls.

A requirement has been made that RQIA is notified of any serious injury to a patient in the home.

Number of requirements	3	Number of recommendations:	3
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4.4 Is care effective?

A review of five patient care records evidenced that a range of validated risk assessments were completed as part of the admission process; however, as discussed in section 4.2 the review evidenced that risk assessments and care plans were not reviewed on a regular basis.

For example, one care record had not been updated to reflect the prescribed wound dressing regime, following a period of hospitalisation. This patient's food and fluid intake chart indicated that the patient's modified diet should be of 'puree' consistency, contrary to the instructions of the last speech and language therapist assessment. The choke risk assessment had not been completed on a regular basis and although there was evidence that the care plan had been reviewed, the care plan had not been formally rewritten since 2013. In discussion, the registered nurse was unable to differentiate between a 'pureed' and a 'mashed' diet. Another record in relation to patient's skin integrity was discussed with the registered nurse. The information provided to the inspector was contradictory and a review of this patient's care record evidenced that their pressure ulcer risk assessment did not reflect changes in the patient's condition and had not been reviewed in six months. As discussed in section 4.2 a previous recommendation made in this regard had not been met and has been stated as a requirement. The registered provider must ensure that care records are reviewed to ensure they are up to date and currently reflect the needs of patients in keeping with best practice. Further detail in regards to care plan audits is discussed in section 4.6.

A review of supplementary care records evidenced that records were not being maintained in accordance with best practice guidance, care standards and legislative requirements. For example, supervision records in relation to hourly checks that are required to be undertaken on patients who were in their bedrooms on the top floor, were not completed contemporaneously. Personal care records which recorded the elements of personal care attended to, were not consistently completed and did not indicate when the patients had received a bath or a shower. A 'bath book' was also reviewed and also evidenced gaps in completion. Although the daily personal care records evidenced that patients had been receiving 'bed baths' or 'full washes', the records did not evidence that baths or showers had been provided on a regular basis. For example, the records did not evidence that one patient had been offered a bath or a shower in 21 days and there was no record on another patient having had a shower or bath in 34 days. As discussed in section 4.2, a recommendation was previously made in regards to the assessment of patients' personal care needs and the maintenance of records to evidence care delivery. This recommendation had not been met and has now been stated as a requirement.

Although patients nutritional risk assessments were not formally reviewed on a regular basis, there was evidence that where patients had been identified as having poor oral intake, staff completed daily food and fluid charts to record the amount of food and drinks consumed and patients' weights were being monitored regularly. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Each staff member knew their role, function and responsibilities; however as discussed in section 4.3, all staff stated that at times it was difficult to meet the patients' needs due to frequent staffing shortages. Although three staff meetings had recently been held, consultation with staff evidenced that communication was not well maintained within the home. Three members of staff consulted stated that they had concerns regarding staffing levels and patients' personal hygiene needs not being met and they felt they could not discuss these concerns in the staff meetings.

Although a meeting with patients had not been held since 3 November 2015, the registered manager obtained feedback from three patients' representatives on a weekly basis, to ascertain their views on the home environment and the care of their relative.

Relatives consulted with stated that the staff informed them of changes to their relative's condition and confirmed that if they had any concerns, they could raise these with the registered manager. The most recent relatives' meeting was held on 25 April and records were retained. The registered manager stated that no concerns had been raised and that 'all were happy', contrary to the inspection findings. Patient engagement is further discussed in section 4.5.

Areas for improvement

A requirement has been made that care records are kept under review and reviewed at any time necessary to do so having regard to any change of circumstances and in any case not less than annually.

A requirement has been made that proper provision is made for the health and welfare of patients. Patients' personal care needs must be assessed and met; and records should be completed to evidence care delivered or not delivered. Records of hourly patients' safety checks must also be maintained.

To ensure that patients receive the right care at the right time, the requirement made in section 4.3, to review the staffing levels must also be considered in the domain of effective care, to ensure that the patients' needs are being met.

Number of requirements	2	Number of recommendations:	0
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4.5 Is care compassionate?

As previously discussed in section 4.3, whilst patients and relatives consulted with were dissatisfied with the staffing levels, a number of positive comments were received regarding individual staff members and a review of compliments records evidenced that three staff members had been nominated by a relative for an award, in recognition of their personal attributes. We read that one relative had commended a staff member's knowledge of her father's needs and described how the staff member would sing to the patient as a means of encouraging him to eat and drink well.

Discussion with patients confirmed that staff used their preferred name and that staff spoke to them in a polite manner. Patients who were unable to verbally express their views were observed to be appropriately dressed and appeared to be relaxed and comfortable in their surroundings. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. However, consultation with patients confirmed that they were generally, but not always, afforded dignity and respect. One patient described that they chose to eat their meal in their bedroom because the staff took up to 30 minutes to assist them back to their bedroom. This patient stated that the staff frequently chatted over them, whilst providing intimate care. One patient who had a visual impairment stated that the staff never described the meals provided to him, therefore he did not know what the meal was until he tasted it. This demonstrates that the staff did not consider the principles of choice, dignity and respect which underpin the care standards for nursing homes, 2015. A recommendation has been made in this regard.

Patients consulted with also stated that they knew how to use their nurse call bells; however all patients consulted with stated that they felt they had to wait a long time for staff to respond. Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. These systems included a 'Quality of Life' (QOL) feedback system which was available at the reception area. This was an iPad which allowed relatives/representatives, visiting professionals and/or staff to provide feedback on their experience of Jordanstown. A portable iPad was also available to record feedback from patients. The registered manager explained that when feedback is received via this system, an automatic email is sent to the management who then must respond to any comments made. Anyone completing feedback has the option to remain anonymous or leave their name. Management have the option to contact people who leave their contact details to gain further clarification on the feedback received. We were informed that all of the comments received were positive and that 'all were happy'. Given the findings of this inspection and the comments provided by patients and relatives, it is recommended that management review the methods available for engagement with patients and relatives, to ensure that they are effective.

In addition to speaking with patients, relatives and staff, questionnaires were provided to the registered manager for distribution; ten for staff and relatives respectively; and five for patients. One relative, three patients and five staff had returned their questionnaires within the timescale for inclusion in this report. All respondents expressed satisfaction within the domain of compassionate care. Comments provided with regard to the provision of staff have been discussed in section 4.3, within the domain of safe care.

Areas for improvement

A recommendation has been made that training is provided to staff, as appropriate, in the principles of choice, dignity and respect which underpin the care standards for nursing homes, 2015.

A recommendation has been made that the management should review the methods available for engagement with patients and relatives to ensure they are effective.

Number of requirements	0	Number of recommendations:	2
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4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home. Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. Information displayed in the front foyer area of the home also included the home's statement of purpose; and whistleblowing arrangements.

Discussion with the registered 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 registered manager; however, as discussed in section 4.3, the management support arrangements over the weekends were not responsive to reports of staff shortages. For example, a review of the staffing rota commencing 11 July 2016 evidenced that the planned staffing levels were not adhered to on three consecutive days due to absenteeism. There was no evidence that the staff had made any efforts to address the staff shortages on two of the three days. A review of the 'weekend on-call report' evidenced that the staff had contacted the on-call management on 16 July 2016 on two occasions in regards to covering short notice sickness absences. On one occasion, it was recorded that no action had been taken and on another occasion, the record stated that the staff were told that the 'ratios of staff to residents was ok'.

Staff also stated that they had concerns regarding staffing levels and the standard of personal care delivery and they felt they could not raise these concerns to the management. Staff and patients' representatives stated that a number of staff had left due to the staffing shortages. This was discussed with the registered manager who stated that there were currently four registered nurse vacancies because a number of registered nurses had recently commenced employment in the local health and social care trusts. There were no care staff vacancies and recruitment was ongoing.

Patients and their representatives were aware of who the registered manager was. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Discussion with the registered 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 DHSSPS Care Standards for Nursing Homes 2015. One complaint was ongoing in regards to an identified patient's needs not being met and staffing arrangements. The progress and outcome of this will be followed up at a future inspection.

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 registered manager and review of records evidenced that 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. Discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- accidents
- wound management
- medicines management
- handwashing
- care records
- complaints
- bedrail checks and audits
- restraint
- quality of life audit (QOL)

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. Information regarding the identity of the patients who had fallen were maintained electronically. As previously discussed in section 4.3, two falls risk assessments were undated; and an injury which was sustained in the home had not been reported to RQIA in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. It was therefore disappointing that the registered manager was unable to access additional information in relation to the analysis of patients accidents, when requested.

Two recommendations that were previously stated were not met and requirements have now been made to ensure compliance and drive improvements in regards to these areas. As discussed in section 4.5, these requirements relate to the completion of care plans and risk assessments and records in relation to the delivery of care. This was discussed with the registered manager who stated that she was aware of the deficits in relation to care records and informed the inspector that the resident experience team were providing one to one support to the registered nurses in relation to the completion of the relevant risk assessments and care plans. The registered manager stated that care record audits were completed on a regular basis and follow up action taken to address the identified deficits would be electronically recorded on the QOL by the registered nurses. This information was also retained electronically and the registered manager was unable to access the information requested on the day of the inspection. As such, we were unable to evaluate the effectiveness of the audits undertaken. A recommendation has been made in this regard.

Areas for improvement

A recommendation has been made that audits completed on the QOL system are accessible at all times to enable evaluation and inspection.

Given that requirements and recommendations have been made in the three other domains, improvements are required to meet the required standards and to demonstrate a well-led service.

Number of requirements	0	Number of recommendations:	1
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered 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 may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for review 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 20 (1)
(a)

Stated: First time

To be completed by:
15 September 2016

The registered persons must ensure that the provision of staffing in the home is reviewed to ensure that there is adequate staff on duty to meet the needs of the patients. This review must include the monitoring of care delivery and the response time to the nurse call system. The registered persons must inform RQIA of the outcome of the review.

Records of the necessary action taken to address staff shortages should also be maintained.

Ref: Section 4.3

Response by registered provider detailing the actions taken:

Staffing levels are reviewed in line with the required needs of the residents within the home at that time. Written evidence will be maintained of actions taken to cover shifts during times of sickness etc. Care delivery needs are monitored and this will be evident in the audit process

All staff have been made aware of the importance of answering nurse calls promptly and this will be monitored by the Home Manager/Nurse in Charge of the home.

Requirement 2

Ref: Regulation 19 (2)

Stated: First time

To be completed by:
15 September 2016

The registered persons must ensure that records pertaining to enhanced criminal records checks with AccessNI are available in the home at all times.

Ref: Section 4.3

Response by registered provider detailing the actions taken:

All staff have an enhanced criminal check completed prior to their commencement of employment. Outcomes of these checks are maintained on a log within the home

Requirement 3

Ref: Regulation 30 (1)
(c)

Stated: First time

To be completed by:
15 September 2016

The registered persons must ensure that RQIA is notified of any serious injury to a patient in the home.

Ref: Section 4.3

Response by registered provider detailing the actions taken:

As per policy RQIA will be notified of any serious injury to any patient within the home. This will be monitored via Audits carried out by the Regional Manager.

<p>Requirement 4</p> <p>Ref: Regulation 16 (1) (b)</p> <p>Stated: First time</p> <p>To be completed by: 15 September 2016</p>	<p>The registered persons must ensure care records are kept under review and reviewed at any time necessary to do so having regard to any change of circumstances and in any case not less than annually.</p> <p>Ref: Section 4.2 and Section 4.4</p> <p>Response by registered provider detailing the actions taken: There is a named nurse system in place. A meeting has taken place with nurses to re-iterate the importance of ensuring that care records are reviewed on a regular basis. As per policy all Care Records are audited on a six monthly basis. The outcome of this audit is shared with the named nurse to address any deficits found. The Audit completed is also available for senior managers to view.</p>
<p>Requirement 5</p> <p>Ref: Regulation 13 (1) (a)</p> <p>Stated: First time</p> <p>To be completed by: 15 September 2016</p>	<p>The registered provider must ensure that the nursing home is conducted so as to promote and make proper provision for the health and welfare of patients. Patients' personal care needs are required to be assessed and met. Records should be completed to evidence care delivered or not delivered.</p> <p>Ref: Section 4.5</p> <p>Response by registered provider detailing the actions taken: Support and training for staff has taken place in the home to reiterate the importance of completing documentation. Completion of this will be monitored through the internal audit process and via visits from the Regional Manager</p>
<p>Recommendations</p>	
<p>Recommendation 1</p> <p>Ref: Standard 39.1</p> <p>Stated: First time</p> <p>To be completed by: 15 September 2016</p>	<p>The registered persons should ensure that all staff, including those who are newly appointed and agency staff, complete a structured orientation and induction; and records are retained.</p> <p>Ref: Section 4.3</p> <p>Response by registered provider detailing the actions taken: All newly appointed staff including agency staff receive induction and orientation to home. These induction records are being retained to evidence this. Timely completion of inductions will be monitored by the Manager and via the auditing system.</p>
<p>Recommendation 2</p> <p>Ref: Standard 38.3</p> <p>Stated: First time</p> <p>To be completed by: 15 September 2016</p>	<p>The registered persons should ensure that two written references linked to the requirements of the job are obtained before commencement of employment.</p> <p>Ref: Section 4.3</p> <p>Response by registered provider detailing the actions taken: Two written references are always obtained prior to commencement of employment. These references once received will be placed in the staff members individual staffs personnel folder.</p>

<p>Recommendation 3</p> <p>Ref: Standard 22.6</p> <p>Stated: First time</p> <p>To be completed by: 15 September 2016</p>	<p>The registered persons should ensure that the falls risk assessment is reviewed in response to patients' falls.</p> <p>Ref: Section 4.3</p> <hr/> <p>Response by registered provider detailing the actions taken: Staff have been reminded that the falls risk assessment is to be reviewed following a fall. The Manager will monitor via the completion of the datix and through the auditing system.</p>
<p>Recommendation 4</p> <p>Ref: Standard 39.4</p> <p>Stated: First time</p> <p>To be completed by: 15 September 2016</p>	<p>The registered persons should ensure that training is provided to staff, as appropriate, in the principles of choice, dignity and respect which underpin the care standards for nursing homes, 2015.</p> <p>Ref: Section 4.5</p> <hr/> <p>Response by registered provider detailing the actions taken: Training has taken place for staff. The effectiveness of this training will be monitored through direct observation and questioning of staff via the Home Manager/Regional Manager</p>
<p>Recommendation 5</p> <p>Ref: Standard 7.1</p> <p>Stated: First time</p> <p>To be completed by: 15 September 2016</p>	<p>The registered persons should review the methods available for engagement with patients and relatives to ensure they are effective.</p> <p>Ref: Section 4.5</p> <hr/> <p>Response by registered provider detailing the actions taken: The Home Manager has an open door policy of all relatives. Regular scheduled meetings are held with residents and families and minutes retained. Attendance at these meetings are encouraged but not always well attended. The Quality of Life IPAD is also available at all times for any person visiting the home to leave feedback. The feedback left via the IPAD is also available to Senior Managers within Four Seasons</p>
<p>Recommendation 6</p> <p>Ref: Standard 35</p> <p>Stated: First time</p> <p>To be completed by: 15 September 2016</p>	<p>The registered persons should ensure that audits completed on the QOL system are accessible at all times, to enable evaluation and inspection.</p> <p>Ref: Section 4.6</p> <hr/> <p>Response by registered provider detailing the actions taken: All audits completed on the QOL will be printed and made accessible at all times.</p>

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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