Unannounced Care Inspection Report
21 February 2017

Jordanstown

Type of Service: Nursing Home
Address: 1a Old Manse Road. Jordanstown, BT37 0RU
Tel no: 028 90 852258
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Jordanstown Care Home took place on 21 February 2017 from 10.00 to 16.00 hours.

The inspection sought to assess progress with any 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.

A review of records, discussion with the registered manager and staff and observations of care delivery evidenced that all of the requirements and recommendations made as a result of the previous inspection have been complied with. This inspection resulted in no requirements or recommendations being made.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

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

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 21 November 2016. Following the inspection and the lack of progress identified since the previous inspection on 18 July 2016, the registered persons attended a serious concerns meeting in RQIA on 25 November 2016, to discuss the inspection findings and to provide RQIA with a detailed and comprehensive action plan which illustrated how the home would return to compliance. RQIA were satisfied with the action plan provided.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare 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-I	**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, three registered nurse, one laundry assistant and two patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- accident and incident records
- audits in relation to care records
- records relating to adult safeguarding
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 November 2016

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

4.2 Review of requirements and recommendations from the last care inspection dated 21 November 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 20 (1) (a) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Consultation with patients confirmed that call bells were responded to in a timely manner. Refer to section 4.3.1 for further detail.	
Requirement 2 **Ref:** Regulation 15 (2) (a) and (b) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: A review of patient care records confirmed that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process. Refer to section 4.3.2 for further detail.	

Requirement 3 **Ref:** Regulation 13 (1) (a) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: A review of personal hygiene charts evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Where a patient refused care, there was evidence that this was recorded on the personal hygiene chart and was reflected in the patient care plan. Refer to section 4.3.2 for further detail.	
Requirement 4 **Ref:** Regulation 13 (1) (b) **Stated:** First time	The registered persons must ensure that the home is conducted to make proper provision for the nursing, and where appropriate, treatment and supervision of patients. This relates particularly to, but is not limited to, the management of patients' food and fluid intake and the safe and effective management of patients with urinary catheters	**Met**
	Action taken as confirmed during the inspection: There was a robust system in place to ensure that patients' fluid intakes were being monitored. A review of patient care records also confirmed that urinary catheter care was well managed. Refer to section 4.3.2 for further detail.	
Requirement 5 **Ref:** Regulation 17 (1) **Stated:** First time	The registered persons must ensure that the systems in place to monitor and report on the quality of nursing and other services provided are reviewed, to ensure that they are accurate; and that action is taken in a timely manner, to address identified shortfalls. This relates to the individual audits, completed by the registered manager; the TRaCA's; and the monthly quality monitoring visits, undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of care record audits confirmed that this recommendation had been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 41 **Stated:** First time	The registered persons should ensure that the allocation of staff to the second floor, is further developed and recorded, to include those staff who have responsibility for care delivery and regular patient supervision.	**Met**
	Action taken as confirmed during the inspection: There was a system in place to record the staff allocation to the second floor. A review of the allocation sheets confirmed that this was consistently completed.	
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time	The registered persons should ensure that a care plan is developed, in consultation with the patients and/or their representatives, as appropriate, to meet the patients' end of life care needs.	**Met**
	Action taken as confirmed during the inspection: A review of care records confirmed that, where appropriate, a care plan was developed to reflect the patients' end of life care needs.	
Recommendation 3 **Ref**: Standard 5.8 **Stated:** First time	The registered persons should ensure that the storage arrangements of patients' care records; and the location of the shift handover meetings are reviewed, to ensure that patients' rights to confidentiality and privacy are respected at all times.	**Met**
	Action taken as confirmed during the inspection: A lockable cupboard was in place, to store the patients' care records on the ground floor. Discussion with staff also confirmed that the handover reports were conducted away from the nurses' station, to ensure that the patients' rights to confidentiality were respected.	

4.3 Inspection findings

4.3.1 Staffing arrangements

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met.

Three staff members informed the inspector that they were not happy with the staffing levels in the home; however, a review of the staffing rota for the week commencing 13 February 2017 evidenced that the planned staffing levels were generally adhered to. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty and discussion with patients and patients' representatives did not evidence any concerns regarding staffing levels. Refer to section 4.3.3 for further detail.

One patients' representative raised concerns that recently there had only been one permanent staff member working on night duty and that all the other staff were agency staff, who would not be familiar with the patients' needs. This was discussed with the registered manager who explained that the home currently had seven permanent nurse vacancies. These vacancies were being filled by permanent staff working additional hours or by agency staff. The registered manager explained that agency staff were block-booked to ensure continuity of patient care and that where new agency staff were scheduled to work in the home, the duty rota would be reviewed to ensure that sufficient permanent staff were also on duty. Discussion with staff confirmed that communication within the home was well maintained. A written report template had recently been introduced to ensure that appropriate information was communicated in the shift handover meetings.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.3.2 Care practices and care records

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. 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.

All patients were observed to be well presented on the day of the inspection. As discussed in section 4.2, a review of personal hygiene charts evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Where a patient refused care, there was evidence that this was recorded on the personal hygiene chart and was reflected in the patient's care plan.

A review of food and fluid intake charts confirmed that patients' fluid intake had been monitored. A protocol was in place, whereby patients' who were identified as being at risk of dehydration, had their fluid intakes reviewed three times during the day. There was evidence that the total fluid intakes had been monitored by the registered nurses and any action taken recorded. This system of monitoring patients' fluid intakes is commended.

A review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of wounds indicated that when a patient required wound care, wound assessment and care plans were updated on a regular basis. There was evidence that the care and treatment provided was reflective of that outlined in the

care plan. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds.

Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. Clear records were also maintained regarding the on-going management of urinary catheters.

Patients who were identified as requiring a modified diet, had the relevant choke risk assessments completed. The prescribed modified diet was included in the care plan, together with recommended strategies for ensuring correct feeding techniques were utilised or maintaining optimum posture. The review of the food and fluid intake charts also confirmed that the patient had been provided with the appropriate diet.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.3.3 Consultation

During the inspection, we met with four patients, three care staff, three registered nurse, one laundry assistant and two patients' representatives. Some comments received are detailed below:

Staff

"Patients are looked after extremely well, there is good patient engagement and relationships with the patients"
"It is grand here now, we are all very conscientious and get good feedback from relatives"
"I have no concerns"
"We provide a good service, everything is tip top"

Three staff expressed that they would like to have some more time to spend talking with the patients. The staffing levels had been increased following the last inspection; however, the staff stated that there had been a lot of staff who had recently started and that the workload was very busy due new staff being inducted. Given that there was no impact on patient care identified during the inspection and the patients' needs were evidentially being met, these comments were relayed to the registered manager to address. One staff member was dissatisfied with allocation of staff within the building. This was discussed with the registered manager, who advised that they would clarify with all staff members that concerns/suggestions could be raised anonymously through the home's Quality of Life system (QOL).

Patients

"I have no complaints, I get everything I need"
"The girls here are wonderful"
"It is all very good, I could not complain"
"It is all very good, they are very helpful"
"I couldn't praise them enough here"

Patients' representatives

"'There have been definite improvements"
"(My relative) is well looked after"

One patients' representative commented in relation to the high rate of agency staff. Refer to section 4.3.1 for further detail.

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. Ten staff and one relative had returned their questionnaires, within the timeframe for inclusion in this report. All staff respondents indicated that they were 'very satisfied' that the care was safe, effective and compassionate; and that the service was well-led. Although one patient's representative responded that they were either 'satisfied' or 'very satisfied' that the care was safe, effective and compassionate, written comments were provided in relation to the patients' individual preferences not always being taken into account. Following the inspection these matters were communicated to the registered manager to address.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.3.4 Management and governance arrangements

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. All those consulted with knew who the registered manager and other members of the senior management team were and stated that they were available at any time if the need arose. Following the last inspection, undertaken on 21 November 2016, management support had been provided by a member of the Resident Experience Team. It was evident that action had been taken to improve the effectiveness of the care.

Observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records evidenced that quality 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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards.

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