



The Regulation and  
Quality Improvement  
Authority

Inspector: Aveen Donnelly  
Inspection ID: IN021807

Antrim Care Home  
RQIA ID: 1434  
88 Milltown Road  
Antrim  
BT41 2JJ

Tel: 02894428285  
Email: [antrim@fshc.co.uk](mailto:antrim@fshc.co.uk)

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**Unannounced Care Inspection  
of  
Antrim Care Home  
  
11 January 2016**

The Regulation and Quality Improvement Authority  
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT  
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: [www.rqia.org.uk](http://www.rqia.org.uk)

## 1. Summary of Inspection

An unannounced care inspection took place on 11 January 2016 from 10.45 to 14.15.

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

### 1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 08 September 2015.

### 1.2 Actions/Enforcement Resulting from this Inspection

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

### 1.3 Inspection Outcome

	Requirements	Recommendations
<b>Total number of requirements and recommendations made at this inspection</b>	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

## 2. Service Details

<b>Registered Organisation/Registered Person:</b> Four Seasons Healthcare Maureen Claire Royston	<b>Registered Manager:</b> Shirley Martin
<b>Person in Charge of the Home at the Time of Inspection:</b> Sharon Smyth	<b>Date Manager Registered:</b> 12 February 2015
<b>Categories of Care:</b> RC-I, NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	<b>Number of Registered Places:</b> 53
<b>Number of Patients Accommodated on Day of Inspection:</b> 23	<b>Weekly Tariff at Time of Inspection:</b> £593

### **3. Inspection Focus**

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

### **4. Methods/Process**

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

Prior to inspection the following records were analysed:

- 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. The inspector also met with four patients, four care staff, two nursing staff and two patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care.

### **5. The Inspection**

#### **5.1 Review of Requirements and Recommendations from the Previous Inspection**

The previous inspection of the home was an unannounced care inspection dated 08 September 2015. The completed QIP was returned and approved by the care inspector.

## 5.2 Review of Requirements and Recommendations from the Last Care Inspection on 08 September 2015.

Last Care Inspection Statutory Requirements		Validation of Compliance
<p><b>Requirement 1</b></p> <p>Ref: Regulation 16 (1)</p> <p><b>Stated:</b> Second time</p>	<p>It is required that a care plan is in place to address all needs identified through the assessment process.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> A review of five patients' care record evidenced that care plans were in place, regarding the management of continence.</p>	<b>Met</b>
<p><b>Requirement 2</b></p> <p>Ref: Regulation 13 (1) (a)</p> <p><b>Stated:</b> Second time</p>	<p>It is required that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients.</p> <p>It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> A review of two patients' care records confirmed that fluid intake had been monitored. There was also evidence in the progress notes that the fluid intake had been validated by the registered nurses.</p>	<b>Met</b>
<p><b>Requirement 3</b></p> <p>Ref: Regulation 19 (1) (a)</p> <p><b>Stated:</b> Second time</p>	<p>It is required that contemporaneous notes of all nursing provided are maintained.</p> <p>Fluid balance charts must be accurately completed.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> A review of two patients' fluid balance charts confirmed that records were accurately maintained.</p>	<b>Met</b>

Last Care Inspection Recommendations		Validation of Compliance
<b>Recommendation 1</b>  <b>Ref:</b> Standard 19.1  <b>Stated:</b> Second time	It is recommended that: <ul style="list-style-type: none"> <li>• bowel assessments should be completed for all patients</li> <li>• separate care plans should be in place for each individual assessed need.</li> <li>• the type of continence pad and size of pants are recorded in the patient's care records the frequency with which urinary catheters require to be changed should be included in the care plan.</li> <li>•</li> </ul>	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> A review of five patients' care records confirmed that bowel assessments and care plans had been completed regarding the identified needs.  The care plans were person centred and included the type of incontinence pad required. The care record of one patient who required an indwelling catheter, had information included in the care plan regarding the frequency with which the catheter required to be changed.	
<b>Recommendation 2</b>  <b>Ref:</b> Standard 32.1  <b>Stated:</b> Second time	It is recommended that the management of odours in the identified area is reviewed and eliminated.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> There were no malodours present on the day of inspection. Discussion with the deputy manager and a review of the complaints record confirmed that no complaints had been received in this regard.	
<b>Recommendation 3</b>  <b>Ref:</b> Standard 32.1  <b>Stated:</b> First time	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; and palliative and end of life care and of the management of an unexpected death.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> A review of the training folder evidenced that staff had been made aware of the policies outlined above.	

<b>Recommendation 4</b>  <b>Ref:</b> Standard 32.6  <b>Stated:</b> First time	Staff should be provided with the opportunity to discuss symptom management in palliative and end of life care. These discussions should include staff, who are not directly involved in direct patient care, if appropriate.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> A review of training records and discussion with the deputy manager confirmed that following the last inspection, all staff had received training in palliative and end of life care. Staff nurses were informed in a staff meeting, of the need to communicate more effectively with staff who are not directly involved in the delivery of patient care.	

### 5.3 Additional Areas Examined

#### Patient, patients' representative and staff comments

All comments received were positive. Some comments received are detailed below:

#### Staff

'I have no concerns'  
 'It is great to have the time to do things'  
 'I love it here. I have no concerns'

#### Patients

'They are all very good here'  
 'They are nice enough'  
 'The food is very good'  
 'I am treated lovely'  
 'It would be better if the staff let me do more of my own care'

#### Patients' representatives

'We have no concerns. The staff are good'  
 'We have never seen anything untoward going on'

#### Environment

A general tour of the home was undertaken which included review of 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, reasonably tidy, well decorated and warm throughout. However, the covering of two armchairs and one two-seater sofa were damaged. These could not be effectively cleaned in keeping with infection control measures.

This was discussed with the deputy manager and the identified furniture was removed from the lounge on the day of inspection.

### Areas for Improvement

There were no areas identified for improvement during this inspection.

<b>Number of Requirements:</b>	<b>0</b>	<b>Number of Recommendations:</b>	<b>0</b>
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It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations.

**6. No requirements or recommendations resulted from this inspection.**

<b>I agree with the content of the report.</b>			
<b>Registered Manager</b>	Shirley Martin	<b>Date Completed</b>	22.01.16
<b>Registered Person</b>	Dr Claire Royston	<b>Date Approved</b>	22.01.16
<b>RQIA Inspector Assessing Response</b>	Aveen Donnelly	<b>Date Approved</b>	22/02/2016

Please provide any additional comments or observations you may wish to make below:

*\*Please ensure this document is completed in full and returned to [Nursing.Team@rqia.org.uk](mailto:Nursing.Team@rqia.org.uk) from the authorised email address\**