Unannounced Care Inspection Report
3 April 2019

Dungannon

Type of Service: Nursing Home (NH)
Address: 100 Killyman Road, Dungannon, BT71 6DQ
Tel No: 02887753034
Inspector: Michael Lavelle

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

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

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 36 patients. The home is divided in to two units, Killybracken and Lambfields, each containing 17 beds.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager and date registered:** Leena Mary Francis Correa 21 May 2018
Person in charge at the time of inspection: Elena Argint, registered nurse from 06.45 hours to 08.00 hours, Susy San, registered nurse from 08.00 hours to 09.00 hours and Leena Mary Francis Correa, registered manager from 09.00 hours onwards.	**Number of registered places:** 36
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 33

4.0 Inspection summary

An unannounced inspection took place on 3 April 2019 from 06.45 hours to 14.45 hours.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to staffing, training and communication between residents, staff and other key stakeholders. Further evidence of good practice was identified in relation to dignity and privacy, taking account of the views of patients, governance arrangements and management of complaints and incidents.

Areas requiring improvement under care standards were identified in relation to contemporaneous record keeping.

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

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

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Leena Mary Francis Correa, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 17 September 2018

The most recent inspection of the home was an unannounced care inspection. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

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

During our inspection we:

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

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

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from weeks commencing 25 March 2019 and 1 April 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records

- two staff recruitment and induction files
- four patient care records
- a selection of patient care charts including food and fluid intake charts, reposition charts, lap belt monitoring and bowel charts
- a sample of governance audits/records
- complaints record
- compliments received
- a sample of monthly quality monitoring reports by the registered provider
- emergency evacuation plan
- annual report
- staff supervision and appraisal planner
- RQIA registration certificate.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 17 September 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 17 September 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (7) **Stated:** Second time	The registered person shall ensure suitable arrangements are in place to minimise the risk/spread of infection between patients and staff. This area for improvement is made in reference to the issues highlighted in section 6.4 of the previous care inspection report.	**Met**

	Action taken as confirmed during the inspection: Review of the environment, observation of practice and examination of records evidenced the deficits highlighted at the previous care inspection had been addressed. This area for improvement has been met.	
Area for improvement 2 **Ref**: Regulation 14 (2) (a) (c) **Stated:** Second time	The registered person shall ensure as far as is reasonably practicable that all parts of the home to which the patients have access are free from hazards to their safety, and unnecessary risks to the health and safety of patients are identified and so far as possible, eliminated. This area for improvement is made in reference to locking domestic stores, maintenance room and supervision of domestic trolleys.	**Met**
	Action taken as confirmed during the inspection: Review of the environment evidenced domestic trolleys were appropriately supervised when in use and the domestic stores and maintenance rooms were locked.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 38.3 **Stated:** Second time	The registered person shall ensure staff are recruited and employed in accordance with relevant statutory employment legislation and mandatory requirements.	**Met**
	Action taken as confirmed during the inspection: Review of two staff recruitment files confirmed staff were recruited in accordance with relevant statutory employment legislation and mandatory requirements. The registered manager was reminded to record when gaps in employment are discussed and also all attempts of seeking references from employee's most recent employers.	

Area for improvement 2 **Ref**: Standard 6.1 **Stated:** First time	The registered person shall ensure that patients are respected and their rights to privacy and dignity are upheld at all times.	**Met**
	Action taken as confirmed during the inspection: Observation of practice confirmed patients were treated with dignity and respect and their privacy was respected.	

6.3 Inspection findings

6.4 Is care safe?

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

We arrived at the home at 06.45 hours and were greeted by the nurse in charge who was friendly and welcoming. They confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for weeks commencing 21 March 2019 and 1 April 2019 evidenced that the planned staffing levels were adhered to. Additional staff were allocated to patients who required one to one supervision. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patient's needs. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. However there was evidence of some confusion regarding the management of one to one supervision. The registered manager confirmed post inspection that this had been reviewed and actioned as required.

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Dungannon.

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

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

Discussion with staff and the registered manager confirmed that staff training, supervision and appraisal was well maintained and actively managed.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

We reviewed accidents/incidents records since January 2019 in comparison with the notifications submitted by the home to RQIA. Records were maintained appropriately and notifications were submitted in accordance with regulation. A small number of head injuries that had occurred since January 2019 had not been notified. This was discussed with the registered manager who agreed to submit these retrospectively.

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

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

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices. There was also evidence of consultation with relevant persons. Care plans were in place for the management of restrictive practices including keypads.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm and well decorated. A malodour was noted in an identified patient's bedroom. The registered manager confirmed the flooring in this room had been recently replaced and agreed to review this again.

Fire exits and corridors were observed to be clear of clutter and obstruction and records evidenced that fire drills had taken place in the home in January 2019 and March 2019. The registered manager confirmed that additional drills were planned for the rest of the year. Review of the evacuation management plan evidenced it was reflective of all patients accommodated in the home on the day of inspection. Personal emergency evacuation plans (PEEPs) were available for review in patient care records.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, training, staff supervision and risk management.

Areas for improvement

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

	Regulations	Standards
Total numb of areas for improvement	0	0

6.5 Is care effective?

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

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

Wound management records for one patient evidenced the need for improvement in accuracy in following the direction of the tissue viability nurse. The matter was actioned immediately during the inspection.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as behavioural support team, General Practitioners (GPs), TVN and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the TVN or the dietician.

We observed the serving of the mid-morning snacks and midday meal. Patients were assisted to the dining room and staff were observed assisting patients with their meal appropriately. Patients appeared to enjoy the mealtime experience and were offered a choice of meal and drinks. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Review of the menu evidenced that planned meals had been adhered to.

Review of supplementary care charts such as food and fluid intake records, bowel charts, lap belt monitoring and repositioning charts evidenced that records were generally well maintained. However, the registered manager must ensure that supplementary records are wholly reflective of care planning directions and completed to demonstrate adherence to the plan as required as deficits were identified in the completion of some care records. This was discussed with the registered manager and an area for improvement was made under the care standards.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted. Observation of the handover evidenced that all grades of care staff actively participated in the handover and nursing staff delegated tasks to identified care staff who were aware of their role for the shift.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they would raise theses with the registered manager or the nurse in charge. When we spoke with staff they had a good knowledge of patients' abilities and level of decision making; staff know how and when to provide comfort to patients because they know their needs well.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other health care professionals. Discussion with three visiting professionals evidenced good communication and rapport with staff in the home. Some comments received included:

"The care is fantastic. The staff are committed and there is a good communication flow."
"The staff are not afraid to lift the phone which is perfect. The referrals are correct and the management of wounds is good."

Discussion with registered manager and review of records confirmed that staff meetings were held regularly and records maintained. We encouraged the registered manager to ensure staff comments/action points are collated and reviewed at each staff meeting and reflected in the minutes of the staff meetings.

Areas of good practice

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

Areas for improvement

One area for improvement under care standards was identified in relation to contemporaneous record keeping.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff and review of the activity programme displayed in the lounge evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. Patient's spoken with stated they enjoyed the activities provided within the home. Discussion with staff confirmed that there are excellent links between the home and the local college of higher education. Two patient's spoken to on the day of the inspection stated they were going on a break to Donegal for a few days with others stating they would be going next month.

The environment had been adapted to promote positive outcomes for the patients. Many of the bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example appropriate signage, photographs and the provision of clocks. The home has a snoezelen room which is a controlled multisensory environment; this was open for patients to use as they wished. Review of the annual report evidenced there are plans to refurbish this room within the next year. A pictorial menu was on display to assist patients at meal times.

During observation of the midday meal we observed that all patients were served drinks in plastic tumblers. None of the tables in the dining room had any condiments and one of the tables had not been cleaned. This was discussed with the registered manager who acknowledged there were particular challenges with some patient's during meal time that made it difficult to use glasses and condiments although they agreed to review the dining experience in both units within the home. This will be reviewed at a future care inspection.

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

"Thank you for staying with XXX in hospital. It meant a lot to know each of you were there when they needed support."

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

"They're very good here."
"I like it alright. They wash your clothes and make my bed. The food is good too."
"Ok."
"The food is fierce good. I love it here."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Five relative questionnaires were provided and staff were asked to complete an online survey; we had no responses within the timescale specified.

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

Discussion with the registered manager and review of records evidenced a relatives survey was completed on October 2018. Review of the responses evidenced positive feedback from all relatives. An annual quality report was also completed on 1 March 2019. Review of the report confirmed systems were in place to consult with patients including food questionnaires, resident's reviews, suggestion box and resident and relatives meetings. Review of records evidenced a residents meeting was held on 21 March 2019 and minutes were available. Relatives meetings were held in November 2018 and March 2019 although there was no attendance at either. This was discussed with the manager who agreed to review the times of the meetings in an attempt to attract greater attendance.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff, patients and visiting professionals evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

There was evidence of good management oversight of the day to day working in the home. A number of audits were completed to assure the quality of care and services; areas audited included wounds, care plans, infection prevention and control/environment, medications and accidents and incidents. Audits generated action plans that highlighted areas for improvement and there was evidence that the deficits identified were actioned as required. Staff also confirmed that flash meetings take place to ensure key issues are highlighted and communicated effectively on a daily basis.

Discussion with the registered manager and review of records evidenced that with the exception of the small number of head injuries, systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. Review of records evidenced that quality monitoring visits were completed on a monthly basis on behalf of the responsible individual in accordance with the relevant regulations and standards.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed appropriately in line with best practice guidance. Patient's spoken with said they would be confident if they raised a complaint that it would be dealt with accordingly.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and management of complaints and incidents.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Leena Mary Francis Correa, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 3 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient, in accordance with NMC guidelines. Registered nurses should evidence review of supplementary care records. Ref: 6.5
	Response by registered person detailing the actions taken: Registered Manager has discussed contemporaneous record keeping with staff under supervision and flash point meetings. Registered staff are conducting spot checks on suppplementary records at end of shift. Further oversight by Registered Manager whilst completing daily walk abouts.

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

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