Inspection Report

10 January 2023

Dungannon

Type of Service: Nursing Home
Address: 100 Killyman Road, Dungannon, BT71 6DQ
Tel no: 028 8775 3034

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Ann's Care Homes Limited **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Mrs Leena Mary Francis Correa **Date registered:** 21 May 2018
Person in charge at the time of inspection: Mrs Leena Mary Francis Correa	**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:** 31
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 36 patients. The home is divided in two units; the Lambfields Unit and the Killybracken Unit. Patients' bedrooms are located on the ground floor. Patients have access to communal lounge and dining areas within each unit and a centralised garden area with access to seating.	

2.0 Inspection summary

An unannounced inspection took place on 10 January 2023 from 9.25am to 4.00pm by a care inspector.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Patients were well presented in their appearance and spoke positively when describing their experiences on living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff members are included in the main body of this report.

Staff members promoted the dignity and well-being of patients and were knowledgeable and well trained to deliver safe and effective care. There was a good working relationship between staff and management.

There were no areas for improvement identified as a result of the inspection and RQIA were assured that the delivery of care and service provided in Dungannon Nursing Home was safe, effective and compassionate and that the home was well led.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the manager and the regional manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with eight patients, seven staff, one visiting professional and three relatives. Patients were well presented in their appearance and appeared relaxed and comfortable in their surroundings. Patients who could verbally communicate told us that they were happy living in the home. The relatives consulted were very positive in relation to the care provided to their loved one. The visiting professional confirmed that staff in the home adhered well to instruction and maintained good record keeping. Staff members were confident that they worked well together and enjoyed working in the home and interacting with the patients.

There were no questionnaire responses received and we received no feedback from the staff online survey.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 7 December 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 16.1 **Stated:** First time	The registered person shall ensure the identified patients care record is reviewed and updated to ensure all current SALT guidance is clearly and accurately reflected in all sections as required.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff members were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. Newly employed staff had protected time in which to complete an induction where they would work alongside a more senior member of staff to become more familiar with the home's policies and procedures. Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

A system was in place to monitor staffs' compliance with mandatory training. The staff compliance rate was at 97 percent. A training schedule was in use to identify practical training dates and training information was shared with staff in a published Ann's Homecare Training Newsletter. Training was completed on a range of topics such as adult safeguarding, infection prevention and control (IPC), patient moving and handling and fire safety. A visiting professional to the home confirmed that in addition to the home's mandatory training, they had been asked by management to provide bespoke training on dysphagia to further enhance staffs' knowledge in this area of care.

A matrix was in place to ensure registered nurses' annual competency assessments were completed on medicines management, wound care, taking charge of the home, catheterisation, syringe driver management and with enteral feeding.

Staff confirmed that they were further supported through staff supervisions and appraisals. Records of completed staff supervisions and appraisals had been maintained to ensure that staff received two recorded supervisions and an appraisal on an annual basis. The completion of supervision and appraisals formed part of the human resource (HR) audits.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff consulted confirmed they were satisfied that patients' needs were met with the staffing levels and skill mix on duty. Staff identified that workload on the evening shifts within the Killybracken Unit could at times be challenging. This was discussed with the manager for their review and action as appropriate. Observation of staffs' practices and discussions with patients raised no concerns in relation to the staffing arrangements in the home.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked. The duty rota identified the nurse in charge of the home when the manager was not on duty. A daily allocation sheet identified which areas in the home staff were allocated to work and with which patients.

Staff spoke positively on the teamwork in the home. One told us, "We have a very good team here; all staff are friendly," and another commented, "The teamwork is good; we all get on well together." Minutes were available of a recent staff meeting. Agreed actions from the meeting had been shared with all staff.

Patients consulted spoke highly on the care that they received and confirmed that staff attended to them when they needed them and that they would have no issues on raising any concerns that they may have to staff.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff members were knowledgeable of patients' needs, their daily routine, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

It was observed that staff provided care in a caring and compassionate manner. Patients were well presented in their appearance and told us that they were happy living in the home. It was clear through patient and staff interactions that they knew one another well and were comfortable in each other's company. The relatives consulted described the care in the home as, 'Brilliant'.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Relatives confirmed that they were part of the initial care planning process and that staff would keep them up to date with any changes in the patients' care. Patients' care records were held confidentially.

All patients had a pressure management risk assessment completed monthly. Where a risk of skin breakdown was identified; a care plan was developed to guide staff in how to manage this risk. When a patient required to be repositioned to maintain their skin integrity, records of the repositioning were well maintained to include the position the patient had been repositioned to and evidence of the patients' skin checks on repositioning. Where a patient had a wound, a care plan was in place to guide staff on how to manage the wound and evaluation records monitored the progress of the care delivery. Body maps and wound photographs were in place to allow for a visual reference to the wound management.

An accident/incident form was completed by staff to record any accidents or incidents which occurred in the home. A review of one patient's accident records, following a fall in the home, evidenced that the appropriate actions had been taken following the fall, the appropriate persons had been informed and the appropriate documentation had been updated. Falls safety calendars were utilised to record the incidences of falls each month. Audits were conducted after all falls in the home to ensure that the appropriate actions had been taken. Falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails or alarm mats. It was established that safe systems were in place to manage this aspect of care. When bedrails were in use, a record of bedrail checks was maintained. It was good to note that the entries made were time specific relating to the actual time the checks were made.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. Staff assisted patients throughout the day with food and fluids in an unhurried manner. Nutritional risk assessments were carried out regularly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST).

Patients dined in their preferred dining area; the dining room, lounge or their own bedrooms. Food was prepared and plated in the home's kitchen then transferred in a heated trolley to the dining area. Food served appeared appetising and nutritious. Meals which had to be modified were well presented. The menu offered patients a choice of meals. The mealtime was well supervised. Staff wore personal protective equipment (PPE) and patients, who required, wore clothing protectors to maintain their dignity. Staff sat alongside patients when providing assistance with their meals. A range of drinks were served with the meals. There was a calm atmosphere at mealtime.

Patients' individual likes and preferences were reflected throughout the records. Daily records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. Appropriate doors leading to rooms which contained hazards to patients had been locked. The home was warm, clean and comfortable. There were no malodours detected in the home.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible. Records of fire drills completed in the home had been maintained.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated and suitably furnished. The manager identified planned improvements for the home including new furnishings and new flooring in identified areas. Patients could choose where to spend their day in the home and staff were observed supporting patients to make these choices.

Systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. All visitors to the home were required to wear face coverings. Environmental infection prevention and control audits had been conducted monthly. There were two domestics on duty each day and records were maintained of general cleaning and deep cleaning of rooms and areas within the home. The manager completed a recorded daily walk around the home and action plans from any deficits identified were developed and reviewed to ensure completion.

Review of records, observation of practice and discussion with staff confirmed that effective training on IPC measures and the use of PPE had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

During the inspection we reviewed an application to relocate the nurses' station from the reception area into each of Killybracken and Lambfields units. The work had been completed to a high standard and on receipt of requested information following the inspection; the application for variation was approved.

5.2.4 Quality of Life for Patients

Two activity therapists oversaw the activity provision in the home. Activities were conducted on a group and on a one to one basis and included chatting, reflexology, arts and crafts, outings, music and movement, games, movies, reminiscence and beauty treatments. The home had access to two buses which facilitated outings for shopping, coffee or walks. A holiday in Donegal had been planned for some patients to attend. Activities were patient led. The activities therapist confirmed that patients meetings were held on a three monthly basis and provision of activities were discussed at these meetings. Individual records of activity involvement were maintained in patients' care records and a weekly programme of activities was available for review. Patients could avail of the activities room, a sensory room, a cinema room and a hair salon in the home. Photographs of patients enjoying activities were taken and shared with relevant Trust staff and patients' relatives.

The activity therapist and patients spoke fondly the activities at Christmas time including going out for Christmas dinner, attending the pantomime, going Christmas shopping and visiting an Enchanted Winter Garden.

Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients. There were five care partner arrangements in place and visiting was conducted in line with Department of Health guidelines.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been no change in the management arrangements. Mrs Leena Mary Francis Correa has been Registered Manager of the home since 21 May 2018. The manager was supported by a deputy manager who confirmed that they were allocated supernumerary hours in which to provide this support. Discussion with the manager and staff confirmed that there were good working relationships between staff and the home's management team. Staff told us that they found the manager and the management team to be 'approachable' and 'would listen to any concerns'.

Staff were aware of who the person in charge of the home was in the manager's absence. Staff told us that they were aware of their own role in the home and how to raise any concerns or worries about patients' safety, care practices or the environment. Staff members were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required. Staff demonstrated good knowledge of the organisational structure in the home.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Areas audited included patients' care records, wound care, medicines management, deprivation of liberty, restrictive practice, the dining experience, food safety, staff training, care reviews, housekeeping and HR procedures.

The manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

A complaint's file was maintained to detail the nature of any complaints and the corresponding actions made in response to any complaints. There were no recent or ongoing complaints relating to the home. Staff had received training on the management of complaints. We discussed that any area of dissatisfaction brought to staffs' or management attention should be recorded as a complaint. Cards and letters of compliments were maintained in a compliments file. A compliments log was completed and included verbal compliments, text messages and written messages received. The manager confirmed that all compliments received would be shared with the staff.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. Completed reports were available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Leena Mary Francis Correa, Registered Manager and Patricia Greatbanks, Regional Manager, as part of the inspection process and can be found in the main body of the report.

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