Unannounced Care Inspection Report
13 July 2016

Dungannon

Type of Service: Nursing Home
Address: 100 Killyman Road, Dungannon, BT71 6DQ
Tel No: 028 8775 2734
Inspector: Bridget Dougan

1.0 Summary

An unannounced inspection of Dungannon Care Home took place on 13 July 2016 from 11.30 to 17.00 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?

There was evidence of competent and safe delivery of care on the day of inspection. Staff were required to attend mandatory training and the observation of care delivery evidenced that knowledge and skill gained, through training, was embedded into practice. Staff also confirmed that there were good communication and support systems in the home including staff meetings and staff were required to attend a 'handover meeting' when commencing duty. Weaknesses were identified in the management of staff inductions.

Patient risk assessments were undertaken, reviewed and updated on a regular basis. Falls audits, however, had not been completed. While the home was found to be warm, fresh smelling and clean, the décor was tired and worn. We were informed that a refurbishment programme was underway.

One requirement and two recommendations have been made.

Is care effective?

There was evidence of positive outcomes for patients, who were being assisted and responded to in a timely and dignified manner.

Each staff member understood their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

There were no requirements or recommendations made.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

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.

There were no requirements or recommendations made.

Is the service well led?

There was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. The manager has been in post since May 2016.

Systems were in place to monitor and report on the quality of nursing and other services provided. Falls audits, however had not been completed.

There were no requirements or recommendations 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	2

Details of the QIP within this report were discussed with Mr. Anthony Edward Hart, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 10 March 2016. 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:** Mr. Anthony Edward Hart
Person in charge of the home at the time of inspection: Mr. Anthony Edward Hart	**Date manager registered:** Registration Pending
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 36

3.0 Methods/processes

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 we met with 20 patients, two registered nurses, five care staff, one catering assistant and one domestic staff.

Questionnaires for patients (eight), relatives (six) and staff (13) to complete and return were left for the home manager to distribute. Three patients and 13 staff completed and returned questionnaires within the required time frame.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training planner for 2016/17
- two staff personnel records
- accident and incident records
- notifiable events records
- sample of audits
- complaints and compliments records
- NMC and NISCC registration records
- nurse competency and capability assessments
- minutes of staff meetings
- minutes of patient meetings.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 10 March 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. Actions taken by the registered person will be validated as part of this care inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 10 March 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 28.1 **Stated:** Second time	It is recommended that the administration of laxative medication prescribed on an "as required" basis is reviewed to ensure that laxatives are administered in response to patient need. The records of bowel movements should be checked prior to each administration.	**Met**
	Action taken as confirmed during the inspection: Review of the medication administration records and patients care records evidenced that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 41.2 **Stated:** First time	It is recommended that the provision and deployment of staff is reviewed to ensure that there are sufficient staff to adequately supervised patients and ensure that their health, welfare and safety needs are met.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and review of a sample of duty rotas evidenced that staff provision and deployment had been reviewed to ensure that there were sufficient staff to adequately supervise patients and ensure that their health, welfare and safety needs were met. Staff felt there was enough staff to meet the needs of patients.	

Recommendation 3 **Ref**: Standard 44.3 **Stated:** First time **To be Completed by:**	It is recommended that an application for variation to registration in regard to the change of use of the identified rooms is submitted to RQIA.	**Met**
	Action taken as confirmed during the inspection: Two new dining rooms had been created. These rooms had previously been in use as a lounge and an activity room. The activity room had been relocated to a room previously used as a dining room. These changes were discussed with the manager and we were informed that the changes made were returning to the original floor plan for the home.	

4.3 Is care safe?

The manager 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 rotas for weeks commencing 4 and 11 July 2016 evidenced that the planned staffing levels were adhered to. Refer to section 4.2 for further details.

Discussion with patients and staff evidenced that there were no concerns regarding staffing levels.

Observation of the delivery of care evidenced that patients' needs were met by the numbers and skill mix of staff on duty.

Discussion with the manager confirmed that there were systems in place for the safe recruitment and selection of staff, and staff consulted confirmed that they had only commenced employment once all the relevant checks had been completed. Two personnel files were viewed and we were able to evidence that all the relevant checks had been completed.

Whilst staff informed us that they completed a structured orientation and induction programme at the commencement of their employment, the induction records for three newly appointed staff members had not been retained on file. These staff members were not on duty and we were unable to verify if they had completed an induction. The manager confirmed that they had been employed prior to him taking up his management post. A requirement has been made accordingly.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. There was also evidence that mandatory training had been completed by all staff in 2015. Discussion with the manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. Staff consulted with and observation of care delivery and interactions with patients clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice. The manager confirmed that staff had also completed a range of other training areas including; the management of behaviours which

challenge, deprivation of liberty standards, restrictive practice, pressure ulcer awareness, dysphagia and training in respect of the malnutrition universal screening tool (MUST).

There was evidence of competency and capability assessments completed for the majority of registered nurses and a planner was in place with dates scheduled for all registered nurses for 2016. A number of staff had received supervision and appraisal since the manager took up his post in May 2016 and we were informed that a planner was in place to ensure all staff received supervision and appraisal in 2016.

Discussion with the manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Discussion with the manager confirmed that, while a range of audits was conducted on a regular basis (refer to section 4.6 for further detail), falls audits had not yet been completed. A recommendation has been made.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident. Trust representatives, patients' representatives and RQIA were notified appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. While the home was found to be warm, fresh smelling and clean throughout, the décor was tired and worn. The manager informed us that a refurbishment programme was underway, with painting and upgrading of bedrooms being completed on a phased basis. It was agreed that the manager would submit plans of the timescales of the refurbishment programme to RQIA.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Comments received from patients and staff indicated that patients were safe and protected from harm. One staff member felt there was not always sufficient incontinence pads and wipes to care for patients. This was discussed with the manager and we were informed that this related to a staff training issue and was being addressed by the manager.

Areas for improvement

Ensure that all newly appointed staff are required to complete a structured orientation and induction and that records are maintained.

Falls should be reviewed and analysed on a monthly basis to identify any patterns or trends and appropriate action should be taken.
An action plan, including timescales for completion, regarding the refurbishment programme of the home should be submitted to RQIA.

Number of requirements	**1**	**Number of recommendations**:	**2**

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that registered nurses, assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. Risk assessments informed the care planning process. It was evident that care records accurately reflected that the assessed needs of patients.

There was evidence that care records were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate. There was evidence also of regular communication with patients' representatives regarding the patients' ongoing condition.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. The manager and staff also confirmed that regular staff meetings were held (at least quarterly) and records were maintained.

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 could raise these with their line manager and /or the home manager.

Patients spoken with expressed their confidence in raising concerns with the home's staff/ management. Some comments received as follows:

- "I'm happy here"
- "Everybody is very good to me"

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Observation of the lunchtime meal confirmed that patients were given a choice regarding food and fluid choices, and the level of help and support requested. Staff were observed to offer patients reassurance and assistance appropriately. The daily menu was displayed in the dining rooms and offered patients a choice of two meals for lunch and dinner. A choice was also available for those on modified diets. Patients all appeared to enjoy their lunch.

Discussions with staff confirmed that they had a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients spoken with were complimentary regarding the care they received and life in the home. Those patients who were unable to verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. For example, there were regular patient and staff meetings. We were advised that relatives meetings had been arranged in the past and attendance was low. The manager had plans to arrange more informal social events to meet with relatives. Quality of life surveys were completed on a regular basis (see section 4.6 for further details). The manager was available to staff, patients and their relatives and operated an 'open door' policy for contacting him. Patients meetings were held on a quarterly basis. The most recent meeting was 2nd June 2016 and records had been maintained.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities. Staff also confirmed that there were good working relationships and that the manager was responsive to any concerns raised. The manager had been in post since May 2016 and an application had been made for registration with RQIA.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the manager, a review of care records and observations confirmed that the home was operating within its registered categories of care.

Review of the home's complaints record and discussion with the manager 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.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.
There was evidence that a range of audits had been completed on a monthly basis, including care records, medication management and infection prevention and control. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. As discussed in section 4.3, the manager confirmed that falls audits had not yet been completed. A recommendation has been made in this regard.

On a daily basis the manager completes a feedback survey with one patient and/or one relative, and completes and records the findings of a daily walk around the home. The information garnered is automatically forwarded to a team in the organisation who generate an action notice where a shortfall had been identified. The findings of any audits completed in the home are also reviewed by the regional manager when completing the monthly quality monitoring visit.

Discussion with the manager and review of records for April, May and June 2016 evidenced that Regulation 29 monthly quality monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

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.

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

Feedback received in the returned questionnaires confirmed that patients and staff felt the service was well led. Some comments from staff included the following:

"the manager is very approachable and open to suggestions from staff. He addresses issues promptly and is very reassuring"

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

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr. Anthony Edward Hart, 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 Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the DHSSPS 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 completed QIP to nursing.team@rqia.org.uk 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) (c) (i) **Stated:** First time **To be completed by:** 31 August 2016	The registered provider must ensure that all staff who are newly appointed are required to complete a structured orientation and induction and records are retained. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Structured induction records are now placed in personnel files as soon as they are completed by the new staff and signed off by the registered manager.
Recommendations	
Recommendation 1 **Ref**: Standard 22.10 **Stated:** First time **To be completed by:** 31 August 2016	The registered provider should ensure that falls are reviewed and analysed on a monthly basis to identify any patterns or trends and appropriate action should be taken. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Accident analysis was completed, however going forward a hard copy will be printed and filed for ease of referencing. Any trends or patterns noted will be analysed in depth and measures taken will be recorded and cascaded to staff for reflective learning.
Recommendation 2 **Ref**: Standard 44.1 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should submit to RQIA the plans (including timescales) for the refurbishment programme of the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Action plan attached. This includes painting, furniture replacement, planned maintenance and flooring upgrade.

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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