The Regulation and Quality Improvement Authority

Inspection Report

20 September 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:** 32
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 20 September 2023 from 9.40am to 4.35pm by a care inspector.

The inspection was 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 of 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, relatives and staff are included in the main body of this report.

Staff 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.

An area for improvement was identified in relation to the safe storage of thickening agents when not in use. RQIA were assured that the delivery of care and service provided in Dungannon nursing home was safe, effective, compassionate and that the home was well led.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

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 at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with patients and staff. Patients spoke positively on the care that they received and on their interactions with staff. One told us, "I really like it here". Staff were confident that they worked well together and enjoyed working in the home and interacting with the patients. Relatives consulted told us, "We are very happy with the care here; xxx always looks happy and staff are very attentive".

We received no questionnaire responses and 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?

The last inspection to Dungannon nursing home was undertaken on 20 January 2023 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. All staff were provided with a comprehensive induction programme to prepare them for working with the patients. An induction booklet was completed to capture the topics covered during the induction.

There were systems in place to ensure staff were trained and supported to do their job. Mandatory training included epilepsy management and learning disability awareness. Deprivation of Liberty Safeguards (DoLS) training was conducted on induction. Training was completed face to face and electronically. Staff and the manager confirmed that they had recently started using a new electronic training platform. A system was in place to ensure staff completed their training and the most recent monthly monitoring report evidenced that 97 percent of staff were compliant with mandatory training requirements. The provider, Ann's Care Homes, issued detail of upcoming training dates on a monthly basis which staff could access.

Staff confirmed that they were further supported through staff supervisions and appraisals. A system was in place to ensure that staff received, at minimum, two supervisions and an appraisal conducted annually. The manager confirmed that a recent supervision had been conducted on nutrition utilising Standard 12 of the Care Standards for Nursing Homes (December 2022).

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.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff confirmed that patients' needs were met with the number and skill mix of staff on duty. Staff said there was good teamwork in the home. One told us, "Teamwork is very good here. Everyone is really nice".

The staff duty rota accurately reflected all of the staff working in the home on a daily basis. Several patients required one to one care as part of their assessed need. Staff members were allocated to provide the one to one care at different time periods during the day. The duty rota identified the nurse in charge of the home in the absence of the manager. The nurse in charge of the home completed a competency and capability assessment on taking charge of the home prior to commencing the role.

The manager confirmed that staff meetings were conducted quarterly with all disciplines of staff. Minutes of the meetings were recorded and staff unable to attend the meetings were requested to read and sign the minutes.

It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through these interactions that the staff and patients knew one another well and were comfortable in each other's company.

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. An allocation sheet identified where staff were to work and with which patients. Staff 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.

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. The home was in a transition period from written record keeping to electronic record keeping. Training for staff had been completed prior to the transition. Additional staff had been employed to assist in the transition of records. Patients care records were held confidentially.

Flash meetings were conducted with staff each Tuesday and Friday at handover times to discuss any changes to patients' care or planned changes initiated by multidisciplinary professionals such as general practitioners, speech and language therapists or physiotherapists. Records were maintained of these meetings. Information shared at these meetings were communicated to other staff at subsequent handovers.

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. Records demonstrated how the safe moving and handling of patients was achieved and what equipment, if any, was necessary to aid in this.

Care plans identified the level of assistance with patients' personal care required. Supplementary personal care records recorded the actual care delivered to patients and included when they last had a shower, body wash or bath.

Where a patient had a urethral catheter insitu to manage continence needs; a care plan was in place in how to manage the catheter. Dates were added to the nursing diary to ensure the catheter was changed at the correct time and leg bag changes were included in the medicine administration records to ensure that they were changed, at minimum, weekly. Staff confirmed that patients' continence needs were attended to at regular intervals during the day and night and records maintained. In addition to the planned continence checks, continence needs were also attended to when patients requested assistance with this.

Incident forms were completed by staff to record any accidents or incidents which occurred in the home. Accidents and incidents were reviewed on a monthly basis for any patterns or trends to identify if any future accidents could be prevented.

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. Staff were knowledgeable in regards to patients' nutritional requirements. Records of patients' intake and outputs were recorded where this was required. There was good availability of food and fluids observed during the inspection. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST).

The majority of patients dined together in the dining room during lunch. Food was plated in the kitchen and served from heated trolleys. The mealtime was well supervised. There were meal options on the menu for patients to choose from. Pictorial menus were displayed in the dining room reflective of the food served. Alternatives were provided for any patient who did not like either of the options. Staff wore the appropriate personal protective equipment (PPE) and patients, who required, wore clothing protectors to maintain their dignity. The food served appeared nutritious and appetising. A range of drinks was served with the meal. There was a calm atmosphere in the dining room and patients spoke positively on the mealtime experience. Food safety audits and dining audits were completed to monitor the quality and patients' experience of the mealtimes.

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. The home was warm, clean and comfortable. There were no malodours in the home. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

Fire safety measures were in place to ensure patients, staff and visitors to the home were kept safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible. Records of fire drills had been maintained. A record of visitors to the home had been maintained. The most recent fire risk assessment had been completed during January 2023 and all actions on the action plan had been marked as completed.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated. There was evidence of an ongoing painting programme and the temperature control for each room was being updated to allow for remote management.

Thickening agents were observed to be stored inappropriately within two areas in the home when not in use. Thickening agents could be harmful to patients if ingested improperly. This was discussed with the manager and identified as an area for improvement.

Review of records and observation of staffs' practice confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided. There were good stocks and supplies of PPE and hand hygiene products. Environmental and hand hygiene audits were conducted frequently and records maintained.

5.2.4 Quality of Life for Patients

Two activities therapists were employed to conduct activities in the home. A programme of activities was displayed for each morning and afternoon Monday to Sunday. Activities included exercises, pampering, gardening, glass painting and church services. Shopping trips, day trips, walking clubs and church services were also included as part of the activity plan. There were regular bus outings from the home to places of interest. Some patients attended the local leisure centre for a 'Fit for You' exercise class each week. The home was equipped with a sensory room and a hairdressing room. Activities were conducted on a group and a one to one basis.

During the inspection we met an external therapist who attended the home to do massage, reike and/or reflexology with patients on a one to one basis. The environment had been prepared for the treatment; calm music was playing in the background and patients were observed to be relaxed and enjoying this. We also met a staff member from a local college who came to the home weekly to do a pottery class with patients. Patients were observed decorating the pottery that they had made and told us that they enjoyed this.

Five patients had recently returned from a holiday to Bundoran in Co. Donegal. Staff confirmed that they have at least three trips each year to Bundoran and patients really enjoy this. There were pictures of patients throughout the home and on the home's Facebook page of patients enjoying taking part in activities. The manager confirmed that the photographs were taken with consent.

Patients' meetings were conducted six monthly. The last meeting was in March 2023 and minutes were maintained. They included patients' opinions on the activity provision in the home and thoughts of different outings that could be arranged. The minutes also included the addition of a new summer house for the home which has now been built, furnished and in good use within the enclosed garden area.

Staff provided care in a dignified manner and were observed interacting with patients in a compassionate manner. Personal care was delivered discreetly behind closed doors. A relative commented, "I am very happy with the care here. Staff go above and beyond and xxx is always well presented. The home is very clean".

Visiting had returned to pre-covid arrangements. Visits could take place in the patients' preferred visiting areas including their bedrooms. Patients were free to leave the home with relatives if they wished.

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 registered with RQIA as manager of the home on 21 May 2018. Discussion with staff confirmed that there were good working relationships between staff and the home's management team. Staff described the manager as 'very approachable' and 'more like a friend'. 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 roles 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. The manager had a monthly audit file. Areas audited included patients' care records, wound care, restrictive practice, DoLS, infection control, medicines management, housekeeping and the environment.

Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

Since the last inspection, a serious adverse incident (SAI) final report was received in relation to an incident which occurred during the Covid-19 outbreak. The manager confirmed that staff are fully aware of the precautions to take during an outbreak and that any advice from the Public Health Authority or Department of Health would be sought and followed in any future infectious outbreaks.

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 and the reports were available for review by patients, their representatives, the Trust and RQIA. Where improvement actions were required, an action plan was included within the report. The action plan would be reviewed at the subsequent monthly monitoring visit to ensure completion.

A complaint's file was maintained. There were no recent or ongoing complaints relating to the home. Cards and letters of compliments were shared with staff and then maintained on file.

6.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan 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.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that thickening agents are stored securely when not in use. Ref: 5.2.3 **Response by registered person detailing the actions taken:** The registered person has reviewed the safe storage of thickening agents with staff. They have been reminded of their personal responsibility to ensure that thickening agents are locked away in treatment room when not in use. Compliance shall be monitored during walk abouts by registered person.

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The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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