Unannounced Inspection Report
15 October 2019

Dungannon

Type of Service: Nursing Home
Address: 100 Killyman Road, Dungannon, BT71 6DQ
Tel No: 028 8775 3034
Inspector: Helen Daly

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, 2015.

1.0 What we look for

2.0 Profile of service

This is a nursing home which is registered to provide care for up to 36 patients with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual(s):** Dr Maureen Claire Royston	**Registered Manager:** Mrs Leena Mary Francis Correa
Person in charge at the time of inspection: Mrs Leena Mary Francis Correa	**Date manager registered:** 21 May 2018
Categories of care: Nursing Homes (NH): LD – learning disability LD(E) – learning disability – over 65 years	**Number of registered places:** 36

4.0 Inspection summary

An unannounced inspection took place on 15 October 2019 from 10.00 to 16.05.

The inspection assessed progress with any areas for improvement identified during and since the last care and medicines management inspections 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 the management of medicines, the environment and the activities provided in the home.

No areas for improvement were identified at this inspection.

Patients spoken with said that they enjoyed living in the home. Patients unable to voice their opinions were seen to be comfortable in their surroundings.

Comments received from patients and staff during and after 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

*The total number of areas for improvement includes one which have been carried forward for review at the next inspection.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs 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 24 April 2019

Other than the action detailed in the QIP no further actions were required to be taken following the most recent care inspection on 24 April 2019. 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 last inspection findings in relation to care and medicines management and any other written or verbal information received.

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 to 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.

No questionnaires were returned to RQIA within the timeframe for inclusion in this report.

During the inspection a sample of records was examined which included:

- personal medication records and medication administration records
- risk assessments, care plans and hospital discharge letters for recently admitted patients
- daily progress notes for patients who had recently been prescribed an antibiotic
- a sample of patients records of care and progress notes
- RQIA registration certificate

Prior to the inspection, the area for improvement identified at the last care inspection was discussed with the care inspector and senior management in RQIA and it was agreed that it would be carried forward for review at the next care inspection.

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 medicines management inspection

There were no areas for improvement identified as a result of the most recent medicines management inspection on 16 February 2018.

6.2 Review of areas for improvement from the most recent care inspection

<table>
<tr><th colspan="3">Areas for improvement from the most recent care inspection dated 24 April 2019</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the DHSSPS Care Standards for Nursing Homes, April 2015</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 4.9

Stated: First time</td><td>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.</td><td rowspan="2">Carried forward to the next care inspection</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.</td></tr>
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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.

Staff advised that they felt that there were usually enough staff to meet the needs of the patients and this was evidenced during the inspection. The three patients we spoke with said that they felt well looked after in the home. Patients' needs and requests for assistance were observed to be met in a timely and caring manner.

The home was observed to be clean and warm, all areas inspected were appropriately decorated and clean. There were no malodours. Corridors were free from trip hazards and equipment/cleaning products were stored in areas not accessed by patients.

We reviewed a sample of personal medication records and medication administration records and found that they had been appropriately maintained. Daily audits on the administration of medicines were completed. There was evidence that medicines were being administered as prescribed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, the management of medicines and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number 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.

Robust systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay and appropriate records maintained. We noted that the reason for and outcome of the administration of medicines which are prescribed to be administered 'when required' for the management of distressed reactions had not been recorded on all occasions. The registered manager advised that this was closely monitored as part of her monthly audits and would be discussed with registered nurses for ongoing vigilance.

We reviewed the midday meal in the main dining room. In order to enhance the mealtime experience lunch was served over two sittings. Patients dined in the dining room or their preferred

dining area. Tables had been laid appropriately for the meal. The pictorial menu offered a choice of meal for lunch and alternatives were also available. Patients who required their meals to be modified were also given a choice of meal. Food was served from a heated trolley when patients were ready to eat their meals or be assisted with their meals. The food served appeared nutritious and appetising. Staff were knowledgeable in relation to patients' dietary requirements. Patients were offered clothing protectors and staff wore aprons when serving or assisting with meals. Staff were observed chatting with patients when assisting with meals and patients were assisted in an unhurried manner. Records of food and fluid intake were maintained.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the timely availability of newly prescribed medicines and antibiotics, communication between patients and staff and the encouragement/assistance provided by staff to ensure that patients received a nutritious meal.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

We observed the morning medication round. The administration of medicines to patients was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible.

Of the questionnaires that were issued, none were returned within the timeframe (two weeks) specified for inclusion in this report.

We spoke with three patients during the inspection. All were complimentary regarding the care provided and staff. The following are some of the comments made:
"I like it here. I like going out on the bus."
"I like it here when I get peace. I like her (activity therapist), she helps me."
"I like going on holiday."

Patients who could not verbalise their feelings in respect of their care were observed to be comfortable. Staff engaged patients in appropriate and caring conversations.

Observation of the care practices evidenced that staff adopted a person centred care approach. Staff communicated with patients in a manner that was sensitive and understanding of their needs.

Bedrooms were being decorated during the inspection. Where possible patients were being encouraged to choose their wallpaper. Where patients were unable to communicate their preferences staff had selected wallpaper which they felt was suitable.

A range of activities were provided in the home. Patients who could knit were being encouraged to develop their skills further and were making hats for premature babies. The home was decorated for Halloween and plans were in place for a party. Staff took patients out on bus outings where possible and patients commented on how much they enjoyed these trips. Patients had recently enjoyed a holiday in Bundoran and a visit from farm animals to the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to ensuring that patients were provided with activities that they enjoyed.

Areas for improvement

No areas for improvement were identified during the inspection.

	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.

Medication incidents had been investigated to identity and implement any learning to prevent a recurrence. The registered manager advised that there were robust auditing processes and that staff knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff advised that they were aware that incidents may need to be reported to the safeguarding team.

We discussed the Mental Capacity Act (Northern Ireland) 2016 and the Deprivation of Liberty Safeguards. The registered manager advised that staff were completing training which was provided by Four Seasons Health Care.

We met with two registered nurses, four care staff and two activity therapists. All staff advised that they felt that patients were well cared for in the home and that they were aware of how to report any concerns regarding patient care. One newly recruited staff member said that she had a good induction and felt well supported by other staff. Staff commented positively on the care and activities provided in the home. They commented on how much they “loved the patients” and said that they liked that they could alternate which area of the home they worked in each day.

Some staff reflected on the day to day challenges they faced within their role. We encouraged them to engage with the registered manager regarding this. We discussed these concerns with the registered manager who was aware and was liaising with the regional manager to address the issues raised.

The systems in place for taking and sharing photographs with family were discussed with the senior management in Four Seasons Health Care to ensure that they were in accordance with

Four Seasons Health Care policy and procedures. Appropriate assurances were provided post inspection. This will be reviewed at a future care inspection,

Areas of good practice

There were examples of good practice found in relation to quality improvement.

Areas for improvement

No areas for improvement were identified during the inspection.

	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 Mrs Leena Mary 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 Homes Regulations (Northern Ireland) 2005 and the DHSSPS 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 via the 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 1 **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: 6.2**
	Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this will be carried forward to the next care **inspection.**

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

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