Unannounced Care Inspection Report
20 and 21 August 2019

Holywood

Type of Service: Nursing Home
Address: 221 Holywood Road, Holywood, BT18 9QS
Tel No: 028 9042 6900
Inspector: Dermot Walsh and Briege Ferris

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 registered nursing home which provides care for up to 71 patients.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual(s):** Dr Maureen Claire Royston	**Registered Manager and date registered:** Roxana Mitrea – 5 January 2018
Person in charge at the time of inspection: Violeta Bote – Deputy Manager	**Number of registered places:** 71 A maximum of 18 patients in category NH-DE located on the Ground Floor and a maximum of 8 patients in categories NH-MP/MP(E) located in the Dunville Unit. There shall be a maximum of 1 named patient in category NH-PH.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 53

4.0 Inspection summary

An unannounced inspection took place on 20 August 2019 from 09.10 to 17.10 hours and on 21 August 2019 from 09.20 to 14.20 hours.

This inspection was undertaken by the care and finance inspectors.

The inspection assessed progress with all areas for improvement identified in the 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 arrangements, recruitment, adult safeguarding, compliance with infection prevention and control, care planning, quality improvement, compassionate care delivery and maintaining good working relationships. Further good practice was observed in relation to the management of patients' monies and valuables,

including the availability of deposit and expenditure receipts, records of the reconciliation (checks) of monies and valuables held in the safe place, the administration of the patients' comfort fund and patients' personal property records.

Areas requiring improvement were identified in relation to patients' smoking arrangements, management of oxygen therapy and with supplementary care recording in relation to the delivery of personal care. Further areas requiring improvement were identified in relation to ensuring that there is a record of the personal possessions brought by each patient into their rooms and that these records are reconciled quarterly; ensuring that treatment records contain the required information as set out in the Care Standards for Nursing Homes (2015) and ensuring individual written patient agreements are kept up to date.

Patients described living in the home as being a good experience and their comments are included throughout this report. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others.

Comments received from patients, people who visit them 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	1	6

Details of the Quality Improvement Plan (QIP) were discussed with Violeta Bote, deputy manager and Elaine McShane, regional 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 6 February 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 6 February 2019. 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 including finance issues, 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 and invited visitors to speak with the inspector.

A lay assessor was present during this inspection and their comments are included within this report. A lay assessor is a member of the public who will bring their own experience, fresh insight and a public focus to our inspections. Comments received by the lay assessor are included within this report.

The following records were examined during the inspection:

- duty rota for all staff for week commencing 12 August 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
- one staff recruitment and induction file
- four patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records
- complaints record
- compliments received
- a sample of reports of visits by the registered provider/monthly monitoring reports from January 2019
- RQIA registration certificate
- a sample of patients' income, expenditure and banking records
- records of the reconciliation of patients' monies and valuables
- the safe contents record
- a sample of patients' comfort fund records
- four patients' personal property records
- a sample of hairdressing and chiropody treatment records
- four patients' finance files

Areas for improvement identified at the last 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 previous inspection(s)

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 12 (1) (a) (b) **Stated:** Second time	The registered person shall ensure that robust arrangements are in place to ensure that all food served to patients in the home, meals, snacks or other, are in accordance with the patients' dietary requirements.	**Met**
	Action taken as confirmed during the inspection: A review of patients' care records, discussion with staff and a review of the mealtime experience evidenced that this area for improvement has now been met.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 45 Criteria (2) **Stated:** First time	The registered person shall ensure that the system to monitor pressure mattress settings in the home is robust and effective.	**Met**
	Action taken as confirmed during the inspection: A review of pressure mattress settings in the home evidenced that these had been maintained in the correct setting.	
Area for improvement 1 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that food supplements consumed by patients are consistently recorded within the patients' food and fluid intake records.	**Met**
	Action taken as confirmed during the inspection: Food supplements were consistently recorded within patients' food and fluid intake records.	

6.2 Inspection findings

6.3 Is care safe?

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

The manager confirmed that the number of staff and the skill mix of staff on duty at any given time. A review of the duty rota for week commencing 12 August 2019 confirmed that the planned staffing level and skill mix was adhered too. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the care staff. Patients' needs and requests for assistance were observed to have been met in a timely and caring manner. Patients and their visitors consulted spoke positively in relation to the care provision in the home. Staff consulted confirmed that they were satisfied the staffing levels and skill mix were sufficient to meet patients' needs.

A review of one recently recruited staff member's recruitment records evidenced that the appropriate pre-employment checks had been conducted prior to the staff member commencing in post. Records also indicated that the new staff member had gone through an induction process at the commencement of their employment to assist them in gaining knowledge of the homes' policies and procedures.

The manager evidenced regular checks made on all staff following employment in the home to ensure that they maintained their registration with Nursing and Midwifery Council (NMC) or Northern Ireland Social Care Council (NISCC) as appropriate. New care staff were required to join the NISCC register as soon as possible following commencement of employment.

A record of any training that staff had completed was maintained in the home. Staff were satisfied that the training provided assisted them in their roles within the team. Staff indicated that they could request additional training which would be pertinent to their role.

An adult safeguarding champion had been identified to manage any potential safeguarding incidents. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

A review of four patients' care records evidenced that appropriate individualised risk assessments were completed on each patient at the time of their admission. Risk assessments had been reviewed regularly and care plans had been developed which were reflective of the risk assessments. Care plans had also been reviewed and updated regularly.

Falls in the home were monitored on a monthly basis for any patterns and trends in times or locations of the fall. This would be to review the pattern to proactively plan measures to reduce the incidences of falls where possible. A review of the management of falls in the home evidenced that these had been managed appropriately and that the relevant persons had been notified of the fall.

We reviewed the home's environment undertaking observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was clean and fresh smelling. However, a smoking arrangement outside of the home impeded on the comfort of an identified patient as the smoke was penetrating into their room. This was discussed with the manager and identified as an area for improvement. Compliance with infection prevention and control had been well maintained. Fire exits, stairwells and corridors were observed to be clear of clutter and obstruction. Patients were seated in one of the lounges or in their bedroom as was their choice. Patients were complimentary in regards to the environment and the surrounding areas.

We observed the delivery of oxygen therapy in one patient's room. There was no signage on the patient's door to identify that oxygen was being administered in the room. The oxygen cylinder had been left positioned in an unsafe manner. This was discussed with the manager and identified as an area for improvement.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, staff training and development, adult safeguarding and with compliance with infection prevention and control.

Areas for improvement

The following areas were identified for improvement in relation to smoking arrangements and with the safe administration of oxygen.

	Regulations	Standards
Total numb of areas for improvement	0	2

6.4 Is care effective?

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

Dietary requirements, such as the need for a diabetic diet, were communicated through staff handovers. Information also included the consistency of patients' food and fluids. Staff confirmed that the shift handover provided them with all necessary information to provide care to patients. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/management.

Patients had been weighed regularly and a nutritional screening tool known as Malnutrition Universal Screening Tool (MUST) was utilised to determine the risk of weight loss or weight gain. Patients and staff confirmed that they had 24 hour access to food and fluids.

We reviewed the lunchtime meal experience in the dementia unit. Patients dined at the main dining area or at their preferred dining area such as their bedroom or the lounge. Tables had been laid appropriately for the meal. The menu offered a choice of meal for lunch. Patients who required to have their meals modified were also afforded 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. A speech and language therapist had changed the dietary requirement for an identified patient on the morning of the first day of inspection. All staff involved in the patients care including kitchen, care and nursing staff were all fully aware of the change prior to the lunchtime meal. Patients wore clothing protectors where required 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. One patient consulted spoke negatively of the food provision. The manager agreed to discuss this with the patient to ensure appropriate alternatives were identified. Records of food and fluid intake were maintained well where appropriate and included information such as food/fluid offered but refused, food/fluid consumed and detail of any supplement the patient was taking.

Patients' risk of pressure related skin damage was assessed on their admission and reviewed on a monthly basis. When a risk was identified, such as immobility, poor diet or incontinence, a care plan was developed to guide staff in measures to prevent skin breakdown. We reviewed one patient's wound care records. A clear wound care plan was evident within the patient's care records to guide the dressing regime and management of the wound. Records of repositioning had been maintained well.

Falls risk assessments were completed on admission and reviewed monthly. Falls care plans were developed when a risk of falls was identified and also updated monthly or following a fall. Accident records had been maintained indicating the actions taken following a fall and confirming that the appropriate persons had been notified of the fall. As previously stated, there was evidence of falls analysis in the home by the manager and the regional manager to prevent, where possible, falls from reoccurring.

Records of personal care delivery were maintained. However, a review of one identified patient's record of personal care evidenced gaps in the recording. It was unclear if the patient had received assistance with personal care or not on these occasions. Other recorded details in the patient's supplementary personal care delivery records were not in compliance with the patient's personal care care plan. This was discussed with the manager and identified as an area for improvement.

When a restrictive practice, such as the use of bedrails had been implemented, there was evidence within the patient's care records of an initial assessment completed to ensure safe use. This assessment was reviewed regularly. The continued use of this restrictive practice was monitored at the evaluation of the patients' care plans.

Each staff member was aware of their roles and responsibilities within the team. Staff spoke positively in relation to the teamwork in the home. One staff commented that the teamwork in the home was, "Brilliant". Staff also confirmed that if they had any concerns, they could raise these with the manager or the nurse in charge.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff handover, teamwork, use of restrictive practice and nutrition management.

Areas for improvement

An area for improvement was identified in relation to the recording of personal care delivery.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 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 were observed to deliver care in a caring and timely manner. Patients confirmed that they were happy with the interactions that they had with staff. Some of their comments can be found in this section. Staff knocked on patients' doors before entering and personal care was delivered behind closed doors. Patients were afforded choice, privacy, dignity and respect.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences.

Consultation with eight patients individually, and with others in smaller groups, confirmed that living in Holywood was a positive experience. Patient questionnaires were left for completion. None were returned.

Patients consulted during the inspection commented:

- "I am very well cared for and I've no other concerns since I came here. My family come and visit me at different times."
- "Roxy is very approachable. She is good at what she does. The entertainment is pretty good."
- "I am very happy here. This place is for me."
- "There is a good feel about the home."

Three patients' visitors were consulted during the inspection. Patient representatives' questionnaires were left for completion. Two were returned. Both respondents indicated that they were satisfied or very satisfied that the home was providing safe, effective and compassionate care and that the home was well led. Patients' representatives commented:

- "If as a family we feel the need to talk, we can do so, with the staff. Issues, if any, dealt with promptly. Pleasant to us and to mum."
- "This place is brilliant. We are over the moon with … in here."
- "Really couldn't fault them (the staff). Communication is really good. Anything we ask to be dealt with, they've done it."

Staff were asked to complete an online survey; we had no responses within the timescale specified. Comments from 13 staff consulted during the inspection included:

- "I am very happy here. The staff are good and the manager's good."

- "I like it very much. I like the atmosphere here."
- "It is good. I get satisfaction here."
- "I am very happy working here."
- "It's very nice. I like it here."
- "It is great. I love it here."

Any comments from patients, patient representatives and staff in returned questionnaires or online responses received after the return date will be shared with the manager for their information and action, as required.

Areas of good practice

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

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 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. This certificate identifies the management arrangements for the home and the maximum number of patients allowed to be accommodated in the home. Since the last care inspection, the management arrangements in the home had not changed.

A review of the staff duty rota evidenced the name of the nurse in charge of the home in the absence of the manager.

A system was in place to record any complaints received including details of any investigation and all actions taken in response to the complaint. The complaints procedure was displayed at reception. Patients and their visitors consulted during the inspection confirmed that they would have no issues in raising any identified concern with the home's staff or management.

Discussion with the manager and review of auditing records evidenced that a number of monthly audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, care records, restrictive practices, wound care and infection prevention and control. We reviewed the infection prevention and control audits. Auditing records evidenced the actions taken in response to any shortfalls that were identified. There was evidence of oversight from both the manager and the regional manager in regards to auditing records.

Monthly monitoring visits to the home were conducted. Reports from the visit were available for review by patients and their visitors, staff, Trust staff and other healthcare professionals.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.
Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Management of patients' monies

The controls in place to safeguard patients' monies were reviewed by examining a sample of the records. This included a review of the following records: income, expenditure and banking records; comfort fund records; patients' valuables deposited with the home for safekeeping; personal property in each patient's room, individual written agreements between patients and the home and records of charges to patients or their representatives.

A review of these areas identified that in general, controls were in place to safeguard patients' monies and valuables and these and operating effectively. However four areas for improvement were identified.

A review of a sample of patients' property records (detailing items in patients' rooms) identified that these were not being reconciled on a quarterly basis as is required. An area for improvement was made in respect of this finding. A review of a sample of treatment records also identified that these were not being maintained in line with the Care Standards for Nursing Homes (2015). An area for improvement was made in respect of this finding. A review of a sample of patient agreements also identified that while each patient had a signed written agreement in place, there was no evidence that these were kept up to date to reflect the most recent changes to the terms and condition including the annual regional increases in fees. An area for improvement was made to ensure that individual written patient agreements are kept up to date.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management of incidents, management of complaints, quality improvement and with maintaining good working relationships. Further good practice was identified in relation to the management of patients' monies and valuables, including the availability of deposit and expenditure receipts, records of the reconciliation (checks) of monies and valuables, the administration of the patients' comfort fund and patients' personal property records.

Areas for improvement

The following areas were identified for improvement in relation to ensuring that there is a record of the personal possessions brought by each patient into their rooms and that these records are reconciled quarterly; ensuring that treatment records contain the required information as set out in the Care Standards for Nursing Homes (2015) and ensuring individual written patient agreements are kept up to date.

	Regulations	Standards
Total number of areas for improvement	1	3

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Violeta Bote, deputy manager and Elaine McShane, regional 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 19 (2) Schedule 4 (10) **Stated:** First time **To be completed by:** 02 October 2019	The registered person shall ensure that a record is made of the furniture and personal possessions which each patient brings into the room occupied by them. Ref: 6.6
	Response by registered person detailing the actions taken: Supervision sessions have been carried out with all care and trained staff regarding the completion of records of funiture and personal possessions. A record will be made of all furniture and personal posessions belonging to each patient on admission to the home.
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 14.26 **Stated:** First time **To be completed by:** 02 October 2019	The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 6.6
	Response by registered person detailing the actions taken: Supervision sessions have been carried out with all care and trained staff regarding residents' inventory of possessions and quarterly reconciliation of property. A reconciliation has taken place with current resident's property. This reconciliation is recorded in each resident's care notes and going forward will be reconcilied each quarter.
Area for improvement 2 **Ref**: Standard 14.13 **Stated:** First time **To be completed by:** 22 August 2019	The registered person shall ensure that where any service is facilitated within the home (such as, but not limited to, hairdressing, chiropody or visiting retailers) the person providing the service and the patient or a member of staff of the home signs the treatment record or receipt to verify the treatment or goods provided and the associated cost to each patient. Ref: 6.6
	Response by registered person detailing the actions taken: Nursing staff will countersign the chiropody receipts and hairdresser's list upon delivery of these services.

Area for improvement 3 **Ref**: Standard 2.8 **Stated:** First time **To be completed by:** 02 October 2019	The registered person shall ensure that any changes to the individual agreement are agreed in writing by the patient or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the patient or their representative is unable to or chooses not to sign the revised agreement, this is recorded. Ref: 6.6
	Response by registered person detailing the actions taken: The 2019 terms and conditions are being reviewed at corporate level and will be issued once received to every resident and/or representative.
Area for improvement 4 **Ref**: Standard 44.14 **Stated:** First time **To be completed by:** 4 September 2019	The registered person shall ensure that the provision made for patients who smoke does not impede on the comfort of other patients accommodated in the home. Ref: 6.3
	Response by registered person detailing the actions taken: Residents in the Mental Health Unit will continue to be encouraged to smoke around the corner from any bedrooms. This will be monitored by the staff in the unit and by the Home Manager.
Area for improvement 5 **Ref**: Standard 30 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that oxygen therapy is delivered to patients in a safe manner in that oxygen cylinders are not left freestanding and that the appropriate signage is in use. Ref: 6.3
	Response by registered person detailing the actions taken: Supervision sessions carried out with all trained staff regarding safe use of oxygen cylinders in the home. All cylinders in the home have been reviewed and are now not left free standing and have appropriate signage in use.
Area for improvement 6 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 21 September 2019	The registered person shall ensure that supplementary care records in relation to personal care delivery are consistently completed contemporaneously to reflect actual care given or offered and that the care given/offered is reflective of the patient's care plan. Ref: 6.4
	Response by registered person detailing the actions taken: Supervisions sessions carried out with all trained and care staff regarding the completion of supplementary care records in relation to personal care delivery. This is being monitored by the sisters in each unit as well as the Home Manager.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

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