Unannounced Care Inspection Report
28 and 29 July 2016

Tennent Street

Type of Service: Nursing Home
Address: 1 Tennent Street, Belfast, BT13 3GD
Tel No: 028 9031 2318
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Balmoral and Sandhurst units of Tennent Street care Home took place on 28 July from 09.30 to 16.40 hours and 29 July 2016 from 09.30 hours to 14.30 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 appraisal and staff supervision systems, staff meetings and staff were required to attend a 'handover meeting' when commencing duty.

The environment of the home was bright and attractive with new furnishings having been purchased to enhance the appearance of the environment.

There were no requirements or recommendations made.

Is care effective?

There was evidence of positive outcomes for patients. All staff demonstrated a high level of commitment to ensuring patients received the right care at the right time. Each staff member understood their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals. Recommendations have been made regarding the care planning process, the involvement of patients in the planning of care, as applicable and affording patients in Sandhurst unit the opportunity to come together, as a group, and comment on and/or plan the services provided by the home. Compliance with these recommendations will further drive improvements in this domain.

There were three 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.

The level of engagement in activities from both patients and staff was evidently having a positive impact on the patients' experience in the home despite the unavailability of an activities coordinator. There was evidence of the transfer of information in the home through the various notice boards in the home, including patients' bedrooms.

There were no requirements or recommendations made.

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

Discussion with the registered manager and staff; and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

As discussed in the preceding sections it was evident that the registered manager had implemented and managed systems of working within the home which were patient focused, impacted positively of the patient experience and involved and encouraged staff, relatives and visitors to participate in the daily life of the home. The registered manager was available to patients and their relatives and operated an 'open door' policy for contacting her. Representatives also commented on the high visibility of the registered manager in the various registered units that comprise Tennent Street Care Centre.

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	0	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Jackie Cairns, 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.

1.2 Actions/enforcement taken following the most recent type e.g. care inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 26 May 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.

There were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered provider: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Jacquelyn Grace Cairns
Person in charge of the home at the time of inspection: Jackie Cairns	**Date manager registered:** 1 April 2005
Categories of care: NH-A, NH-DE	**Number of registered places:** 27

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, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with 18 patients, three care staff, ancillary staff, two registered nurses and one relative.

Questionnaires for patients (8), relatives (10) and staff (10) to complete and return were left for the home manager to distribute. Please refer to section 4.5 for further comment.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspectors.

The following were examined during the inspection:

- validation evidence linked to the previous QIP
- staff roster
- patient care records
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- staff supervision and appraisal planner
- complaints and compliments records
- incident and accident records
- records of quality audits and
- records of staff, patient and relatives meetings

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 27 May 2016

The most recent inspection of the home was an unannounced medicines management inspection. There were no requirements or recommendations made as a result of the inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 28 January 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 4.9 **Stated:** First time **To be Completed by:** 15 March 2016	The registered person shall ensure registered nurses evidence the monitoring of patients bowel function in care records.	**Met**
	Action taken as confirmed during the inspection: The review of four patient care records evidenced that registered nurses were monitoring patients' bowel function on a daily basis. Evidence was present of treatment being administered, where appropriate.	

4.3 Is care safe?

The registered 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. Review of the staffing rota from 25 July 2016 to 7 August 2016, evidenced that the planned staffing levels were adhered to. Discussion took place with the registered nurses regarding senior cover for the three nursing units in Tennent Street, in the absence of the registered manager. Staff confirmed that there is a registered nurse in charge of each unit one of whom was designated the senior nurse in charge. The registered manager had established a reference file for senior cover that contained information relating to, for example; duty rosters for the three units, a senior report pertaining to each unit, maintenance related information, contact telephone numbers for the adult safeguarding teams and unit fire lists. This was good practice.

Discussion with patients, representatives 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 levels and skill mix of staff on duty.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff were mentored by an experienced member of staff during their induction. Records for three staff members were reviewed and found to be completed in full and dated and signed appropriately. The registered manager had signed the induction records to validate the satisfactory completion of the induction for the staff members.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Staff training was delivered by combining an e-learning programme and face-to-face training in the home. Training outcomes for 2016, so far, indicated that the registered manager was monitoring staff compliance with mandatory training requirements. For example, 100 percent compliance had already been achieved in infection prevention and control procedures and 94 percent in first aid awareness; the overall compliance level for mandatory training was 88 percent. The registered manager had a system to alert the nurse in charge of each unit for staff who had not completed their training. Staff are given a timeframe to complete any outstanding training and if not done so the staff member responds directly to the registered manager. 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 registered manager confirmed that staff had also completed a range of other training areas provided by the local trust including; stoma care, the management of a patient with Huntingdon's disease, enteral feeding, the management of subcutaneous fluids and training in respect of palliative and end of life care.

Staff of Balmoral unit had recently completed the Dementia Care Framework training. The training focused on helping staff understand dementia from the perspective of a person with dementia. Training included 'experiential' sessions whereby staff were enabled to experience for themselves what it is like to have a cognitive and/or sensory impairment. Families and representatives were also invited to attend training sessions and a number of relatives did.

Staff commented that they were 'given more insight into dementia especially in relation to communicating with others' and 'I can see a difference in how relatives respond to us following the training.' A relative commented that he was impressed with staff as 'staff spend time talking to patients.'

Discussion with the registered 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 registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and the review of staff training records confirmed 98 percent of staff had completed training in respect of adult safeguarding procedures. A review of documentation confirmed that any potential safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were also notified appropriately.

Review of 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.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of the Nursing Home Regulations (Northern Ireland) 2005. Review of accidents/incidents records confirmed that notifications were forwarded to RQIA 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. The home was found to be warm, well decorated, fresh smelling and clean throughout. New furnishings had been purchased, areas of the home had been repainted and new flooring had been laid and the dining room and new curtains purchased. The courtyard areas of both units had been decorated and the fencing painted with a good effect. Patients and staff spoken with were complimentary in respect of the home's environment.

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.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

Review of four 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 regarding records and record keeping. Risk assessments informed the care planning process. The review of a patient's care record in Balmoral unit evidenced the need to further develop the interventions in the care plan which referred to a distressed reaction which the patient periodically displayed in order to protect the dignity of the individual. A recommendation has been made. Care records evidenced that, where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that care was delivered and records were maintained in accordance with best practice guidance, care standards and legislative requirements. Care records were computerised documents and staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to access of the records.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and included regular communication with representatives within the care records. However, in Sandhurst unit a consistent approach to the collaboration with patients regarding planned care was not in evidence. This was discussed with the registered manager and the nurse in charge of Sandhurst who agreed to address this area. A recommendation has been made.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff also confirmed that staff meetings were held, that they could contribute to the agenda and the meeting and minutes were available. The review of the minutes of staff meetings evidenced that, as was found in Sandringham unit, the frequency of planned staff meetings was not regular. However, the staff team was a small well-established and stable team and staff confirmed they found the level of communication from the registered manager and registered nurses to be very good and clarified what was expected of them. Staff also stated the registered manager was receptive and encouraged their ideas.

Staff stated they knew they worked together effectively as a team and had strong communication skills. Comments such as, 'Everyone, patients and staff all work together,' and 'This is a great place to work,' were received. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients spoken with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives were aware of who their named nurse, named worker and the name of the registered manager as this information was displayed on a notice board in each patient's bedroom.

There was information available to staff, patients and representatives in relation to advocacy services, the home's complaints procedure, the menu and the availability of the annual quality report and monthly quality monitoring reports displayed on the information board in each unit.

Staff communicate with relatives on a one to one basis. Family meetings had previously been held and were recorded. The information in relation to these meetings is now directly inputted onto the patient's computerised care records. This information was reviewed and provided evidence that the care needs of patients were discussed with the patient or the patient's representative.

The opinion of patients regarding the quality of services provided by the home is completed by the registered manager using the organisations electronic quality assurance tool, quality of life indicators (QoL). Refer to section 4.5 for further information. However, as discussed with the nurse in charge of Sandhurst unit, patients may wish to have the opportunity to discuss collectively the issues relevant to them. Therefore, a recommendation has been made that patient or unit meetings commence in Sandhurst unit, at a frequency decided by the patients, until such times as patients feel the meetings are not of benefit.

Observation of the mid-day meal arrangements was reviewed. Dining tables were attractively set, a range of condiments were available and patients, including patients who required a therapeutic diet, were afforded a choice of meals at mealtimes. Meals were delivered on trays to patients who choose to not come to the dining room, the meal was appropriately covered and condiments and the patients preferred choice of fluid, for example; juice or milk were on the tray. Staff confirmed a registered nurse was present in the dining room to assist and monitor patients' nutritional intake.

Areas for improvement

The auditing of care records should ensure that care interventions, stated in care plans, accurately define the actions to be taken by staff to meet an individual's assessed need and are framed to reflect the core values of privacy, dignity and respect. (Balmoral unit)

Evidence should be present in patients care records that patients have been consulted regarding the planning of their care. (Sandhurst unit)

Patient or unit meetings should commence, at a frequency decided by the patients, until such times as patients feel the meetings are not of benefit. (Sandhurst unit)

Number of requirements	**0**	**Number of recommendations**:	**3**

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. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients in Balmoral unit 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.

On this occasion the arrangements for the provision of activities was not assessed and will be reviewed at the next inspection. However, staff in Balmoral unit were observed chatting to patients in the lounge and responding to the patients on an individual basis. Staff engaged with patients in a sensitive and caring manner over a considerable period of time and as previously stated in section 4.3 a relative commented on how pleased they were that staff actually spent time talking to and being with patients. The personal activities leader (PAL) was on leave and in the absence of the PAL staff in Sandhurst unit were ensuring patients had some form of activity on a daily basis, as was evident at the time of the inspection.

The registered manager had displayed the cumulative responses from the quality of life auditing programme from February 2016 to May 2016 in the unit. The responses from patients, visiting professionals, friends of the home and relatives included the below.

Comments from friends of our home:
'The home is lovely and smells beautiful, the staff are very helpful and caring offering drinks to all visitors.'
'I see Jackie, the manager, out and around the unit all the time and I know I can say anything to her.'

Comment from a relative:
'The staff are excellent, they have looked after my relative for 10 years, and they're worth their weight in gold.'

Comments from a visiting professional:
'Staff members are always smiling and helpful in all aspects.'
'Everything is well organised.'

Comments from patients included:
'A great place to live.'
'I feel safe and cared for.'
'Staff are very good.'

Questionnaires

In addition 10 relative/representatives; eight patient and 10 staff questionnaires were provided by RQIA to the registered manager for distribution. At the time of issuing this report, two patients, four staff and three relatives returned their questionnaire within the specified timeframe. The returned questionnaires were generally positive regarding the quality of nursing and other services provided by the home.

One staff member included the comment, 'We have done the dementia care framework (DCF) and it really helps to know how the residents with dementia feel.'

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 registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients knew the staff in the home and whom they should speak to if they had a concern.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed. Discussion with the registered manager and observations evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and review of the home's complaints record 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. Representatives spoken with and who responded by questionnaire, confirmed that they were aware of the home's complaints procedure. Staff and representatives confirmed that they were confident that staff and management would manage any concern raised by them appropriately.

Discussion with the registered 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. A review of notifications of incidents to RQIA since the last care inspection in December 2015 confirmed that these were managed appropriately.

Discussion with the registered manager and staff as well as a review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints and incidents/accidents. 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. The organisations governance arrangements include a range of other audits to be completed as well as the audits listed above. For example, the registered manager completes, on a monthly basis, audits in relation to housekeeping, the use of bed rails (there are no bedrails in use in Tennent Street Care Home), restrictive practice and a health and safety walk around audit.

On a daily basis the registered 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 (refer to section 4.5 for an example of some electronic comments received). 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 audit completed in the home are also reviewed by the regional manager when completing the monthly quality monitoring visit.

Discussion with the registered manager and review of records for March, April and May 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, as discussed in the previous sections.

Also, as discussed in the preceding sections, it was evident that the registered manager maintained a highly visible profile in the home and had implemented and managed systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff to participate in the life of the home. The registered manager was available to patients and their, relatives and operated an 'open door' policy for contacting her and she provided staff with a positive role model for their practice and attitude.

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 Jackie Cairns, Registered 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 The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The 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 for review 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

Recommendations	
Recommendation 1 **Ref:** Standard 4.2 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that the auditing of care records includes a review of the care interventions, stated in care plans. The interventions should accurately define the actions to be taken by staff to meet an individual's assessed need and are framed to reflect the core values of privacy, dignity and respect. (Balmoral unit) **Ref: section 4.4**
	Response by registered provider detailing the actions taken: The care plan in question was reviewed to reflect the individuals core values of privacy , dignity and respect
Recommendation 2 **Ref:** Standard 4.5 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that patients care records evidence that patients, as applicable have been consulted regarding the planning of their care. (Sandhurst unit) **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Patients as applicable have now been consulted regarding planning their care
Recommendation 3 **Ref:** Standard 7.1 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that patient or unit meetings commence, at a frequency decided by the patients, until such times as patients feel the meetings are no longer of benefit. (Sandhurst unit) **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Unit patients meeting have commenced and frequency of same will be decided by the patients

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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