



Unannounced Care Inspection Report

4 March 2019



Tennent Street

Type of Service: Nursing Home (NH)
**Address: Balmoral and Sandhurst Suites, 1 Tennent Street,
Belfast, BT13 3GD**
Tel No: 028 9031 2318
Inspector: Kieran McCormick

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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.

1.0 What we look for



2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 27 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care Responsible Individual(s): Maureen Claire Royston	Registered Manager: Methyl Dagooc
Person in charge at the time of inspection: Methyl Dagooc	Date manager registered: 7 December 2018
Categories of care: Nursing Home (NH) DE – Dementia A – Past or present alcohol dependence.	Number of registered places: 27 There shall be a maximum of 14 persons in category NH-DE located in the Balmoral Suite and a maximum of 13 persons in category NH-A located in the Sandhurst Suite. The home is also approved to provide care on a day basis to 1 person in the Balmoral Suite.

4.0 Inspection summary

An unannounced inspection took place on 4 March 2019 from 10.30 to 16.00 hours.

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 Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and 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 the holistic culture and ethos of care delivery; communication between staff, patients and relatives; the dining experience of patients and governance arrangements. Other notable areas of good practice were also found in relation to the environment, teamwork, understanding of roles and responsibilities and completion of Regulation 29 monitoring visits.

No areas for improvement were identified during this inspection.

Patients described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. There was evidence that the management team listened to and valued patients and their representatives and taking account of the views of patients.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Methyl Dagooc, registered manager and Lorraine Kirkpatrick, regional manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 20 November 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 20 November 2018. Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 20 November 2018.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- pre-inspection audit.

During the inspection we met with six patients and six staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten patients' questionnaires and ten patients' relatives/representatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. We provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision. A poster informing visitors to the home that an inspection was being conducted was displayed in the nursing home.

The following records were examined during the inspection:

- duty rota for all staff for weeks beginning 25 February and 4 March 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

- two staff recruitment and induction files
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 the most recent inspection dated 20 November 2018

The most recent inspection of the home was an unannounced care inspection.

The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 20 November 2018

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 19 (5) Stated: Second time	The registered person shall ensure that confidential patient records/information are maintained in accordance with best practice guidance and legislative requirements.	Met
	Action taken as confirmed during the inspection: Observations observed on the day of inspection confirmed that confidential patient information was maintained in accordance with best practice guidance.	

Area for improvement 2 Ref: Regulation 27 (4) Stated: First time	The registered person shall ensure that the practice of wedging fire doors in the home is ceased.	Met
	Action taken as confirmed during the inspection: Observations of the environment confirmed that magnetic holds had been fitted to previously identified doors. There was no evidence of a common practice of wedging of doors observed.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 Ref: Standard 4 Stated: First time	The registered person shall ensure that patients care plans and risk assessments are consistency reviewed/evaluated in accordance with individual patient need and in keeping with policy and procedure.	Met
	Action taken as confirmed during the inspection: Review of patient care records confirmed that care plans and risk assessments had been consistently reviewed/evaluated.	
Area for improvement 2 Ref: Standard 4 Stated: First time	The registered person shall ensure that a person centred care plan is devised for those patients at risk of dehydration and whom the home identify as consistently not meeting their daily fluid intake target.	Met
	Action taken as confirmed during the inspection: Review of patient care records confirmed, that where applicable, an individualised care plan had been devised which included the assessed daily fluid target for the patient. Fluid intake records reviewed were consistently maintained and total fluid intake was reviewed daily by a registered nurse.	

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.

The registered manager confirmed the planned daily staffing levels for the home. A review of the staffing duty rota for all staff for weeks beginning 25 February and 4 March 2019 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Staff who met with the inspector were satisfied that there was sufficient staff on duty to meet the needs of the patients. Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Tennent Street.

Review of two staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work. 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.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with NISCC.

We discussed the provision of mandatory training with the registered manager and reviewed staff training records. Training records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients.

Review of three patients care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

We reviewed accidents/incidents records and noted that records were maintained appropriately and notifications were submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounge, dining room and storage areas. The home was found to be warm, fresh smelling and clean throughout. Fire exits and corridors were observed to be clear of clutter and obstruction. The home is to be commended on the efforts made to enhance the environment and experience for patients.

Observation of practices, care delivery, discussion with staff and review of records evidenced that infection prevention and control best practice guidance was consistently adhered to.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, staff management, training, the home's environment, infection prevention and control practices, governance and risk management.

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.

Review of three patients' care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patients. Care plans were person centred and were evaluated monthly.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), speech and language therapists (SALT) and dieticians. Supplementary care charts such as food and fluid intake records evidenced that contemporaneous records were maintained. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff were able to describe the arrangements for staff/team meetings provided in the home.

There was evidence of regular communication with representatives within the care records.

Patient spoken with expressed their confidence in raising concerns with the home's staff/management.

There was information available to patients and their representatives in relation to advocacy services.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to liaising with other members of the multi-professional team, teamwork and communication between patients and staff.

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 arrived in the home at 10.30 hours and were greeted by staff who were helpful and attentive. Patients were observed seated in the lounge areas or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice and staff were observed assisting patients to enjoy their chosen activity and to eat and drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. It was reassuring to observe how members of support staff in the home also had understanding of patients' individual needs. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality. Discussion with the registered manager and staff confirmed that communication with patients often required a highly knowledgeable and focused approach due to patients' varying care needs. Observation of staff interaction with patients evidenced the provision of such care and this is commended.

Discussion with patients and staff and review of the activity programme displayed evidenced that arrangements were in place to meet patients' social needs within the home. We observed morning and afternoon activities taking place in the home.

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.

We observed the serving of the lunchtime meal. Patients were assisted to the dining room or had trays delivered to them as required. Staff were observed assisting patients with their meal appropriately and a registered nurse was overseeing the mealtime. Condiments were available for patient use if required. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes.

Cards and letters of compliment and thanks were displayed in the home. There were systems in place to obtain the views of patients and their representatives on the running of the home. Feedback received from a relatives survey was displayed.

Consultation with six patients individually, and with others in smaller groups, confirmed that they were happy and content living in Tennent Street. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

There were no responses received from questionnaires left on the day of inspection.

Staff were asked to complete an online survey; we had no completed responses within the timescale specified.

Any comments from patients, patient representatives and staff in returned questionnaires received before or after the return date were shared with the registered 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, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients, the meal time experience, staff knowledge of patients' wishes, preferences and assessed needs.

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.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. All staff spoken with were able to describe their roles and responsibilities and confirmed that there were good working relationships within the home. Staff also stated that management was responsive to any suggestions or concerns raised.

The certificate of registration issued by RQIA was appropriately displayed in the home. The registered manager was knowledgeable in regards to the registered categories of care for the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered. A valid certificate of employer's liability insurance was also displayed.

Since the last inspection there have been no changes in management arrangements. Discussion with staff/patients/representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015. The complaints procedure was displayed in areas throughout the home.

Discussion with the registered manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, IPC practices and care records. In addition, robust measures were also in place to provide the registered manager with an overview of the management of wounds, restraint and use of bed rails.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis on behalf of the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.



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