Unannounced Care Inspection Report
2 May 2017

Domnall

Type of Service: Nursing Home
Address: 48-50 Old Dundonald Road, Belfast, BT16 2EH.
Tel No: 02890419796
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Domnall took place on 2 May 2017 from 09:50 hours to 17:00 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment. Observation of the delivery of care and discussion with patents and staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Infection prevention and control measures were adhered to. Sluice rooms and bathroom/toilets were observed to be clutter free and well organised. A recommendation was made that a check should be completed on all pedal operated bins and any which are broken should be replaced.

We discussed the management of fire safety and observed that fire exits and corridors were observed to be clear of clutter and obstruction.

Is care effective?

We reviewed three care records. One patient, who was receiving long term care, had care records which were regularly reviewed and contained good details of patients' individual needs and preferences.

A review of care records for two patients admitted for intermediate care evidenced improvements were required to ensure that patients were comprehensively assessed at the time of admission to the home and care plans created for all assessed needs. Two recommendations were made. We were assured that the registered manager was aware of the weaknesses in record keeping and that systems would be implemented to ensure the necessary improvements would be made.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. We observed good recording systems to ensure that recommendations and treatment plans by visiting healthcare professionals, for example physiotherapists and occupational therapists, were clearly communicated to staff and patients. Patients were well informed regarding their treatment plans and timeframes for discharge.

Is care compassionate?

We arrived in the home at 09:50 hours. There was a calm atmosphere and staff were busy attending to the needs of the patients. We observed staff knock bedroom doors prior to entering; this included bedroom doors which were open. Patients confirmed that they had been asked how they wished to be addressed/preferred name; this information was clearly displayed in their bedroom.

Discussion with patients individually and with others in smaller groups, confirmed that the care they were receiving in Domnall was making a positive contribution to their recovery and discharged plans. All of the patients spoke highly of the staff. A number of their comments are included in the report.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. The registered manager explained that the feedback questionnaires had recently been reviewed to include a range of questionnaire specifically for patients receiving intermediate care.

We issued ten questionnaires to relatives, nursing, care and ancillary staff; none were returned prior to the issue of this report.

There were no areas for improvement identified in this domain.

Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

The registered manager's hours were clearly recorded and discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. As previously discussed it is planned that the frequency of care record auditing will be increased following implementation of new documentation. This will help insure that the required improvements to record keeping will be made.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the regional manager. A copy of the quality monitoring reports were available in the home.

There were no areas for improvement identified in this domain.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**3***

*The total number of recommendations includes one recommendation which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Leeanna Bonner, registered manager and Alana Irvine, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 1 December 2016. There were no further actions required to be taken following the most recent 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.

2.0 Service details

Registered organisation/registered provider: Four Seasons Healthcare Maureen Claire Royston	**Registered manager:** Leeanna Bonar
Person in charge of the home at the time of inspection: Leeanna Bonar	**Date manager registered:** 5 November 2012
Categories of care: 52	**Number of registered places:** NH-I, NH-PH, NH-PH(E)

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with 13 patients individually and with the majority in small groups, one nursing sister, one registered nurse, six care staff, one domestic, the personal activity leader (PAL) and two resident's visitors/representative.

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 inspector.

Questionnaires were also left in the home to facilitate feedback from relatives and staff not on duty. Ten, staff and patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- Duty rota for all staff for the week of the inspection
- 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 files
- competency and capability assessments of nurses
- staff register
- four patient care records
- record of staff meetings
- patient register
- complaints record
- record of audits
- RQIA registration certificate
- certificate of public liability
- monthly monitoring reports.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 1 December 2016

The most recent inspection of the home was an unannounced medicines management inspection.

There were no issues identified during this inspection, and a QIP was neither required, nor included, as part of this inspection report.

4.2 Review of requirements and recommendations from the last care inspection dated 17 June 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 21(1)(a) **Stated:** First time	The registered person must ensure that all of the information required in regard to the selection and recruitment of staff is obtained prior to the commencement of employment.	**Met**
	Action taken as confirmed during the inspection: A review of two recruitment files evidenced that all of the information required in regard to the selection and recruitment of staff was obtained prior to the commencement of employment. This requirement has been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 4.1 **Stated:** First time	It is recommended that a comprehensive assessment to identify patient need should be completed for all patients on admission.	**Not Met**
	Action taken as confirmed during the inspection: A review of three care records evidenced that only one had a comprehensive assessment completed on admission. This recommendation is assessed as not met and is stated for a second time. Care records are further discussed in section 4.4 of this report.	
Recommendation 2 **Ref**: Standard 16.11 **Stated:** First time	It is recommended that the record of complaints is further developed to include how complainants' level of satisfaction was determined.	**Met**
	Action taken as confirmed during the inspection: A review of recorded complaints evidenced that this recommendation has been met.	

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. A review of the staffing rota for week commencing 1 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping

were on duty daily. A Personal Activity Leader (PAL) was employed to deliver activities. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients and relatives spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in timely manner.

We sought relatives' and staff opinion on staffing via questionnaires; none were returned in time for inclusion in this report.

A nurse was identified on the staffing rota to take charge of the home when the registered manager was off duty; this information was also clearly displayed in the foyer of the home to inform visitors who was in charge when they arrived in the home. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

Staff recruitment records were available for inspection and, as previously discussed, were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

A record of staff including their name, address, date of birth, position held, contracted hours, NMC registration number of registered nurses, date commenced and date position was terminated (where applicable) was held in a register and provided an overview of staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager. A review of the records of NMC registration evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The record of the checks of care staff registration did not include the expiry date of their registration with NISCC. The administrator explained that they received an e mail from the NISCC to alert them when a staff member's registration was due for renewal. We discussed the benefits of including the individual expiry dates for staff as an additional safeguard. It was agreed that the record would be updated to include these dates.

The registered manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe.

We discussed the provision of mandatory training with staff and reviewed the training records for 2016/2017. Training records evidenced good compliance; for example all staff had completed fire safety training, safeguarding and infection prevention and control in the past 12 months. Mandatory training compliance was monitored by the registered manager.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

Review of three patient care records evidenced that validated risk assessments were completed as part of the admission process and reviewed as required. However a full range of risk of assessments had not been completed at the time of admission to the home for one patient. This is further discussed in section 4.4.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since January 2017 confirmed that these were appropriately managed. 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.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment.

Infection prevention and control measures were adhered to. We spoke with one member of housekeeping staff who were knowledgeable regarding the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths. Sluice rooms and bathroom/toilets were observed to be clutter free and well organised. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately. We observed a number of the pedal operated bins were damaged and could not be opened by foot. To ensure adherence with good infection prevention and control practice a check should be completed on all pedal operated bins and any which are broken should be replaced. A recommendation was made.

We discussed the management of fire safety and observed that fire exits and corridors were observed to be clear of clutter and obstruction. The weekly testing of the fire alarm was completed during the inspection. It was good to note that patients, staff and visitors were made aware that the fire alarms were being tested prior to the alarms being activated.

Areas for improvement

To ensure adherence with good infection prevention and control practice a check should be completed on all pedal operated bins and any which are broken should be replaced.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

We reviewed three care records. One patient, who was receiving long term care, had a comprehensive assessment of need and a range of validated risk assessments completed. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

A review of care records for two patients admitted for intermediate care evidenced that a pressure damage risk assessment, malnutrition universal screening tool (MUST) and an oral risk assessment were completed at the time of admission for one patient. There had been no further assessments completed at the time of the inspection, more than a week after the patient's admission. A number of care plans were in place. Another patient admitted for intermediate care had no risk assessments completed at the time of admission to the home; a range of risk assessments were completed on the fifth day following admission. Care plans were not in place for all needs identified in the risk assessments. An assessment to identify daily need had not been completed for either patient.

A recommendation was made as a result of the previous inspection that a comprehensive assessment to identify patient need should be completed for all patients on admission. This recommendation has not been met and is stated for a second time. A further recommendation is made to ensure that individual care plans are in place to direct the care required to meet the patient's assessed needs.

We discussed the weaknesses identified in record keeping with the registered manager and regional manager and established that in the 10 days prior to the inspection there had been an unusually high number of admissions and discharges to the intermediate care scheme; there had been 16 admissions and 19 discharges. The registered manager explained that, following a recent review of the assessment and care planning processes for intermediate care, new documentation had been piloted and was due to be implemented in the next few weeks. The regional manager confirmed that the frequency of auditing would be increased in the initial period following implementation. We were assured that the registered manager was aware of the weaknesses in record keeping and that systems would be implemented to ensure the necessary improvements would be made.

We observed that care was delivered to patients admitted for intermediate care with support from a range of healthcare professionals such as physiotherapist and occupational therapists. The registered manager confirmed that multidisciplinary meetings were held weekly to review the care and progress of patients receiving intermediate care.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians. Care management reviews for patients receiving long term care were arranged by the relevant health and social care trust. These reviews could be held in response to a change to patient need and as a minimum annually. They could also be requested at any time by the patient, their family or the home. There was evidence within the care records of regular, ongoing communication with relatives.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

We observed good communication and recording systems to ensure that recommendations and treatment plans by visiting healthcare professionals, for example physiotherapists and occupational therapists, were clearly communicated to staff and patients. Patients were well informed regarding their treatment plan and timeframes for discharge. Staff reported that there was effective teamwork and that if they had any concerns, they could raise these with the nurse in charge or the registered manager

The registered manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting was held on 28 April 2017 with registered nurses and 30 April 2017 with care staff.

A record of patients including their name, religion, address, date of birth, marital status, religion, date of admission, date they left the home (where applicable) and details of where they were transferred to, details of death (where applicable) and the name of the public body responsible for arranging each patients admission was held in a patient register. This registered provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

A comprehensive assessment to identify patient need should be completed for all patients on admission.

Individual care plans should be in place to direct the care required to meet all of the patient's assessed needs.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

We arrived in the home at 09:50. There was a calm atmosphere and staff were busy attending to the needs of the patients. The majority of patients were in their bedrooms as was their personal preferences; some patients remained in bed, again in keeping with their personal preference. We observed staff knock bedroom doors prior to entering; this included bedroom doors which were open. Patients confirmed that they had been asked how they wished to be addressed/preferred name; this information was clearly displayed in their bedroom.

Discussion with patients individually and with others in smaller groups, confirmed that the care they were receiving in Domnall was making a positive contribution to their recovery and discharged plans. Patients who were convalescing prior to commencing a rehabilitation programme were satisfied that they were receiving care to support them in their recovery and prepare them for active rehabilitation when the time was right. These patients were well informed regarding the date of their next hospital appointment/review. All of the patients spoke highly of the staff. Patients and staff confirmed that when they raised a concern or query, they were taken seriously and their concern/query was responded to appropriately.

The following are examples of comments provided:

"Very different atmosphere to hospital and the food is much better."
"A very homely place."
"I couldn't fault the care in anyway."
"They could do with bigger beds, its hard to get used to a single bed."

Activities were provided throughout the day for all patients. On the morning of the inspection a number of ladies were engaged in making picture frames and felt flowers. It was obvious from the interactions between patients and the Personal Activity Leader (PAL) that they were enjoying the opportunity to socialise whilst attempting the crafts. The activity room was a

bright airy room which was nicely decorated. Patients all commented positively regarding the range of activities.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. The home continues to use the "Quality of Life" system which patients, relatives/visitors and staff can access through the portable iPad available in the reception of the home. The registered manager explained that the feedback questionnaires had recently been reviewed to include a range of questionnaire specific to patients receiving intermediate care. When feedback is submitted via the Quality of Life system the registered manager receives notification and they review the feedback provided. An overview report of the number of feedbacks received and the outcomes was available. Any complaints received via the "Quality of Life" system would also be recorded in the record of complaints and addressed through the complaints process.

We issued ten questionnaires to relatives, nursing, care and ancillary staff; none were returned prior to the issue of this report.

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

Areas for improvement

No areas for improvement were identified with the delivery of compassionate care during the inspection.

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

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.

Discussion with the registered manager and 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 DHSSPS Care Standards for Nursing Homes 2015.

The registered manager confirmed that monthly audits were completed, for example wound analysis, medication and care records. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement. As previously discussed in section 4.4 due to the imminent introduction of new documentation for the assessment and care planning for patients admitted for intermediate care the frequency of

care record auditing will be increased in the initial period following implementation. This will help insure that the required improvements to record keeping will be made.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

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.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the regional manager. An action plan was included within the report to address any areas for improvement. There was evidence that the action plan was reviewed at the next visit. A copy of the quality monitoring reports were available in the home.

Areas for improvement

No areas for improvement were identified within this domain 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 the QIP were discussed with Leeanna Bonner, registered manager and Alana Irvine, regional 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/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment 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

Statutory requirements: No statutory requirements were made as a result of this inspection.

Recommendations	
Recommendation 1 **Ref**: Standard 4.1 **Stated:** Second time **To be completed by:** 30 May 2017	It is recommended that a comprehensive assessment to identify patient need should be completed for all patients on admission. **Ref section 4.2 & 4.4**
	Response by registered provider detailing the actions taken: Comprehensive assessments are now being carried out on admission and reviewed for compliance through the audit process on day 5 following admission to ensure best practice guidelines are being adhered to.
Recommendation 2 **Ref**: Standard 46 **Stated:** First time **To be completed by:** 30 May 2017	The registered provider should check all pedal operated bins to ensure they can be opened by foot. Any which are broken should be replaced. **Ref section 4.3**
	Response by registered provider detailing the actions taken: All broken pedal bins have now been replaced.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 30 May 2017	The registered provider should ensure that individual care plans are in place to direct the care required to meet the patients' assessed needs. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Systems are now in place to ensure all patient's have care plans in place to direct the care required to meet their assessed needs. This will be reviewed through the audit process and an action plan put in place to address any deficits with an agreed timeframe to complete.

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