The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
17 June 2016

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 17 June 2016 from start time 09:45 to 18:15 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?

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 and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

Deficits were identified with the online recruitment processes. A requirement was made.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that that the outcome of care delivery was positive for patients. Records evidenced that care was planned and delivered with support from a range of healthcare professionals, for examples physiotherapists and occupational therapists. Discussion with patients and observations made confirmed that there was a programme of active rehabilitation. There were arrangements in place to monitor and review the effectiveness of care delivery.

We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Patients and staff were of the opinion that the care delivered provided positive outcomes.

One area for improvement was identified to ensure that all patients had a comprehensive assessment of need completed at the time of their admission. A recommendation was made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding day to day issues affecting them. Patients spoken with commented positively in regard to the care they received.

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure and staff were aware of their roles and responsibilities. A review of care confirmed that the home was operating within the categories

of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide. There was evidence of good leadership in the home and effective governance arrangements.

An area for improvement was identified with the recording of complaints. A recommendation was 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 DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**1**	**2**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Leanna Bonner, 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 announced care inspection undertaken on 22 October 2015. 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.

An SAI investigation was undertaken by the South Eastern Health and Social Care Trust in February 2016 and recommendations were made. It is the responsibility of the relevant health and social care trust to ensure recommendations they make are adhered to. However, where issues have the potential to be breaches of regulations or associated standards RQIA will review the issues through our inspection process. Following a review of care records we concluded that the recommendations have been complied with. Please refer to section 4.4 of this report.

2.0 Service details

Registered organisation/registered provider: Maureen Claire Royston	Registered manager: Leanna Bonar
Person in charge of the home at the time of inspection: Leanna Bonar	**Date manager registered:** 1 October 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 eight patients individually, two registered nurses, nine care staff, personal activity leader (PAL), the cook, a visiting professional and two patients' visitors/representative.

Ten questionnaires were issued to patients, relatives and staff with a request that they were returned within one week from the date of this inspection.

The following information was examined during the inspection:

- three patient care records
- staff duty roster for the week commencing 13 May 2016
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- reports of monthly quality monitoring visits

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 22 October 2015.

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 22 October 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32.1 **Stated:** First time	It is recommended that a system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; and palliative and end of life care.	**Met**
	Action taken as confirmed during the inspection: Policies were available in the nursing office on both floors of the home. The registered manager explained that the home now had access to the "care blox" system; a multi-functional electronic communication system. Staff are required to log into this system at the beginning of each shift. A message, for example of a new updated policy or training, would appear to alert staff. Staff are asked to confirm that they have actioned the alert. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 32 **Stated:** First time	It is recommended that relevant information on support services should be further developed, to ensure that patients and their relatives have access to support services that are based in Northern Ireland.	**Met**
	Action taken as confirmed during the inspection: A range of leaflets, published by local organisations, for example Health and Social Care Board and local health and social care trusts were available in the home. This recommendation has been met.	

Recommendation 3 **Ref**: Standard 21 **Stated:** First time	It is recommended that patient's pain assessments are updated as appropriate and that care plans are reviewed in line with the outcomes of such risk assessments. **Action taken as confirmed during the inspection**: A review of care records evidenced that pain assessments were reviewed regularly and care plans in place as required. This recommendation has been met.	**Met**

4.3 Is care safe?

The registered manager confirmed the current occupancy of the home and the planned daily staffing levels. They advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 13 June 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic, laundry and maintenance staff were on duty daily. There was also a personal activity leader (PAL) employed full time. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients commented positively regarding the staff and care delivery.

The registered manager and registered nurses spoken with were aware of who was in charge of the home when the manager was off duty. The nurse in charge of each floor and the nurse in charge of the home in the absence of the registered manager was clearly identified on the staffing roster. The nurse in charge of the home was also displayed in the foyer.

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.

Discussion with the registered manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed. The registered manager was knowledgeable regarding the management of the Northern Ireland Social Care Council (NISCC) registration process for newly employed care staff.

The recruitment procedures were discussed with the registered manager and two personnel files were reviewed. The employee of the first file reviewed had applied for the post via Four Seasons Health Care (FSHC) online application system. It is required in accordance with The Nursing Homes Regulations (Northern Ireland) 2005, regulation 21(1)(b) that a full

employment history, together with a satisfactory written explanation of gaps in employment and reasons why the employment or position ended is obtained. This information was not included on the pro forma for online applications and therefore was not available for this employee. A requirement has been made. We were able to determine from additional records that a reference had been obtained for the person's present or most recent employer. All other information required under regulation was available. Confirmation was received via email on 20 June 2016 that a full employment history, together with reasons for the employment or positions ending had been obtained for the identified employee.

Prior to the conclusion of the inspection confirmation was received from the Head of Human Resources and Training for FSHC advising of the additional steps registered managers must complete at the time of interview to ensure that all of the information required under regulation is obtained for candidates who apply via the online process.

We reviewed one personnel file of an employee who had applied for a post by completing a hard copy application form. This file was maintained in accordance with regulation.

The record maintained of Access NI checks was reviewed. The records included the date the certificate was issued, the registration number of the certificate and that date the certificate was checked by the home. Records evidenced that the outcome of the Access NI check had been confirmed prior to the candidate commencing employment.

Discussion with the registered manager and staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme the registered manager signed the record to confirm that the induction process had been satisfactorily completed.

Training was available via an e learning system and internal face to face training arranged by FSHC. Whilst training opportunities were also provided by the local health and social care trust and external agencies such as The Royal College of Nursing (RCN). The registered manager had systems in place to monitor staff attendance and compliance with training. These systems included a print out of which staff had completed an e learning training and signing in sheets to evidence which staff had attended face to face training in the home.

A review of the print out of mandatory training evidenced good compliance with mandatory training; for example 92% of staff had completed first aid awareness, 97% fire safety and 98% adult safeguarding training, in the past 12 months.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses and care staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans.

Discussion with the registered manager and a review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies.

A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A monthly analysis of accidents to identify any trends or patterns was included in the monthly programme of audits undertaken.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. In 2015 an application for a minor variation to registration was received by RQIA. The proposed variation was to relocate the treatment room and create a hairdressing room on the ground floor. This work has now been completed. In addition the activity room has also recently been refurbished to include tearoom facilities. Staff spoken with were enthusiastic regarding the new facilities.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for improvement

All information required in regard to the selection and recruitment of staff must be obtained prior to the commencement of employment.

Number of requirements	**1**	**Number of recommendations**:	**0**

4.4 Is care effective?

We reviewed three patients' care records; two records of patients admitted for intermediate care and one to evaluate the management of wound care.

The deputy manager confirmed that a range of assessments were completed for patients admitted for intermediary care.

A comprehensive assessment to identify daily need had been completed for one patient at the time of admission. This assessment should be completed for all patients on admission. A recommendation was made. Assessments of patient need, completed by a range of healthcare professionals involved in the delivery of care, for example physiotherapists were available.

As previously discussed a range of risk assessments were completed. Care records reflected that an assessment of patients' skin condition was recorded on admission; staff confirmed that an assessment of skin condition was also recorded on discharge. Records evidenced that care was planned and delivered with support from a range of healthcare professionals, for examples physiotherapists and occupational therapists. Discussion with patients and observations made confirmed that there was a programme of active rehabilitation. Patients spoken with were well informed of their mobility needs. Message boards were available in each bedroom to remind the patients of their level of mobility; these boards were updated following review by the physiotherapists. Patients spoken with commented positively regarding the boards as an aid memoire; staff found them useful as an aid to communication.

The prevention of pressure ulcers and wound management in respect of one patient was reviewed. There was evidence of appropriate assessment to identify the risk of the development of pressure ulcers. Repositioning charts were maintained for patients who required assistance with postural changes; charts for two patients evidenced that positional changes were carried out regularly.

A review of wound care records evidenced that details of the wounds and frequency with which they required to be dressed were recorded in the patient's care plan. The care record contained an initial wound assessment and an assessment of the wound following each dressing renewal. Review of completed wound assessment records evidenced that prescribed dressing regimes were adhered to.

There was evidence within the care records of regular, ongoing communication with relatives. The registered manager confirmed that multidisciplinary meetings were held weekly to review the care and progress of patients receiving intermediate care. 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.

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. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

The registered manager confirmed that staff meetings were held regularly, and staff were enabled to contribute to the agenda. The most recent meeting was held on 10 June 2016. Minutes of this meeting detailing the areas discussed were available. Meetings had also taken place with domestic/housekeeping staff on 14 January 2016. A number of meetings had been held with staff throughout 2015. The records of these meeting included the names of the staff who attended and the issues discussed. The record of each meeting was made available to staff.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff confirmed that if they had any concerns, they would raise these with the registered manager. One staff member spoke of the challenges of meeting the differing needs of those patients in the home for a short period and the patients for whom Domnall was their home. Staff reported they would like to have more time, outside of task orientated care, to spend time generally with the patients who were in Domnall permanently. Staff recognised that the PAL spent time on a one to one basis with these patients but reported that they would like to have more time to meet the patients psychological and social needs; especially in the evenings. This opinion was shared with the registered manager who agreed to consider the comments further and discuss with the staff to identify how this could be achieved.

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

We spoke with one healthcare professional who visited the home weekly. They commented positively on the outcome of care for patients and the good communication between the registered manager, staff and the team of healthcare professionals involved in the intermediary care in the home.

Areas for improvement

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

Number of requirements	0	Number of recommendations:	1

4.5 Is care compassionate?

Throughout the inspection there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. The majority of patients spent their day in their bedroom, as was their personal preference.

Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:

"This has been a great experience."
"I am always well informed by the physios and nurses."
"I'm very satisfied with everything."

We spoke with the relatives of three patients. Two commented positively with regard to the standard of care, the attentiveness of staff and communication in the home. They confirmed that they were made to feel welcome into the home by all staff and were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately. The third relative spoken with was dissatisfied with their experience of the home; they confirmed that the relevant health and social care trust were aware of their dissatisfaction and asked that we did not discuss their issues with the registered manager.

We were assured through a general discussion with the registered manager that they were aware of the relative's opinion and were working closely with the health and social care trust to reach a satisfactory outcome for the patient and their relative.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. They explained that they had regular, daily contact with the patients and any visitors and was available, throughout the day, to meet with both on a one to one basis if needed. There were also systems in place to obtain the views of patients, their representatives, and staff on the running of the home. A 'Quality of Life' feedback system was available at the reception area. This was an iPad which allowed relatives/representatives, visiting professionals and/or staff to provide feedback on their experience of Domnall. A portable iPad was also available to record feedback from patients. Anyone completing the feedback has the option to remain anonymous or leave their name. Management have the option to contact people who leave their contact details to gain further

clarification on the feedback received. Any complaints received via the "Quality of Life" system would also be recorded in the record of complaints and addressed through the complaints process. Examples of comments received included;

"amazing place my mum is well looked after."

"Staff friendly and helpful."

"Cleanliness is of a good standard."

"Mum enjoyed the activities and meeting new people."

The provision of activities was reviewed and we spoke at length with the personal activity leader (PAL) who explained that activities were planned on both a group and one to one basis. Given that the patients are mostly in Domnall for a short period we discussed how they kept up to date with the patients in the home. The PAL explained that, following admission, they visited each patient, introduced themselves and explained their role. Often their role began as a "befriender" and then as their relationship with the patient grew they would persuade the patient to try an activity. They explained that persuading the patient to venture out of their bedroom was often the biggest challenge. The PAL explained that in addition to displaying the activity programme all of the patients were informed each morning of what activities would be taking place and if they wish to participate; while we were talking with patients we heard staff informing patients and checking who wished to attend. There were a number of patients who declined the invitation to the morning activity but enquired what was planned for the afternoon, demonstrating they were familiar with the activity provision. Patients were reminded, and assisted as required, when the activity was due to start. An activity room was located on the first floor of the home. The PAL explained that patient participation varied from those who could take an active role in activities to those engaged in talking about the activity to patients who were observers. The activity leader confirmed that there was good support from staff which was vital in enabling her to do her job. Arrangements were in place to support patients with their spiritual needs. Ministers and representatives of various denominations visited regularly to attend to the patients. Patients commented that they enjoyed the activities provided.

As previously discussed, the activities room has recently been refurbished to included tea and coffee making facilities for patients and their relatives/visitors. The standard of the decoration was commended. Activities provided included crafts, baking, armchair bowls and quizzes.

The registered manager informed us of a Belfast Heath and Social Care Trust (BHST) initiative which was being introduced into the home to help remind staff, patients and visitors at times of the need for a quiet, peaceful environment. It was explained that, with the consent of the patient and/or their relatives, a laminated photo of a waterlily would be displayed in the surrounding corridor areas of a patient who was nearing end of life. They explained that a poster was displayed in the foyer of the home to inform patients, relatives and visitors of the significance of the waterlily and that the pictures would act as a reminder to keep noise and activity in the identified area to a minimum.

Numerous thank you cards with compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in the cards received:

"Thank you to all the staff for all your excellent care. It is greatly appreciated."

"Without exception the nurses and carers were very kind and made me very comfortable."

"All of the staff displayed empathy and professionalism throughout my time here. I cannot praise you all enough."

Ten questionnaires each were issued to patient, relatives and staff; none were returned prior to the issue of this report.

Areas for improvement

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

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 displayed and available in the reception area of the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff spoken with were knowledgeable regarding the line management arrangements within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships; staff stated that management were responsive to any suggestions or concerns raised.

Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients and their representatives confirmed that they were confident that staff and/or management would address any concern raised by them appropriately.

Patients were aware of who the registered manager was and reported that they would have daily contact.

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint and the action taken by the registered manager. The records evidenced that the complaints recorded were closed. However there was no information to indicate how the registered manager had concluded that the complaint was closed. The recording of complaints should be further developed to include how the complainant's level of satisfaction was determined. A recommendation was made.

There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included care records, falls, complaints and the maintenance and cleanliness of the

environment. A review of the record of audits evidenced that where an area for improvement was identified there was evidence of re-audited to check that the required improvement had been completed.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. A copy of the report was maintained and available in the home; the report included an action plan to address any identified areas for improvement. There was evidence in the reports from February 2016 the action plans were reviewed during the next visit.

Areas for improvement

The recording of complaints should be further developed to include how complainants' level of satisfaction was determined.

Number of requirements	0	Number of recommendations:	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Leanna Bonar, 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 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 the completed QIP to nursing.team@rqia.org.uk 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	
Requirement 1 **Ref**: Regulation 21(1)(a) **Stated:** First time **To be completed by:** 15 July 2016	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. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Processes are now in place to ensure that all applicants who apply for positions online complete a FSHC application form at interview so that reasons for leaving previous posts can be recorded.
Recommendations	
Recommendation 1 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** 15 July 2016	It is recommended that a comprehensive assessment to identify patient need should be completed for all patients on admission. **Ref section 4.4**
	Response by registered provider detailing the actions taken: All patients now have all needs assessments completed, this will be monitored by the Registered Manager through the audit process..
Recommendation 2 **Ref**: Standard 16.11 **Stated:** First time **To be completed by:** 15 July 2016	It is recommended that the record of complaints is further developed to include how complainants' level of satisfaction was determined. **Ref section 4.6**
	Response by registered provider detailing the actions taken: All complaints are now fully investigated and the level of satisfaction is now recorded.

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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