Domnall
RQIA ID: 1866
48-50 Old Dundonald Road
Belfast
BT16 2EH

Inspector: Sharon McKnight
Inspection ID: IN021931

Tel: 02890419796
Email: domnall@fshc.co.uk

Unannounced Care Inspection
of
Domnall

30 June 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 30 June 2015 from 10 00 to 14 30 hours.

The inspection sought to assess progress with the issues raised during and since the previous inspection.

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in this report.

Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 of this report.

1.1 Actions/ Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 19 November 2014.

1.2 Actions/ Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care	**Registered Manager:** Leeanna Bonar
Person in Charge of the Home at the Time of Inspection: Jordan Pereira (Deputy manager)	**Date Manager Registered:** 5 November 2012
Categories of Care: 40 NH-I, NH-PH, NH-PH(E)	**Number of Registered Places:** 52
Number of Patients Accommodated on Day of Inspection: 40	**Weekly Tariff at Time of Inspection:** £683.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/ Process

Specific methods/processes used in this inspection include the following:

- discussion with the deputy manager
- discussion with staff
- discussion with patients
- discussion with relatives
- review of records
- observation during a tour of the premises
- evaluation and feedback.

Prior to inspection the following records were analysed:

- 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 previous care inspection report.

During the inspection, the inspector met with eleven patients individually, two registered nurses, six care staff and four patient's visitors/representative.

The following records were examined during the inspection:

- accident and incident reports and records of monthly analysis
- care records of five patients
- complaints and compliments record.

.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 19 November 2014. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last care (Same specialism) Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 19.1 **Stated:** First time	It is recommended that: • continence assessments should be reviewed to ensure that the patients assessed needs are clearly identified • care plans are in place to prescribe the required care • the type of continence products that patients' require should be specified in the patients' care plans.	**Met**
	Action taken as confirmed during the inspection: Review of five patient's care records evidenced that continence needs were clearly identified, care plans were in place to prescribe the required care and the type of continence products required were specified in the care plans. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 12.1 **Stated:** First time	The current method for calculating daily fluid targets should be reviewed and alternative good practice guidance consider helping identify more achievable daily targets.	**Met**
	Action taken as confirmed during the inspection: Daily targets recorded had been reviewed and an alternative method of calculating adopted. The targets reviewed were between 1200 – 1500mls. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 19.2 **Stated:** First time	Best practice guidance on the management of bladder and bowel continence and catheter and stoma care should be readily available in the home to inform and guide staff.	**Met**
	Action taken as confirmed during the inspection: The deputy manager confirmed that best practice guidance on the management of bladder and bowel continence and catheter and stoma care was available in the home to inform and guide staff. This recommendation has been met.	

5.3 Inspection findings

Is Care Safe? (Quality of Life)

Review of staffing, observation of care delivery and discussion with staff, patients and relatives evidenced that staffing levels were appropriate to meet the needs of the patients in a timely manner. The deputy manager confirmed that staffing was adjusted in relation to occupancy.

The pre-admission assessment process for the admission of patients requiring intermediary care was reviewed. Prior to admission the commissioning health care trusts provide a record of assessments of patient need for review by the registered or deputy manager; a decision is then made whether or not the placement is appropriate. Six care staff spoken with confirmed that they were made aware of each patient's individual needs prior to admission. A process to monitor the hospital discharge procedure was in place; a form was available for staff to complete to escalate any incidents were the agreed admission process was not adhered to by health and social care trust staff. This form is sent to the intermediate care co-ordinator for each Trust for investigation and response to the home. The deputy manager confirmed that, generally, the agreed admission procedure was adhered to. To help ensure that the admission process was completely safely and effectively parameters were in place to manage the number of admissions on a daily basis.

Review of the records of accidents and incidents evidenced that accidents were managed appropriately. An analysis of accidents, including time, location and injury sustained was completed monthly. A review of notifications to RQIA evidenced that the home notified RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Discussion took place regarding the notification of patients who were prescribed antibiotics.

Is Care Effective? (Quality of Management)

There was an established management structure within the home with systems in place to ensure that the delivery of care provided was in accordance with legislative requirements and DHSSPS care standards.

Review of five care records evidenced that a holistic assessment of patient need alongside a range of risk assessments, for example moving and handling, nutrition and pain assessments, were completed for patients at the time of admission to the home. Care plans were generated from these assessments and reviewed and updated regularly. On admission patients personal preferences, for example preferred name, rising and retiring times and food preferences were recorded. Care records evidenced that patients and/ or their representatives were informed of changes to patient need and/or condition and the action taken by staff in responce to need.

Is Care Compassionate? (Quality of Care)

Staff were observed responding to patients' needs and requests promptly and cheerfully. Good relationships were evident between patients and staff. Those patients who were being nursed in bed confirmed that they were attended by staff on a regular basis.

Discussion took place with eleven patients individually and with the majority of others in smaller groups. Patients receiving intermediate care and long term care were spoken with. Comments from patients regarding the quality of care, food and in general the life in the home were positive. Some examples of comments received were:
"They go the extra mile, little things that you won't get in a hospital, a more informal style."
"Service with a smile."
"It has the feel of a hotel with a medical element."
"No complaints."
"The staff are excellent"
"This is like family."

Four relatives confirmed that they were happy with the standard of care and communication with staff in the home. They confirmed that the staff kept them informed of any changes to their relatives' condition and consulted with relevant healthcare professionals in a timely way.

Numerous written compliments had been received from patients and relatives. Some examples of compliments received were;

"The treatment I received was second to none…"
"I send you this card to let you know my gratitude for your wonderful care."
"Thank you so much for your excellent and compassionate care of my mum."

Three questionnaires were completed by patient's representatives and return following the inspection. All of the comments received were very positive. Some examples were:
"Excellent care, always there for you, very good communication."
"…would recommend to anybody."
"…everyone from the front door right through to the kitchen are more than good."

Staff spoken with stated that they were happy working in the home and were satisfied that they were enabled to delivery care in a timely manner. They commented positively in regard to the care delivery in the home. Staff were knowledgeable regarding individual patient need.

Four staff questionnaires were completed by staff and returned following the inspection. Responses indicated that staff were either satisfied or very satisfied that care within the home was safe, effective and compassionate. Comments included:
"Domnall intermediary care home is a very busy pace but teamwork is great."

One staff member commented that it can take quite long waiting for referrals to healthcare professionals. They were satisfied or very satisfied with all other aspects of care.

Areas for Improvement

There were no areas for improvement identified during this inspection.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Leeanna Bonar	**Date Completed**	26/8/15
Registered Person	Dr M Claire Royston	**Date Approved**	26/08/2015
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	27/08/15

Please provide any additional comments or observations you may wish to make below:

***Please complete in full and returned to RQIA nursing.team@rqia.org.uk ***