THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY

FAILURE TO COMPLY NOTICE

Name of Registered Establishment or Agency:	FTC Ref:
Dunmurry Manor	FTC/NH/12230/2016-17/01(E)
Address of Registered Establishment or Agency:	
Rowan Drive, Seymour Hill, Dunmurry, BT17 9PX	
Name of Registered Person:	**Issue Date:**
Mr Nadarajah (Logan) Logeswaran	26 October 2016

Regulation not complied with:

The Nursing Homes Regulations (Northern Ireland) 2005

Regulation 10.- (1)

The registered provider and the registered manager shall, having regard to the size of the nursing home, the statement of purpose, and the number and needs of the patients, carry on or manage the nursing home (as the case may be) with sufficient care, competence and skill.

Specific failings to comply with regulations:

During an unannounced inspection on 17 and 18 October 2016, RQIA was unable to validate that effective quality monitoring and governance systems had been implemented, which had the potential to place patients at risk of harm. Serious concerns regarding the lack of management and oversight were evidenced in relation to the following:

The registered person failed to ensure that complaints were appropriately managed. Records examined failed to evidence a record of the complaint received, details of the investigation, and the outcome of the investigation and the level of satisfaction of the complainant.

The registered person failed to ensure that an appropriate quality audit of patient care records was maintained. This was particularly relevant from August 2016, when a review of the completed care plan audits failed to identify that the name of the patient, the name of the registered nurse completing the audit or the date of the audit were recorded. There was also a lack of evidence of any action taken when a shortfall was identified.

The registered person failed to ensure that an audit of accident records was undertaken. The acting home manager was unable to produce evidence of audit on the day of inspection. There was no structure to the accident/incident records available and no evidence of regular review of events occurring, which facilitated an analysis of trends and patterns, which would enable staff to minimize risks to patients.

The registered person failed to ensure that the learning outcomes from a number of recent safeguarding investigations, either completed or ongoing, have been disseminated to staff and embedded into practice. Areas such as wound care, management of patient repositioning and staff not adhering appropriately to the instructions from the tissue viability nurse (TVN) are referenced. The registered person failed to ensure that the unannounced monthly monitoring reports, as required in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, were available for inspection. The report for August 2016 was not available on the day of inspection. Therefore, the inspector was unable to validate that actions identified in the July 2016 report had been appropriately managed.
Action required to comply with regulations: The registered person must ensure that any complaint received into the home is recorded and processed in accordance with regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005. The complaints records must be available for inspection by RQIA at any time. The registered person must ensure sufficiently robust auditing systems are in place to quality assure the delivery of nursing and other services provided. This includes, but is not limited to: patient care records, complaints, wound care and accident and incidents. Records regarding the completion of these quality assurance audits must be available for inspection by RQIA. The registered person must ensure that accident and incident records are appropriately maintained to clearly demonstrate management oversight of each event. Accidents/incidents must be subject to regular review to facilitate the identification of patterns and trends, thus ensuring that risks to patients are minimized. The registered person must ensure that the learning outcomes of any safeguarding investigation are appropriately disseminated to staff, training delivered as required and a governance check must ensure that the learning is fully embedded into practice. The registered person must ensure that the monthly monitoring reports, in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 contain clear action plans, detailing all areas of improvement required. The reports should be developed and monitored to ensure compliance. On completion, the monthly monitoring reports are to be submitted on a monthly basis to RQIA, no later than three days after the last day of the month.

The registered person may make written representations to the Chief Executive of RQIA regarding the issue of a failure to comply notice, within one month of receipt of this notice.
Date by which compliance must be achieved 27January 2017 Signed.. Director of Regulation and Nursing

This notice is made under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

It should be noted that failure to comply with some regulations is considered to be an offence and RQIA has the power under regulations to prosecute for specified offences.

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FAILURE TO COMPLY NOTICE

Name of Registered Establishment or Agency: Dunmurry Manor	**FTC Ref:** FTC/NH/12230/2016-17/02(E)
Address of Registered Establishment or Agency: Rowan Drive, Seymour Hill, Dunmurry, BT17 9PX	
Name of Registered Person: Mr Nadarajah (Logan) Logeswaran	**Issue Date:** 26 October 2016
Regulation not complied with: **The Nursing Homes Regulations (Northern Ireland) 2005** **Regulation 12.- (1)(a) and (b)** The registered person shall provide treatment, and other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient – (a) meets his individual needs (b) reflects current best practice	
Specific failings to comply with regulations: During an unannounced inspection on the 17 to 18 October 2016, concerns were identified in relation to the delivery of safe and effective care to patients in Dunmurry Manor, which included the following: The registered person failed to ensure that patient care records, including risk assessments and care plans were maintained and regularly reviewed in response to the changing needs of the patient. Records examined on the day of inspection contained conflicting information. The registered person failed to ensure that patient's care records evidenced that the advice of other health care professionals was being adhered to. On the day of inspection it was evidenced that the recommendations of the tissue viability nurse (TVN) were not being adhered to. The registered person failed to ensure that patient's pressure relieving equipment was used as prescribed. On the day of inspection, a patient's care record confirmed that pressure relieving equipment had been disconnected at a point in time, placing the patient at risk.	

The registered person failed to ensure that staff reviewed and monitored the effectiveness of analgesia prescribed to patients. One identified patient had been prescribed a controlled analgesic on an 'as and when' required basis. There was however, no evidence of pain assessment being undertaken on a regular basis, to ensure the patient's pain was effectively controlled. The registered person failed to ensure that staff responded in a timely manner to patients' call bells. The call bell in an identified patient's room was observed to be continually sounding for a period of 30 minutes without staff responding. The registered person failed to ensure that patients presenting with distressed reactions were appropriately managed. One patient presented with behaviours that challenged staff. This was not appropriately managed, and staff did not respond as required to the patient's calls for help. The registered person failed to ensure that the dining experience for patients was managed in keeping with dementia best practice guidelines. There was a lack of supervision of patients in the dining rooms; patients were observed to be left sitting in the dining room until 11.30 hours after breakfast and until 14.40 hours, after serving of the midday meal. The mid-morning snack service only commenced at 12.00 hours.
Action required to comply with regulations: The registered person must ensure that care plans are established and maintained to meet the assessed care needs of patients. The registered person must ensure that risk assessments and care plans are regularly reviewed. The registered person must ensure that care is delivered to patients in accordance with the prescribed interventions of any plan of care, including instructions from the multiprofessional team. The registered person must ensure that all patients with wounds and/or pressure damage have up to date care plans in place, to direct staff in the provision of wound care. The registered person must ensure that an accurate record is maintained in relation to the number, type and status of wounds in the home. Individual patient records must reflect the recommendations of the multiprofessional team as applicable. The registered person must ensure that patient repositioning charts are accurately maintained and reflect the assessed needs of the patients, as prescribed in the patient's care plan. The registered person must ensure that a robust system is established regarding the assessment and management of pain, including the effectiveness of prescribed analgesia.

The registered person must ensure that patient call bells are answered promptly. The registered person must ensure that meals and mealtimes are in accordance with best practice for persons living with dementia.
The registered person may make written representations to the Chief Executive of RQIA regarding the issue of a failure to comply notice, within one month of receipt of this notice.
Date by which compliance must be achieved 27 January 2017 **Signed.. Director of Regulation and Nursing**

This notice is made under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

It should be noted that failure to comply with some regulations is considered to be an offence and RQIA has the power under regulations to prosecute for specified offences.