THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY

FAILURE TO COMPLY NOTICE

Name of Registered Establishment or Agency:	**FTC Ref No:**
Kingsway	FTC/NH/1261/2015-16/01
Address of Registered Establishment or Agency:	
299 Kingsway, Dunmurry, Belfast, BT17 9EP	
Name of Registered Person:	**Issue Date:**
Mr Christopher Walsh	15 December 2015

Regulation not complied with:

The Nursing Homes Regulations (Northern Ireland) 2005

Regulation 12.-

(1) The registered person shall provide treatment, and any 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) meet his individual needs;.
(b) reflect current best practice; and
(c) are (where necessary) provided by means of appropriate aids or equipment.

Specific failings to comply with regulations:

An unannounced inspection was undertaken on 7 December 2015 to assess progress with the issues identified during the previous care inspection on 5 October 2015. These issues had also been raised during an inspection on 16 April 2015 and during the subsequent serious concerns meeting on 29 April 2015. It was evidenced that there had been insufficient progress in addressing the deficits identified at the previous inspections in that:

Repositioning charts were not being recorded accurately, and long gaps were noted between repositioning entries of up to 17 hours on one occasion. The lack of evidence to support the timely delivery of care to patients requiring repositioning could seriously impact on individual patients. There is a potential for nursing staff to fail to prevent, identify or manage pressure area care/ pressure ulcers appropriately.

Food and fluid intake charts were inconsistently recorded, with evidence of long gaps between entries and in some cases, no entries made. Registered nurses did not make any record of the action they had taken when food and /or fluid intake was inadequate. There was also insufficient evidence within the care records that patients' weight loss was being identified and appropriately managed.

The failure to accurately record food and fluid intake could seriously impact on individual patients, with the potential for nursing staff to fail to identify deficits and respond in a timely manner to prevent dehydration and malnutrition.

The mealtime experience of patients requires improvement to ensure that patients' nutritional needs are met. Concerns were identified in relation to the quality of the food; the presentation of puree meals; meals uncovered when transported to patients' rooms; the lack of timely assistance from care staff to enable patients to eat and drink; and the absence of a menu.

Patients also reported that food and drink was left in front of them by hospitality staff but that they had to wait for assistance from care staff to enable them to eat or drink. Registered nursing staff were not present in the dining room to lead and direct care at mealtimes.

Patients' call bells were not always being answered within an acceptable timeframe.

The lack of attention to patients' choice, privacy and dignity was concerning, for example; the practice of administering medicines covertly; the manner in which personal care was being delivered; the communal use of underwear and tights and staff attitude which was described by patients as patronising and uncaring.

There was a reliance on agency nurses working in the main nursing unit. There were concerns identified which impacted on the continuity of care for patients. In addition, robust systems were not in place to facilitate effective communication between the registered nurses and the home manager and that concerns were being escalated appropriately.

Action required to comply with regulations:

- The responsible individual must ensure repositioning charts are recorded accurately, indicating the frequency of repositioning required as stated in the care plan and the actual position of the patient.
- The responsible individual must ensure registered nurses evaluate the delivery and effectiveness of the repositioning schedule for each patient, and evidence that subsequent action has been taken in response to any identified concerns.
- The responsible individual must ensure fluid intake charts are recorded accurately, including if a patient is offered a drink and refuses. These charts must also be accurately reconciled.
- The responsible individual must ensure registered nurses evaluate the fluid intake of each patient and evidence the subsequent action taken in response to any identified deficits.
- The responsible individual must ensure food intake charts are recorded accurately, including if the patient is offered food and refuses.
- The responsible individual must ensure that patients' weights are monitored and evaluated, in accordance with their care plans and level of risk, and that subsequent action is taken in response to any identified deficits.
- The responsible individual must ensure registered nurses monitor and evaluate the nutritional intake recorded on the daily food intake charts of each patient and evidence that subsequent action has been taken in response to any identified deficits.

- The responsible individual must review the mealtime experience for all patients, to ensure that their nutritional needs are met, particularly in relation to the following:

  - the quality of the meals served including modified diets
  - the assistance given to patients must be appropriate and timely
  - that registered nurses are present to lead and direct the care at mealtimes
  - food is not transported to patients uncovered
  - that the menu choices for each day are made available to patients in a suitable format.

- The responsible individual must ensure call bells are answered in a timely manner, with a system in place to monitor call bell response times, and evidence of action taken in response to any identified deficits.
- The responsible individual must ensure the nursing home is conducted in a manner that respects the privacy and dignity of patients.
- The responsible individual must ensure a system is in place to ensure effective communication between all grades of staff and the manager, and that any concerns are escalated appropriately to ensure that the nursing needs of patients are met.

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 11 February 2016

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.

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY

FAILURE TO COMPLY NOTICE

Name of Registered Establishment or Agency:	**FTC Ref No:**
Kingsway	FTC/NH/1261/2015-16/02
Address of Registered Establishment or Agency:	
299 Kingsway, Dunmurry, Belfast, BT17 9EP	
Name of Registered Person:	**Issue Date:**
Mr Christopher Walsh	15 December 2015

Regulation not complied with:

The Nursing Homes Regulations (Northern Ireland) 2005

Regulation 13.-

(1) The registered person shall ensure that the nursing home is conducted so as –

(a) to promote and make proper provision for the nursing, health and welfare of patients;
(b) to make proper provision for the nursing and where appropriate, treatment and supervision of patients.

Specific failings to comply with regulations:

An unannounced inspection was undertaken on 7 December 2015 to assess progress with the issues identified during the previous care inspection on 5 October 2015. These issues had also been raised during an inspection on 16 April 2015. It was evidenced that there had been insufficient progress in relation to the care and management of pressure ulcers and wounds in that:

There was no evidence that significant pressure ulceration had been identified in a timely manner by staff.

It was not clear that the instructions of the tissue viability specialist nurse were being followed, and there was insufficient evidence that wound care was being delivered in a consistent and timely manner.

Multiple care plans, in relation to pressure ulcers, were in place for one patient.

Wound dressings observed were noted to be soiled and in need of attention, and wound care assessment charts were inconsistently completed.

A registered nurse was unable to demonstrate knowledge of the wound care needs of one patient.

Pressure ulcers were not being appropriately graded in accordance with best practice in the prevention and management of pressure ulcers.

The audits of wounds did not accurately reflect the number of wounds in the home or the condition of these wounds. The system for auditing of wounds was not robust, entries were inconsistently completed, and did not accurately record all the information required.

Action required to comply with regulations:

- The responsible individual must ensure registered nurses and care staff are updated in relation to their roles and responsibilities for wound care, pressure ulcer prevention and management, and that the effect of training on practice is evaluated as part of quality improvement.
- The responsible individual must ensure any patient identified as "at risk" of pressure ulceration, using a validated tool, has a corresponding care plan in place to meet their identified needs.
- The responsible individual must ensure all patients with wounds and/ or pressure ulcers have up to date care plans in place detailing their treatment.
- The responsible individual must ensure care plans detail the frequency of repositioning of the patient, and any pressure relieving equipment required to meet their identified needs.
- The responsible individual must ensure all patients with wounds and/ or pressure ulcers have their treatment regimes carried out as prescribed.
- The responsible individual must ensure that an accurate record is kept of the condition of patient wounds at each dressing change.
- The responsible individual must ensure registered nurses evidence that they have taken appropriate action when the condition of a wound and/ or pressure ulcer changes.
- The responsible individual must ensure effective systems are put in place to record the incidence of wounds and/ or pressure ulcers occurring at the home, including the condition and current treatment plan. Any deficits identified must be addressed.

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 11 February 2016

Signed..... Director of Regulation and Nursing

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