

Inspection Report

10 April 2024



Dunanney Care Centre

Type of Service: Nursing Home
Address: 12 Glebe Road, Newtownabbey, BT36 6UW
Telephone Number: 028 9084 9349

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation: Ann's Care Homes Limited Registered Person/s OR Responsible Individual Mrs Charmaine Hamilton	Registered Manager: Mr David Leitch – not registered
Person in charge at the time of inspection: Mr David Leitch	Number of registered places: 36
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment.	Number of patients accommodated in the nursing home on the day of this inspection: 34
Brief description of the accommodation/how the service operates: Dunanney Care Centre is a nursing home registered to provide nursing care for up to 36 patients.	

2.0 Inspection summary

An unannounced inspection took place on 10 April 2024 from 9.30 am to 5.00 pm by a Care Inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

As a result of this inspection, three new areas for improvement were identified; and two areas for improvement relating to medicines management were carried forward for review at a future inspection. These are discussed in the main body of this report and in the quality improvement plan (section 6).

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, and a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

A poster was provided to the manager detailing how staff could provide their views and opinions by completing an online questionnaire. Questionnaire leaflets were also provided, to allow patients and those who visit them, the opportunity to provide feedback after the inspection with their views of the home.

The daily life within the home was observed and how staff went about their work.

A range of documents and records were examined to determine that effective systems were in place to manage the home.

4.0 What people told us about the service

The inspector spoke with a number of staff, patients, relatives and the management team during the inspection.

Patients spoke positively about the care that they received, and patients who were less able to tell us about how they found life in the home were seen to be relaxed in their surroundings.

Discussions with staff confirmed they were positive about their roles and duties, the provision of care, staffing, teamwork, and managerial support; comments made were shared with the management for review and action as appropriate.

Relatives spoken with, reported that they were satisfied with the level of care provided.

As stated in section 3.0, questionnaires and a poster with a link to an online survey were provided to allow patients, relatives, visitors and staff unable to meet with the inspector, the opportunity to provide feedback on the home. There were no questionnaires returned and no feedback was received from the staff online survey within the allocated timeframe.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 5 th September 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 13 (4) Stated: First time	The registered person shall review the management of the identified controlled drug to ensure that quantities are accurately receipted and that this medicine is not administered after expiry.	Carried forward to the next inspection
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		Validation of compliance
Area for improvement 1 Ref: Standard 18 Stated: First time	The registered person shall ensure that a patient specific care plan is in place and the reason for and the outcome of administration is recorded on every occasion, when medication is prescribed/administered on a 'when required' basis, for the management of distressed reactions.	Carried forward to the next inspection
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a system was in place to ensure staff were recruited correctly to protect patients.

The staff duty rota accurately reflected the staff working in the home over a 24-hour period and identified the nurse in charge when the manager was not on duty. Registered nurses taking charge of the home in the absence of the manager are required to have undertaken a competency and capability assessment prior to commencing in the role; review of a sample of these records confirmed these had been completed as required.

Discussion with the manager confirmed that a system was in place to monitor the dependency levels of patients and ensure the number of staff on duty was regularly reviewed to assist in meeting the needs of patients. Observation during the inspection, evidenced that staff attended to patients' needs in a timely manner; and where patients required support on a 1:1 basis, care staff assisted them with their assessed care needs.

Review of records provided assurances that a system was in place to ensure all nursing staff were registered with the Nursing and Midwifery Council (NMC). There was also a system in place to monitor registration status of care staff with the Northern Ireland Social Care Council (NISCC).

There were systems in place to ensure staff were trained and supported to do their job. Mandatory training was progressing for staff and the manager confirmed that training compliance was kept under review.

Staff should have the opportunity to attend, at minimum, two supervisions and an appraisal annually to review their roles and enhance their professional development. The manager confirmed that a matrix had been developed and was ongoing; progress with this will be reviewed at a future inspection.

Staff were seen to attend to patients' needs in a timely manner, and patients' were offered choices throughout the day.

5.2.2 Care Delivery and Record Keeping

Staff said they met for a handover at the beginning of each shift to discuss any changes in the needs of the patients, and a handover record was available and included detailed meaningful information pertaining to patients' individual needs.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans were developed to direct staff on how to meet patients' needs. A review of a sample of records evidenced that these were generally well maintained, however, where a gap in one record was identified, pertaining to a patient's ability to use the call bell, this was discussed with the manager for immediate review; an area for improvement was identified.

The previous inspection had identified a sample of hand written care records that were not consistently legible, this was reviewed and whilst it was pleasing to note that there had been an improvement, some records remained difficult to read; an area for improvement was identified.

Care records evidenced that risk assessments pertaining to a patient's level of risk for choking had been undertaken, however, a discussion took place with the manager to further develop these assessments, this will be reviewed at a future inspection.

Patients who required 1:1 bespoke care had care plans in place, however, a discussion took place with the manager to further develop the care plans pertaining to 1:1 bespoke care. This will be reviewed at a future inspection.

Patients who are less able to mobilise were assisted by staff to mobilise or change their position as required. It was observed that, where required, there were care plans in place to direct care for the prevention of pressure ulcers and pressure relieving equipment was in use as directed.

Falls in the home were monitored on a regular basis to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring. Care records for patients who experienced a fall evidenced that care plans and risk assessments were reviewed and updated appropriately.

Daily records were also kept of how each patient spent their day and the care and support provided by staff.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients' needs determine that they may require a range of support with eating and drinking; this may include simple encouragement through to full assistance from staff. Some patients may require their food to be modified and /or may require specific utensils to aid eating and drinking following assessment by the Speech and Language Therapist (SALT).

The serving of lunch was observed, observation noted the food served was attractively presented, smelled appetising and a variety of drinks were served with the meal. Staff told us how they were made aware of patients' nutritional needs to ensure they were provided with the right consistency of diet; and where patients preferred to have their meal in their own room, this was readily accommodated with support provided as required. A menu was available to inform patients of the meal and choice available.

Observation evidenced that staff attended to patients' dining needs in a caring and compassionate manner and, where required, staff engaged with patients' on a one to one basis to assist them with their meal.

Records were kept of what patients had to eat and drink daily where required, however, recording of the total daily fluid intake was inconsistent in the care records reviewed. Monitoring of total daily fluid intake should be robust in order that action can be taken in a timely manner to address issues such as low fluid intake; an area for improvement was identified.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms and communal areas such as lounges. The home was warm, clean and comfortable. Patients bedrooms were clean, tidy and personalised with items of importance to each patient, such as, family photos and sentimental items from home.

Corridors and fire exits were found to be free of clutter and obstruction.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of personal protective equipment (PPE) had been provided. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

5.2.4 Quality of Life for Patients

Observation of life in the home and discussion with staff and patients established that staff engaged well with patients. Patients appeared content and settled in their surroundings.

There was a range of activities provided for patients by activity staff and the programme of activities was available and displayed in a central part of the home. The activities included, for example, music, arts and crafts and religious services. Hairdressing services were also available for those patients who chose to attend.

Activity records were maintained which included patient engagement with the activity sessions in the home; a discussion took place with staff and the manager as to how these records should be further developed to evidence more meaningful content. This will be followed up at a future inspection.

5.2.5 Management and Governance Arrangements

Dunanney Care Centre changed ownership in October 2023 to Ann's Care Homes Limited. Mr David Leitch has been the manager since September 2023 which reflects a change in management since the last inspection on 20 April 2023. RQIA were notified appropriately.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients.

The manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

There was a system in place to manage complaints.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These were available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	1*	4*

* the total number of areas for improvement includes two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with the management, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (4) Stated: First time To be completed by: With immediate effect (5 September 2023)	The registered person shall review the management of the identified controlled drug to ensure that quantities are accurately receipted and that this medicine is not administered after expiry. Ref: 5.1 Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 18 Stated: First time To be completed by: With immediate effect (5 September 2023)	The registered person shall ensure that a patient specific care plan is in place and the reason for and the outcome of administration is recorded on every occasion, when medication is prescribed/administered on a 'when required' basis, for the management of distressed reactions. Ref: 5.1 Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.

<p>Area for improvement 2</p> <p>Ref: Standard 43</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (10 April 2024)</p>	<p>The registered person shall ensure that all patients have effective access to the nurse call system or nurse supervision as required.</p> <p>Any patient assessed as not having capacity to use the nurse call system should have arrangements in place for regular checks to ensure patient safety and comfort, and this should be documented in the patient's individual care plans.</p> <p>Ref: 5.2.2</p>
<p>Area for improvement 3</p> <p>Ref: Standard 4</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (10 April 2024)</p>	<p>The registered person shall ensure that handwritten care records are legible.</p> <p>Ref: 5.2.2</p> <p>Response by registered person detailing the actions taken: Whilst regular checks had been performed hourly (minimum) in all such cases, in terms of documentation, this particular issue has been rectified and care-planned from date of inspection, therefore meeting the expected standard and addressing this AFI..</p>
<p>Area for improvement 4</p> <p>Ref: Standard 4.9</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (10 April 2024)</p>	<p>The registered person shall ensure that accurate and consistent records of patients total daily fluid intake are maintained, monitored and acted upon by nursing staff as appropriate.</p> <p>Ref: 5.2.2</p> <p>Response by registered person detailing the actions taken: The home is now implementing a twice daily check of the fluid totals and both nursing staff and care staff have had remedial learning with respect to the importance of calculating and recording fluid tallies in an accurate and timely manner. This has been effective and has addressed the issue, thus meeting the required standard and addressing this AFI</p>

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