The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: St Francis Private Care Home Ltd

Provider: St Francis Private Care Home Ltd

Date of Inspection: 17 October 2024

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	St Francis Private Care Home Ltd
Responsible Individual:	Mr Cathal Breen
Registered Manager:	Mrs Keyara Johnson – Not registered
Service Profile – This home is a registered nursing home which provides general nursing care for up to 25 patients. Patients have access to communal lounge and dining areas and a garden space. Patients' bedrooms are located over two floors.	

2.0 Inspection summary

An unannounced inspection took place on 17 October 2024 from 7.10am to 1.15pm by two care inspectors.

RQIA received information which raised concerns in relation to rising and retiring times, night checks not completed, unsafe moving and handling of patients, working routines and continence care practices. In response to this information RQIA decided to undertake an unannounced inspection which focused on the concerns raised.

The inspection found that the allegations were unfounded and that safe, effective and compassionate care was delivered to patients. It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

In addition to reviewing the concerns raised, we reviewed the two areas for improvement made at the previous care inspection on 22 July 2024. One of the areas was met and the second area, in relation to the completion of admission documentation, was not met and stated for the third and final time. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the 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, registration information, and any other written or verbal information received from patient's, relatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "Staff are very good", "Food is good" and "Really like it here".

Patients told us that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options and where and how they wished to spend their time.

3.3 Inspection findings

3.3.1 Staff Training

The home's management team had identified what training was deemed mandatory. A system was in place to monitor staff training compliance in these areas. Training records evidenced that all staff were compliant with patient moving and handling training. Staff were not asked to perform any tasks that they had not been trained to do nor did they require specific training to manage physically aggressive patients as no patients presented in this manner.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles. Handover sheets were shared with staff containing the pertinent patient details.

Staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

Patients could choose what time they went to bed or what time they got washed and dressed each morning. Some patients preferred to get up early and this was documented within their care plans. Staff completed an early morning round to attend to continence needs and only those patients who requested, or required it, were fully assisted with personal care needs. On the day of inspection, patients who were awake and had personal care needs fully met had consented to this.

Suppers were served from 8.15pm onwards normally taking around 45 minutes to complete. Neither staff nor patients raised any concerns in regards to this arrangement. Patients had access to food and fluids throughout the day and night if they wished.

3.3.3 Management of Care Records

A recently admitted patient still did not have all important care plans in place seven days following their admission. This had been initially raised as an area for improvement during a care inspection on 16 April 2024 and then stated for a second time during the previous care inspection on 22 July 2024. This was discussed with the responsible individual (RI) and nurse in charge (NIC) and stated for the third and final time.

Additional attention was required with completion of pressure management care records. When a patient was required to be repositioned to maintain skin integrity, the repositioning regime was not always included within the pressure management care plan. Repositioning records did not consitently identifiy the position in which the patient had been repositioned to and when pressure relief was given during the day, this was not always recorded. Night time repositioning records were not time specific. An area for improvement was identified.

The continence care plan for an identified patient, did not demonstrate the level of assistance required with their needs. Several continence care plans did not identify the specific continence aids which the patients required. Bowel management charts maintained by registered nurses were not consistently recorded. An area for improvement was identified.

A review of personal care records evidenced that nail care had not been recorded as been given for periods of up to four weeks for some patients. There was nothing in the personal care care plans to indicate that the patient attended to their own nail care. An area for improvement was identified. Other aspects of personal care had been recorded well. Patients were well presented.

Many patients had their preferred rising and retiring times recorded within their care plans. Some did not. The management confirmed that this would be reviewed. Records of checks conducted on patients overnight had been recorded well.

3.3.4 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Keyara Johnston has been the Manager in this home since 13 November 2023. The RI was reminded of the importance of registering the manager with RQIA.

Review of a sample of records evidenced that there was a system in place for reviewing the quality of care, other services and staff practices. However, given the findings with patients' care record keeping, an area for improvement was identified to ensure a more robust care record audit to drive improvements in this area of care.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	3*	2

*The total number of areas for improvement includes one that has been stated for the third time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Cathal Breen, Resonsible Individual and Romegen Uy, Nurse in Charge, 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 16 (1) **Stated:** Third time	The registered person shall ensure that admission documentation, to include risk assessments and care plans, is completed in a timely manner from the date of admission. Ref: 3.3.2
To be completed by: With immediate effect (17 October 2024)	**Response by registered person detailing the actions taken:**

	The registered person shall ensure admission documentation, to include risk assessments and care plans is completed in a timely manner. Manager to monitor care plans and audit within a week of admission.
Area for improvement 2 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** With immediate effect (17 October 2024)	The registered person shall ensure that pressure management is assessed and care planned in full and evidence of all pressure care delivered is recorded within the care records. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered person shall ensure that pressure management is assessed and care planned and evidence of all pressure care delivered is recorded within the care records. Staff have been informed to record all forms of care in relation to pressure relief.
Area for improvement 3 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** With immediate effect (17 October 2024)	The registered person shall ensure that continence needs are assessed and care planned in detail to include specific individual requirements and identify all continence aids required. Registered nurses must evidence an oversight of continence care. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered person shall ensure that continence needs are assessed and care planned in detail to include specific individual requirements and identify all continence aids requires. Registered Nurses must evidence an oversight of continence care. Care plans have been developed to include continence requirements and nurses have been involved in discussion in relation to incontinence care.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 6 Criteria (14) **Stated:** First time	The registered person shall ensure that personal care plans are specific to the needs of pateints and supplementary care records detail all care provided to the patient. This is with specific reference to nail care. Ref: 3.3.3

To be completed by: With immediate effect (17 October 2024)	**Response by registered person detailing the actions taken:** The registered person shall ensure that personal care plans are specific to the needs of patients and supplementary care records detail all care provided to the patient. This is with specific reference to nail care. Nail care has been included in the supplementary hygiene records.
Area for improvement 2 **Ref:** Standard 35 **Stated:** First time **To be completed by:** With immediate effect (17 October 2024)	The registered person shall ensure a more robust system of auditing care records to drive improvements in this area of care. Ref: 3.3.4
	Response by registered person detailing the actions taken: The registered person shall ensure a more robust system of auditing care records to drive improvements in this area of care. Some care records have been identified as not being audited and the manager is aware of these and audits have been initiated and are now completed.

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

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