The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **The Peninsula Care Home**

Provider: **Dunluce Healthcare Newtownards Ltd**

Date of Inspection: **5 December 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:	Dunluce Healthcare Newtownards Ltd
Responsible Individual/Responsible Person:	Mr Ryan Smith
Registered Manager:	Mrs Emma Kerrigan

Service Profile –
This home is a registered nursing home which provides nursing care for up to 40 patients. The home is divided in two Suites: the Willow Suite which provides care for up to 20 patients living with dementia and the Starling Suite which provides general nursing care for up to 20 patients under and over 65 years of age.

Patients' bedrooms are located on the ground floor. Patients also have access to communal lounges and dining areas within each Suite and a centralised garden area with access to seating.

There is a separate registered residential care home which occupies the same building; this service is managed by a different registered manager.

2.0 Inspection summary

An unannounced inspection took place on 5 December 2024 from 9.20am to 6.40pm by two care inspectors.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 17 September 2024.

Patients spoke positively when describing their experiences of living in the home and on their interactions with staff. Patients' comments can be found in the main body of the report and within Section 3.2.

While we found care to be delivered in a compassionate manner, a number of areas for improvements were identified to ensure the effectiveness and oversight of certain aspects of care delivery. Seven areas for improvement remained unmet at this inspection and have been stated for a second time. As a result of this inspection RQIA required the provider to attend a meeting in line with RQIA's enforcement procedures. An intention meeting to serve two Failure to Comply (FTC) notices was held on 17 December 2024. At this meeting the management team provided a robust action plan addressing the concerns identified. RQIA were satisfied with the assurances from the provider and decided to take no further enforcement action.

Details of the concerns identified can be found throughout the body of the report and in Section 4. A further inspection will be conducted to monitor compliance with the concerns identified.

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 patients, 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 told us that they were happy living in the home and spoke positively when describing interactions with staff. Patients' comments included, "I am very happy here," and "I am very comfortable here".

Staff told us that they worked well and communicated well with one another and that there were good working relationships between staff and the home's management team. Staff felt that they had received good training to fulfil their roles in the home.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Recruitment checks had been completed in full prior to new staff commencing employment in the home. Structured inductions were in place. However, a review of one staff's induction evidenced that they had been completed and signed off within three days despite the member of staff never having worked in a care environment before. This was discussed with the manager and identified as an area for improvement.

A system was in place to ensure staff completed mandatory triaining. This included infection prevention and control training and patient moving and handling training. Observation of staff practice evidenced that moving and handling training was embedded into practice. Staff consulted told us that they were happy with the training they received.

There was a system in place to ensure nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

Patients did not raise any concerns in relation to the staffing levels in the home. Staff were satisfied that patients' needs were met with the level of staff on duty. There was a good mix of new staff and experienced staff on duty working together. However, concerns were identified with the timeliness of the delivery of care and supervision for some patients; this is further discussed in section 3.3.2. An area for improvement with regard to the provision, deployment and skill mix of staff on duty to ensure that the needs of the patients are met in a timely manner was made as a result of the previous inspection and is now stated for a second time.

The duty rota clearly indicated all the staff working in the home and the designation in which they worked. The nurse in charge of the home in the absence of the manager was identified on the rota as were the first aider and the fire marshall.

There was evidence of staff meetings following the previous RQIA care inspection to discuss the inspection findings and the home's action plan to move forward.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be caring and compassionate. It was clear that staff and patients knew one another well and were comfortable in each other's company. One patient told us, "The home is very nice and the staff are excellent". Another commented, "It is very good here; staff are good and I've no concerns".

Patients confirmed that activities took place. Two activities staff were employed to oversee activity provision. A weekly planner was available to identify the upcoming activities. Activities were scheduled for the morning and for the afternoon each day and included sing-a-long, lingo, games and exercises. There were church services planned, Christmas parties and decoration making. The home was tastefully decorated for Christmas.

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 containing the pertinent patient details were updated and shared with staff.

Concerns were identified in relation to the morning routines. A number of patients in the Willow Suite were observed fully dressed in bed at 10.30am. Staff advised that four patients had been washed and dressed by night staff. There was no clear rationale why these patients had been assisted to wash and dress by the night staff when some of them remained in bed until mid-morning. Staff explained that patients were assisted to wash and dress early morning in accordance with their preferred wishes. One patient's care plan identified that the patient's preferred rising time was 8.00 am; as night staff end their shift at 8 am their rising time was not respected. The need to ensure that detailed, person centred care plan were in place to direct care was identified as an area for improvement as a result of the previous inspection and is now stated for a second time.

The breakfast, snack time and lunch were observed to have blended into one another in Willow Suite. Patients were only finishing breakfast and being assisted into the lounge at 11.50am with the planned lunch mealtime beginning at 12.30pm. An area for improvement was identified.

It was observed as patients were assisted from the dining tables, that drinks and foods, served to them at breakfast, were still sitting in front of them uneaten. Patients assessed as requiring prompting/encouragement to eat their meal were not provided with the appropriate care in a timely manner. An area for improvement was identified.

On one occasion there was a delay between the patient receiving their meal and staff offering encouragement and assistance; staff were not observed checking if the meal was still warm enough prior to assisting the patient to eat. A patient who was assessed as requiring supervision with their meals was not appropriately supervised. An area for improvement was identified.

It was unclear within the Willow Suite if a safety pause was in place prior to the serving of the meal. A checklist detailing patients' needs was in place for the staff member directing each mealtime to sign prior to the serving of meals. However, the checklist had been signed as correct but was not accurate for one patient which placed the patient at potential risk of receiving the incorrect consistency of food and fluids. An area for improvement was identified. The care assistant assisting the patient with their meal was aware of their assessed needs and the patient did get the correct consistency of meal. A safety pause was conducted in the Starling Suite prior to the serving of meals. Staff were knowledgeable of patients' nutritional requirements.

The menu was displayed in both dining rooms showing the meal choices for the day. There was choice for all patients, including those who required their food to be modified. The food served appeared appetising and nutritious. Patients enjoyed their meal. One told us, "The food is very nice and the care is very good here".

Records were maintained of patients' food and fluid intakes, any supplements taken and any food/fluids which had been offered but refused.

Oral healthcare was assessed on admission and plans of care were in place to direct staff in how to meet this need. However, care records did not always evidence if oral care had been delivered. This was identified as an area for improvement.

Pressure management risk assessments had been completed. Where a risk of skin breakdown was identified a care plan was in place and detailed the equipment required and frequency of repositioning where required. Records of repositioning had been maintained well. Many of these patients were nursed on a pressure relieving mattress; several of the mattresses were not set in accordance with the patients' weights. This was identified as an area for improvement.

A patient who had an identified wound did not have a care plan in place to guide staff on how to manage the wound. This was identified as an area for improvement.

Two out of three patients, who required assistance with their mobility and who liked to remain in their bedroom, did not have a call bell within reach should they need to summon assistance from staff. This was identified as an area for improvement.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse 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 and included any advice or recommendations made by other healthcare professionals.

The daily nursing evaluation of care delivery during the shift had been completed half way through the day; there were no additional entries to evidence the care delivered later in the day. This was identified as an area for improvement as a result of the previous inspection and now is stated for a second time.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy and patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, well furnished, warm and comfortable. The home had been tastefully decorated for Christmas and patients had been involved in decorating. There were several Christmas Trees strategically placed around the home.

Fire safety measures were in place to protect patients, visitors and staff in the home. Fire exits and corridors were clear of clutter and obstruction and fire extinguishers were easily accessible.

Observation of staff and their practices evidenced that basic infection prevention and control (IPC) practices were not consistently adhered to. Staff were not bare below the elbow and were wearing jewellery and gel nails. In addition, several staff did not take the appropriate opportunities for hand hygiene between patient contact at the lunch mealtimes. Concerns were identified during the previous inspection with hand hygiene practices and an area for improvement was made; this is now stated for the second time.

Concerns were identified regarding the management and oversight of risks to the health and safety of patients within the home's environment. For example, a cleaning chemical, food and fluid thickening agent, and dishwasher tablets were accessible to patients in the Starling Suite. The medicine trolley was left unattended in the Willow Suite with medicines accessible on top of the trolley. Similar concerns were identified during the previous inspection; this area for improvement is now stated for the second time.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Emma Kerrigan has been the Manager in this home since it was registered on 3 May 2024. Staff commented positively about the manager and described them and the home's management team as approachable. All staff told us that they felt supported by the management team. At the meeting with RQIA the responsible individual confirmed plans to increase the number of senior roles in the home to give additional support to the manager.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further.

There was a system in place to monitor complaints and many cards had been received expressing thanks to staff for their care given.

There were processes in place to monitor the quality of care and other services provided to patients. However, given the inspection findings, these processes should be reviewed to ensure that the deficits identified at this inspection are managed appropriately. An area for improvement was stated for the second time.

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	8*	8*

*The total number of areas for improvement includes seven that have been stated for a second time and one which has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ryan Smyth, Responsible Individual; Emma Kerrigan, Registered Manager and Claire Hughes, Deputy Manager, 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 20(1)(a) **Stated:** Second time **To be completed by:** 31 December 2024	The registered person shall review the provision, deployment and skill mix of staff on duty to ensure that the needs of the patients are met in a timely manner. Ref 2.0 and 3.3.1
	Response by registered person detailing the actions taken: The Home has completed a full internal review of all staffing levels. A new Home Manager and a new Home Deputy Manager have been appointed and this will mean that the home will have in place A Home Manager and two Deputies, to provide senior leadership and management within the care teams, over the full seven day working week. The Home has also appointed new Senior Care Assistants to help with appropriate skill mix of staff on duty and to provide support and guidance to new care staff. The Home has also actively recruited for new Registered Nurses. Registered Nurse deployment will constitute 3.0 WTE on each shift.
Area for improvement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 17 September 2024	The registered person shall ensure that staff manage falls in keeping with best practice and the homes' own policies and procedures. Ref: 2.0
	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.
Area for improvement 3 **Ref:** Regulation 13 (1) (b) **Stated:** Second time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure that patients who are identified as being at risk of choking are appropriately supervised at mealtimes in keeping with their assessed needs and plan of care. Ref: 2.0 and 3.3.2
	Response by registered person detailing the actions taken: The Home has reviewed its full meal times experience for the residents and has consulted with professional colleagues within speech and language therapy within the Trust, to develop enhance procedures for mealtimes

	and to provide additional in-house face to face training to augment existing training provision. This has culminated in the development of a new Meal Times Matter's Safety Pause check list, which is operatonalised daily within each shift at all meal times. This requires a Senior Care Assistant or the Nurse in Charge to supervise the mealtimes experience and to ensure verbalisation of the safety pause at all meals. Moreover, the Home has also operationalised a staggered meal times delivery to ensure that those residents who have greater need for assistance or 1-1 supervision receive this and thus they attend for their meals at least half-an-hour earlier that those residents who are more independent. The Home has also implemented a full internal care plan review of all care planning approaches to ensure comprehensive assessments relating to the residents choking risk are detailed within the holistic care plans. This approach was also augmented with additional emergency skills first aid training on the management of foreign body obstructed airways.
Area for improvement 4 **Ref:** Regulation 16 (1) **Stated:** Second time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure detailed and person centred care plans are in place for all patients. Ref: 2.0 and 3.3.3
	Response by registered person detailing the actions taken: The Home has carried out an internal review of care planning approaches in a consultative and collegiate manner with all registered nurses. This resulted in the revision of the allocations of primary nursing responsibilities within the team to ensure that all residents will have person-centred care plans in place. Moreover, the Senior Management Team led by the Director of Nursing working with the Acting Home Manager complete regular key checks on all computerised records pertaining to the application of care planning approaches and all assessment methodologies in place for all residents. The Home has also developed key performance evaluative strategies to monitor and evaluate care planning and assessment approaches for all residents in a timely manner. This resulted directly in a revised Care Plan Audit Protocol for Electronic Care Records and a total of approximately four of these are completed as part of the Monthly Audit Cycle. Furthermore, a Post-Admission Check List Audit Tool which is completed for all admissions to the unit within a specified time frame has been operationalised and this is subject to Audit and Review by the Acting Unit Manager and Director of Nursing.

Area for improvement 5 **Ref:** Regulation 14 (2) (a) (c) **Stated:** Second time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure that all areas of the home to which patients have access are free from hazards to their safety. Ref: 2.0 and 3.3.4
	Response by registered person detailing the actions taken: The Home has carried out a comprehensive review of all health and safety protocols in place. This resulted directly in the application of new coded door locking systems for all areas where access could constitute a hazard to a resident's safety. Revised standards were also put into place for COSHH procedures within the unit dining and kitchen facilities with household chemicals being locked away in cupboards with clear signage attached for increased awareness and responsiveness of all staff members.
Area for improvement 6 **Ref**: Regulation 13 (7) **Stated:** Second time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure a system is implemented to monitor staff practice in relation to the appropriate use of personal protective equipment including donning and doffing and staff knowledge and practice regarding hand hygiene. Where deficits are identified during the monitoring system, an action place should be put in place to drive the necessary improvement. Ref: 2.0 and 3.3.4
	Response by registered person detailing the actions taken: The Home has completed further mandatory in-house training in all aspects of infection prevention and control (IPC) and this has been aligned to a 'return to basics' training. The Home has also implemented revisions to the Home Manager's Daily Walk Around procedures to ensure that these also adequately include IPC as a central observational theme for review. The Home has also operationalised unannounced IPC compliance inspections within different shift patterns and where necessary action plans have been implemented to both improve and sustain IPC protocols wtihin the Home. The Home has also implemented an increased approach to the utilisation of IPC signage in all areas within the home where residents, visitors and staff have access and this approach is designed to ensure continuous reminders relating to IPC procedures to maintain enhanced sustainability.
Area for improvement 7 **Ref**: Regulation 10 (1) **Stated:** Second time **To be completed by:**	The registered person shall ensure that there is a robust system of governance in place, that it is effective and proactive in identifying shortfalls and driving improvements through clear action planning**.** Ref: 2.0 and 3.3.5

31 December 2024	**Response by registered person detailing the actions taken**: The Home has in direct consultation with the RI developed revised corporate strategies and approaches to governance. The RI organised for external professional input into a review of all governance procedures within the home in a collaborative manner with Ulster University academics. A Corporate Governance series of lectures was provided to all senior nurse managers who were also provided with direct opportunities to engage with the Ulster University lead. A Teaching and Learning Resource Pack has been developed in consultation with Ulster University and the Director of Nursing and this has been made directly available to all nursing and management staff on all PC systems within Dunluce Health Care. Revised corporate structures are operational and the RI has increased the number and frequency of Senior Management Staff Meetings with all Nurse Managers.
Area for improvement 8 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** 31 December 2024	The registered person shall review the morning routines in the home to make sure that patients are washed and dressed at their preferred times and, receive their drinks and meals at appropriate intervals Ref: 3.3.2
	Response by registered person detailing the actions taken: The Home has carried out an internal review of routines and day to day procedures. This has resulted in the development of an Audit Tool for the two hourly comfort checks for all residents within the home and this has been aligned to the provision of all other aspects of daily living skills. Moreover, all care planning records were reviewed to ensure that these accurately detailed the individualistic approach to care as expressed by the individual resident.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure that nursing staff evaluate care in a meaningful manner that is person centred. Ref: 2.0 and 3.3.3
	Response by registered person detailing the actions taken: The registered manager can assure nursing records reflects the residents' activities over the 24h. The requirement for personal and centred nursing notes throughout the day was disseminated with all staff on safety briefing to make sure there is a person-

	centred written notes for the day. Any additional information to is be added onto the records. The registered manager will be monitoring with regular monthly audits within the residents' records and act on the non-compliant nursing notes with the responsible nurse.
Area for improvement 2 **Ref:** Standard 39 **Stated:** First time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure that meaningful inductions are conducted with new employees; especially those who have never worked in the care environment before. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Home induction programme has been revised and this will be a cyclic process following evaluative reviews following each induction programme. The Home has implemented both formative and summative assessment approaches within the overall six-month induction and probationary period for all new staff appointments, to ensure that comprehensive and supportive assessments in core and mandatory skills areas are completed using direct participatory assessments of skills and also non-participatory, reflective application of approaches to assessments. The Home has also applied their Buddy and Mentorship programme to all new appointees and staff who are new to caring will be paired with more senior experienced staff to promote their learning and adaptation to the caring profession.
Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure that patients are encouraged and assisted with their meals in a timely manner. Ref: 3.3.2
	Response by registered person detailing the actions taken: A revised Meal Times Matters Daily Audit protocol has been implemented which has been developed in consultation with the SLT teams within the Trust and which has also been subjected to evaluation during SLT unannounced audits within the Home. Meal times have been staggered within both the Starling and Willow unit to maximise on supportive measures for those residents who require more time, support and supervision with their nutritional support.
Area for improvement 4 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that when a patient's nutritional requirements change, all care records relating to the patient are consistently updated to reflect the change. Ref: 3.3.2

To be completed by: With immediate effect (5 December 2024)	**Response by registered person detailing the actions taken:** The Home has liaised closely with the SLT teams within the Trust to ensure that all proactive and responsive measures are detailed within the resident's care plans and that these are also reflective of any changes within the monthly assessment processes. Reporting mechanisms are in place to ensure a consistent approach to reflect any changes in the resident's nutritional status. A new Audit protocol has also been added to the Manager's Monthly Audit Protocols.
Area for improvement 5 **Ref:** Standard 6 **Stated:** First time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure that care records accurately reflect when oral care is provided. Ref: 3.3.2
	Response by registered person detailing the actions taken: The Home has engaged in a pro-active manner with all Registered Nurses and Care Staff to ensure that real time reporting on resident's health status occurs. The Home has also consulted with the software providers for their electronic care records system to provide additional training and support mechanisms for staff using these record systems.
Area for improvement 6 **Ref:** Standard 23 **Stated:** First time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure that patients' pressure mattress settings are maintained in accordance with the patients' weights. Ref: 3.3.2
	Response by registered person detailing the actions taken: This has been reviewed and the Manager's Monthly Audit Tool now incorporates these additional safety checks on all mattress settings to ensure they are consistent with the current monthly weight as recorded for the resident.
Area for improvement 7 **Ref:** Standard 23 **Stated:** First time **To be completed by:** With immediate effect (5 December 2024)	The registered person shall ensure that care plans are in place to direct staff in the management of the wound. Ref: 3.3.2
	Response by registered person detailing the actions taken: The Acting Home Manager and Director of Nursing carry out systematic and periodic reviews of all care plan approaches for the management of resident's wounds. These are identified within the cyclic process of Key Checks completed by the Acting Home Manager and Director of Nursing. Continuous Professional and Developmental (CPD) feedback is provided to Registered Nurses with respect to the management of wounds, the involvement of Tissue Viability Nurse Specialists and all other members of the MDT as necessary. Primary Nursing and Secondary Nursing allocations are designed to ensure that wounds are attended to in

	accordance with the individual's care plan within the appropriate time frame.
Area for improvement 8 **Ref:** Standard 22 **Stated:** First time	The registered person shall ensure that patients' who remain in their bedrooms have access to call bells to summon staff when they need assistance. Ref: 3.3.2
To be completed by: With immediate effect (5 December 2024)	**Response by registered person detailing the actions taken:** The Home has implemented a two-hourly comforts check audit tool to enhance comfort checks on all patients. A core number of areas are included within these comforts check protocol, and includes current presence, proximity of call bells and the potential identification of any other unmet physical or psychological needs. The comforts check is operationalised by the Care Staff with the direct supervision of the Nurse in Charge. It can be increased in frequency where a specific resident's situation indicates the need to do so. All care plans have been systematically reviewed to ensure that they identify the individualistic expressed needs for the resident.

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The Regulation and Quality Improvement Authority

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