Unannounced Care Inspection Report
3 January 2020

Maryland Healthcare Care Centre of Distinction

Type of Service: Nursing Home
Address: 95 Knockbracken Road, Castlereagh, Belfast BT6 9SP
Tel no: 028 9044 8797
Inspector: Joanne Faulkner

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 84 patients. The home is divided in to four units; Rowan which has 20 beds, Larch which has 20 beds, Willow which has 22 beds and Juniper which has 22 beds.

3.0 Service details

Organisation/Registered Provider: Maryland Healthcare Limited **Responsible Individual:** Susan McCurry	**Registered Manager and date registered:** Jacquelyn Grace Woods 18 September 2017
Person in charge at the time of inspection: Jacquelyn Grace Woods	**Number of registered places:** 84 A maximum of 20 patients in category NH-DE to be accommodated in the Rowan Unit. A maximum of 20 patients in category NH-DE to be accommodated in the Larch Unit.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 77

4.0 Inspection summary

An unannounced inspection took place on 3 January 2020 from 10.10 hours to 15.30 hours.

This inspection was undertaken by the care inspector.

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

The following areas were examined during the inspection:

- staffing arrangements
- environment
- care records
- adult safeguarding
- complaints
- accident/incidents
- governance arrangements.

Evidence of good practice was found in relation to staff attentiveness to patients and the delivery of care which took into account personal choice for patients. Staff had a good understanding of the individual needs of the patients and worked well as a team to deliver the care patients' required. The delivery of care took into account needs, personal choice and independence of the individual patients.

No areas requiring improvement were identified.

Patients described living in the home as being a good experience/in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others/with staff.

Comments received from patients, people who visit them and staff during the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Jacquelyn Grace Woods, registered manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 1 and 2 July 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 1 and 2 July 2019 by care, pharmacist, finance and estates inspectors. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. No questionnaires were returned to RQIA prior to the issuing of this report. A poster was provided for staff detailing how they could complete an electronic questionnaire; no responses were received within the relevant timescales.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were reviewed during the inspection:

- duty rota information for all staff from 16 December 2019 to 5 January 2020
- incident and accident records
- two patient care records, including food and fluid intake charts
- a sample of governance audits/records
- complaints records
- adult safeguarding records
- the monthly monitoring reports for October, November and December 2019
- RQIA registration certificate

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspections

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure that equipment such as hoists, slings, gloves and aprons are stored in line with good practice guidance for infection prevention and control and that staff practice is monitored to ensure compliance.	**Met**
	Action taken as confirmed during the inspection: It was noted that equipment was appropriately stored. Gloves and aprons were stored in line with good practice for infection prevention and control.	
Area for improvement 2 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that the system in place to notify RQIA of incidents/accidents, in accordance with regulations, is effective.	**Met**
	Action taken as confirmed during the inspection: From records viewed it was identified that there was an effective system in place for notifying RQIA of incidents/accidents, in accordance with regulations.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 12.3 **Stated:** First time	The registered person shall ensure, through regular monitoring, that nutritional risk assessments are completed for all patients on admission and that, as required, care plans are developed which reflect the patient's nutritional needs; such as speech and language recommendations.	**Met**
	Action taken as confirmed during the inspection: It was identified from care records viewed that nutritional risk assessments are completed for patients on admission and that care plans are developed and updated as required to reflect the patient's nutritional needs.	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

6.2.1 Staffing

We reviewed staffing arrangements within the home. Discussions with the manager indicated that they were knowledgeable in relation to their responsibilities with regard to the Regulations. Discussions with the manager and staff evidenced that there was a clear organisational structure within the home. The manager is supported by three unit managers who coordinate a team of registered nurses and a number of senior healthcare assistants and care assistants. In addition, there is a team of support staff which includes housekeeping, laundry, maintenance and kitchen staff and an activities coordinator. There is currently a vacancy for a unit manager.

On the date of inspection the certificate of registration was on display and reflective of the service provided. No concerns regarding the management of the home were raised during the inspection.

Discussions with the manager, staff and patients, and rota information viewed provided assurances that the home endeavours to ensure that there is at all times the appropriate number of experienced persons available to meet the assessed needs of the patients. Discussions with a number of patients and a relative during the inspection identified that they had no concerns with regards receiving the appropriate care and support.

The manager stated that staffing levels were subject to regular review to ensure the assessed needs of the patients were appropriately met. They discussed how they only permit two admissions per day to the interim care unit; this is to ensure that they have adequate staff available to meet the needs of the patients in the unit. The duty rota information viewed, reflected the staffing levels discussed with the manager during inspection. Observation of the delivery of care provided evidence that patients' needs were met by the levels and skill mix of staff on duty. Staff consulted confirmed that they were satisfied the staffing levels and skill mix were sufficient to meet patients' needs.

Staff rota information viewed indicated that the care is provided by a core staff team which included agency staff when required; it was felt that this supports the home in ensuring continuity of care to patients. Staff stated that they felt that continuity of staff can have a positive impact on the patients' experience in relation to their human rights such as privacy, dignity and respect.

Staff had a clear understanding of their roles and responsibilities. Discussions with patients and relatives demonstrated that they were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

Staff demonstrated that they had a good understanding of the individual assessed needs of patients and could describe the importance of respecting patients' personal preferences and choices. Throughout the inspection patients' needs and requests for assistance were observed to have been met in a timely, respectful and caring manner. Interactions between staff and patients were observed to be compassionate and appropriate. Observations of patient and staff interactions evidenced that patients were offered choice; staff provided care in a manner that promoted privacy, dignity and respect. Patients and a relative consulted with spoke positively in relation to the care provided. Patients who could not verbalise their feelings in respect of their care they received were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. During the inspection call bells were noted to be answered promptly.

6.2.2 Environment

We reviewed the home's environment undertaking observations of a sample of bedrooms, bathrooms, lounges, dining room and storage areas within each of the four units within the home. Fire exits and corridors were observed to be clear of clutter and obstruction. Fire doors were alarmed as appropriate.

The entrance areas and a number of shared areas were noted to be decorated to a high standard, clean and uncluttered. Patients' bedrooms were clean, warm and welcoming and had been personalised to the individual interests, preferences and wishes of patients. The manager provided evidence that storage units had been ordered for the patients' bathrooms for the storage of toiletry items.

There were no malodours detected in the home. Compliance with best practice on infection prevention and control (IPC) had been well adhered to. A supply of gloves and aprons were readily available to staff in all of the four units and noted to be used appropriately while they were attending to patients' needs. The provision and use of handwashing facilities throughout the home was observed to be consistently utilised. Information leaflets with regard to IPC issues such as hand hygiene were available for patients and their visitors.

It was noted that an exit door in the Juniper unit which led to an enclosed garden space was not closing securely; this was highlighted to the manager. It was identified that the doors are not required to be locked in this unit. During the inspection the maintenance person inspected the door and identified that the electronic mechanism was not operating correctly and that door needed to be pulled to ensure it was securely closed. It was noted that the alarm was activated if the door was not closed securely. The manager stated that a notice would be placed on the door to alert those using the door of the need to ensure that it is closed securely after entering or exiting.

6.2.3 Care records

Care records viewed during the inspection were noted to be retained electronically. The review of care records for two patients identified that they were detailed and individualised; they included details of patient's likes and preferences. Records viewed included referral information received from a range of HSCT representatives and in addition included risk assessments, safety assessments and care plans. The electronic system will identify when matters require attention or review.

Care plans viewed were noted to provide details of the specific care required by individual patients; they included details of any practice deemed to be restrictive. Staff record daily the care provided to patients; the inspector observed staff imputing the information electronically throughout the inspection. Staff stated that they aim is to support patients to be as independent as possible.

There was evidence that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. There was evidence that the care planning process included input from patients and/or their representatives, as appropriate. Discussions with staff and patients, and observations made provided assurances that care is provided in an individualised manner.

Records viewed indicated that there was regular communication with relevant representatives. A review of the care provided is facilitated at least annually in conjunction with relevant representatives. Staff described the benefits of regular reviews for ensuring that the needs of patients were being appropriately met and that risks are identified.

The home has a process for monitoring patients with significant weight loss or those patients identified to be at risk of malnutrition. Patients had been weighed regularly and a nutritional screening tool known as Malnutrition Universal Screening Tool (MUST) was utilised to determine the risk of weight loss or weight gain. Staff stated that patients had 24 hour access to food and fluids.

6.2.4 Dining experience

We observed the serving of the midday meal; the atmosphere in the dining room was calm and relaxed. The dining room was clean and uncluttered and table settings were noted to be very well presented with appropriate table coverings, napkins, cutlery and condiments. Food served was well presented and discussion with a number of patients evidenced that they enjoyed a pleasurable dining experience. Staff were observed offering and providing assistance in a discreet and sensitive manner when necessary. Staff who were supporting patients to eat their meal were sitting close to the patients and chatting to them as they provided assistance. Food was covered when being transferred from the dining room to patients who were eating in the bedrooms.

A number of patients spoken with stated that the food was good and confirmed that they had a choice of menu; one patient described how the chef had met with them in order to identify food which they required due to their specific dietary requirements.

6.2.5 Activities

The inspector observed a number of patients participating in a musical activity. There was evidence that a varied programme of activities is available to patients in the home. Activities, such as art, music and crafts were part of the weekly programme.

6.2.6 Complaints

A review of complaints received since the previous inspection, evidenced that they had been managed appropriately. Complaints are audited monthly as part of the quality monitoring audit. A copy of the complaints procedure was available in the home. It was identified from records viewed that information relating to the investigation, the actions taken and outcomes of the complaint is retained in a detailed manner.

6.2.7 Adult safeguarding

A review of adult safeguarding information and discussions with the manager provided evidence that no referrals had been made in relation to adult safeguarding since the last care inspection. Adult safeguarding matters are reviewed as part of the monthly quality monitoring process. Discussions with the manager and staff demonstrated that they were knowledgeable in matters relating to adult safeguarding and the process for reporting adult safeguarding concerns. A safeguarding champion was identified for the home.

Staff could clearly describe their responsibility in relation to reporting poor practice and had awareness of the home's policy and procedure with regard to whistleblowing.

6.2.8 Incidents

A review of a sample of the accidents and incidents which had occurred within the home identified that they had been managed appropriately. There are systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. It was noted that details of incidents are audited monthly as part of the quality monitoring process; this assists in highlighting trends and risks, and identifying areas for improvement.

6.2.9 Consultation

During the inspection we spoke to three patients, small groups of patients in the dining room or lounge areas, a relative and three staff. Patients who could verbalise their views provided positive feedback in relation to the care provided by staff. As previously stated, patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others.

Patient's comments

- "Very happy here; only here until I can get a care package."
- "Would like to get home."
- "I have no issues or concerns."
- "Staff are good; some of the staff are very young."
- "Staff are excellent; couldn't say a thing about them."
- "Really happy with the help."
- "We are well looked after."
- "Very happy; nice place."
- "I am on a special diet; the chef spoke to me about my needs."
- "Food is good."

Staff comments

- “Happy working here; have been here since it opened.”
- “Have worked in all the units.”
- “The manager accommodated me with set days to work as I have a young child to care for.”
- “We have a good team.”
- “We are well supported.”
- “The residents are well cared for.”
- “We have to help them to be as mobile as possible.”
- “We can speak to the manager.”

A matter relating to the duty rota and the timescales within which it is made available to staff was discussed with the manager and assurances provided that this would be discussed with staff.

A visiting professional stated that staff keep them informed of any changes in the needs of the patient’s; they stated that communication is good. They stated that they felt that patients were well cared for and that staff are attentive in making sure their needs are met.

A relative who spoke to the inspector indicated that they had no concerns in relation to the care provided to their relative. They stated that staff were approachable and felt that care provided was of a high standard.

Patients and relatives stated that staff were friendly and approachable; they stated that they had no concerns in relation to the care provided to them. The manager and staff discussed the challenges in relation to one resident relating to their personal hygiene and appearance; details of the actions taken to support this individual are recorded in their care records.

We observed a number of staff supporting patients in the dining room and lounge; they were encouraging and supporting them to be involved in an organised activity. Staff indicated that they were respectful of the patients by asking them their choices in relation to a range of matters such as food and participation in activities. There was a relaxed, welcoming atmosphere in all the units within the home.

Discussion with patients, the manager and staff provided evidence that there were systems in place to obtain the views of patients and their representatives on the day to day running of the home. There was evidence that suggestions for improvement had been considered and used to improve the quality of care delivered.

Ten questionnaires were provided for distribution to the patients and/or their representatives; no responses were received prior to the issuing of this report.

At the request of the inspector, the manager was asked to display a poster within the home. The poster invited staff to provide feedback to RQIA via an electronic means regarding the quality of service provision; no responses were received prior to the issuing of this report.

6.2.10 Governance Arrangements

The manager provided evidence that robust and effective systems were in place to monitor and report on the quality of care provided. The inspector viewed audits completed monthly that are in accordance with best practice guidance in relation to infection prevention and control, falls, choking risk, dependency levels, wound management, nutrition, medication, complaints, incidents/accidents and adult safeguarding.

The home has implemented a system for completing quality monitoring audits on a monthly basis and for developing a report in accordance with Regulation 29. The inspector reviewed records that evidenced Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan is generated to address any areas for improvement. The records indicated engagement with patients, and where appropriate their representatives; the inspector discussed the benefits of recording comments made by those people engaged with. The reports available were noted to include details of the review of the previous action plan, review of care records, staffing arrangements, accidents/incidents, adult safeguarding referrals, nutrition/ weight loss, environmental matters, wound management and complaints.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, provision of individualised care and engagement with patients, relatives and other relevant stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

The Regulation and Quality Improvement Authority

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