The Regulation and Quality Improvement Authority

Unannounced Post-Registration Care Inspection Report
23 October 2017

Maryland Healthcare Care Centre of Distinction

Type of Service: Nursing
Address: 95 Knockbracken Road, Castlereagh, BT6 9SP
Tel No: 028 90448797
Inspector: Aveen Donnelly

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 provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 79 persons.

3.0 Service details

Organisation/Registered Provider: Maryland Healthcare Limited Responsible Individual: Susan McCurry	Registered Manager: Jacquelyn Grace Woods
Person in charge at the time of inspection: Jacquelyn Grace Woods	**Date manager registered:** 18 September 2017
Categories of care: Nursing Home (NH) DE – Dementia. LD – Learning disability. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 79 comprising: 18 patients in category NH-LD to be accommodated in the Juniper Unit. 12 patients in category NH-PH 9 patients in category NH-PH(E) to be accommodated in the Willow Unit. 20 patients in category NH-DE to be accommodated in the Rowan Unit. 20 patients in category NH-DE to be accommodated in the Larch Unit.

4.0 Inspection summary

An unannounced inspection took place on 23 October 2017 from 10.15 to 15.45.

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 Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and since the pre-registration care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

There were examples of good practice found throughout the inspection in relation to staff development and training, adult safeguarding, infection prevention and control, risk management and the cleanliness of the home's environment. Patient care records were generally well maintained; and there was evidence of timely communication between residents, staff and other key stakeholders. The culture and ethos of the home promoted treating patients with dignity and respect, patients were listening to and their views had been taken into account. Mealtimes and activities were well managed. There were examples of good practice found throughout the inspection in relation to governance arrangements, quality improvement and maintaining good working relationships within the home.

An area for improvement made under the regulations related to the oversight registered nurses had of the bowel functioning records. Areas for improvement made under the care standards related to the robustness of the system for checking the NMC registrations; the environment of the dementia units; and the system for managing urgent communications, safety alerts and notices.

Patients indicated verbally and non-verbally that they were happy living in the home and staff were kind to them.

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	1	3

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Jacqueline Woods, Registered Manager, and Susan McCurry, Responsible Person, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

5.0 How we inspect

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the previous care inspection report
- pre inspection assessment audit

During the inspection the inspector met with three patients, three care staff and one registered nurse. No patients' representatives were present during the inspection. Questionnaires were also left in the home to obtain feedback from patients and their' representatives. Ten questionnaires for staff and relatives and eight for patients were left for distribution. A poster inviting staff to complete an online survey was also left with the registered manager, to display.

A poster informing visitors to the home that an inspection was being conducted was displayed. The following records were examined during the inspection:

- staffing arrangements in the home
- one staff personnel file to review recruitment and selection
- one staff induction record
- staff training records for 2017
- accident and incident records
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- personal emergency evacuation plans
- two patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- patient register
- staff register
- RQIA registration certificate
- certificate of public liability
- audit templates in relation to falls and wound care
- minutes of staff' meetings held since the previous care inspection

The findings of the inspection were provided to the registered persons at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 7 September 2017

The most recent inspection of the home was an announced pre-registration care inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 7 September 2017

There were no areas for improvement identified as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

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

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. The planned staffing levels were based on the patients' dependency needs which also included specific staffing arrangements for some patients as outlined by the commissioning Trust. A review of the staffing rota from 16 October to 22 October 2017 evidenced that the planned staffing levels were adhered to. The registered manager advised that adequate numbers of staff had been recruited to cover each unit, in anticipation of patients being admitted.

Observation of the delivery of care evidenced that the patients' needs were met by the number and skill mix of staff on duty. Discussion with staff evidenced that there were no concerns regarding staffing levels.

Staff consulted with confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Discussion with the registered manager and a review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their registrations were checked with NMC and NISCC, to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with AccessNI and satisfactory references had been obtained, prior to the staff member starting their employment.

A record of staff including their name, address, date of birth, next of kin, position held, contracted hours, date of receipt of AccessNI certificate, date commenced and date position was terminated (where applicable) was maintained and provided an overview of all staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. The registered manager met with all staff at the end of their probationary period, to confirm that the induction process had been satisfactorily completed.

The registered manager advised that plans were in place to commence a rolling programme of staff supervisions. The registered manager explained and the review of records confirmed that competency and capability assessments had been completed for all registered nurses who took charge of the building in the absence of the registered manager.

Staff consulted with stated and a review of the staff training records confirmed that training had been provided in all mandatory areas and records. A review of staff training records confirmed that staff completed face to face and e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm.

Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the registered manager.

A review of records evidenced that arrangements were in place for monitoring the registration status of staff in accordance with NMC and NISCC. Although a system was in place to remind staff to renew their registrations, a review of the records identified two registered nurses who had renewed their registrations between checks. This meant that the system in place was not sufficiently robust. This has been identified as an area for improvement under the care standards.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. The registered manager identified herself as the safeguarding champion for the home and explained that training had been planned, to ensure that the new regional operational safeguarding policy and procedure would be embedded into practice.

Review of patient care records evidenced that validated risk assessments were generally completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that there had been no patients had fallen in the home since the last care inspection. The registered nurse consulted with was knowledgeable regarding the process to follow in relation to falls management.

There were processes in place to check that emergency equipment, such as the suction machines were regularly checked as being in good order and fit for use. This meant that in the event of an emergency the equipment was ready for use.

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, tidy, well decorated and warm throughout.

Although the home had previously commissioned a design consultant to be involved in the design process of the dementia units, there was still a lack of items/visuals to promote reminiscence and appropriate paintings, specifically along the corridor areas of the dementia units. Whilst RQIA acknowledges that some work had commenced in relation to this, sufficient progress had not been made to ensure that the environment was conducive for patients with a diagnosis of dementia. This has been identified as an area for improvement under the care standards.

Fire exits and corridors were observed to be clear of clutter and obstruction. The emergency evacuation register was up to date and included the details of the last patient admitted to the home.

Infection prevention and control measures were adhered to and equipment was stored appropriately.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

Areas for improvement made under the care standards related to the robustness of the system for checking the NMC registrations; and the environment of the dementia units.

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of two patient care records evidenced that prior to admission a range of validated risk assessments and care plans were completed in consultation with the commissioning Trust. There was evidence that risk assessments informed the care planning process. The majority of care plans reviewed were detailed and person centred; however there were some discrepancies identified in relation to the detail included in the care plans. This was discussed with the management team who provided assurances that further training was planned with registered nurses in relation to the use of the electronic care record system.

There were a number of examples of good practice found throughout the inspection in this domain. Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as speech and language therapist (SALT) or dieticians. Discussion with registered nurses and care staff evidenced that they were knowledgeable regarding the recommendations made and confirmed care delivered was reflective of same.

Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. Abbey pain assessment tools were completed for patients who could not verbalise their pain. Advice was given to the registered manager in relation to sourcing an appropriate pain assessment tool for patients who could verbalise their pain.

Supplementary care charts such as repositioning/food and fluid intake evidenced that records were maintained in accordance with best practice guidance, care standards and legislation. Food and fluid intake charts confirmed that patient's fluid intake was monitored effectively. Patient's fluid intake was totalled over the 24 hour period and recorded within the daily progress notes.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality. Care staff used portable digital assistance (PDA) hand held devices to record information regarding the care delivered. This included recording information on when patients were repositioned, assistance given with personal hygiene, oral intake, activities and bowel functioning. However, a review of the electronic record evidenced gaps in the completion of the bowel functioning records and there was no evidence within the daily progress notes that the registered nurses had oversight of the bowel functioning records. This was discussed with the registered manager and has been identified as an area for improvement under the care standards.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition.

A Staff meeting had been held on 4 October 2017 and records were maintained. The registered manager advised that meetings with patients and their representatives would be held as per the Care standards for Nursing Homes, 2015, when the home becomes more established.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping; and communication between patients, staff and other key stakeholders was well maintained.

Areas for improvement

An area for improvement made under the regulations related to the oversight registered nurses had of the bowel functioning records.

	Regulations	Standards
Total number of areas for improvement	1	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

The level of verbal communication achieved with patients was minimal due to their category of care. However, it was apparent from their gestures that they liked living in the home. The registered manager explained that there was one diversional therapist and two activities coordinators currently employed in the home and that plans were in place to have a designated activities person assigned to work in each of the four units, as the occupancy of the home increased.

Patients were involved in decision making about their own care in relation to when they chose to get up or when they wanted to eat their meals. Patients were asked what they wanted to eat at every mealtime and this was provided. Staff also had a good awareness of patients' likes and dislikes and there was evidence that the patients' representatives had been engaged with in relation to this.

During the inspection, we met with three patients, three care staff and one registered nurse. There were no patients' representatives present during the inspection. Some comments received are detailed below:

Staff

"The atmosphere is very homely."
"The patients are very well treated."
"They get really good care here, the patients get a lot of attention."
"I have no concerns."

Patients

"It is excellent, I get everything I need."

A poster inviting staff to complete an online survey was also left with the registered manager, to display. No staff had responded within the required deadline.

We also issued two questionnaires to patients and relatives respectively. One staff and one relative had returned their questionnaires, within the timeframe for inclusion in this report. Both respondents indicated that they were 'very satisfied' that the care was safe, effective and compassionate; and that the home was well-led. One written comment included '(my relative) has gone from living in inappropriate care to living his best ever life.'

Any comments received in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Mealtimes and activities were well managed.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The registered manger, Jacqueline Woods was registered on 18 September 2017 and was involved in the commissioning of the home.

The registration certificate was displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager and review of records and observations evidenced that the home was operating within its registered categories of care.

There was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

There was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager. The registered manager also explained that there was a 'senior cover' file, which provided the nurse in charge of the home with the information they needed to manage the home, in the absence of the registered manager.

A copy of the complaints procedure was displayed in the home. There had been no complaints received from the last care inspection. Discussion with the registered manager confirmed that there was a system in place to ensure that complaints would be managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

A review of notifications of incidents to RQIA since the home was registered confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. Audit templates had been developed in accordance with best practice guidance in relation to care records, infection prevention and control, environment, wound care management, complaints and incidents/accidents. The effectiveness of the audits will be reviewed at future inspection.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

The registered manager was aware of the correct process for managing urgent communications, safety alerts and notices. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies. However, there was no system in place to evidence that these had been reviewed. This has been identified as an area for improvement under the care standards.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

The quality monitoring visit was been completed on the day of the inspection, in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. This will be reviewed at future inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships within the home.

Areas for improvement

An area for improvement made under the care standards related to the system for managing urgent communications, safety alerts and notices. This relates particularly to, but is not limited to the management of alerts regarding staff that had sanctions imposed on their employment by professional bodies.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Jacqueline Woods, Registered Manager, and Susan McCurry, Responsible Person, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 20 December 2017	The registered persons shall ensure that registered nurses have oversight of the bowel functioning records. Evidence of any action taken should be recorded in the daily progress notes. Ref: Section 6.5
	Response by registered person detailing the actions taken: All Nurses have been informed of the importance of monitoring the bowel functioning records and this is recorded in the daily progress notes
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 20 December 2017	The registered persons shall ensure that the system for checking the NMC registrations is further developed, to ensure that it is robust. Ref: Section 6.4
	Response by registered person detailing the actions taken: NMC registration checks are carried out monthly and the dates of these checks are completed at registration expiry dates
Area for improvement 2 **Ref:** Standard 43 **Stated:** First time **To be completed by:** 20 December 2017	The registered persons shall ensure that the environment of the dementia units are enhanced to ensure that they are conducive to the category of care for which the units are registered. This relates specifically to the corridor areas. Ref: Section 6.4
	Response by registered person detailing the actions taken: The dementia units enviornment has been enhanced to ensure it is conducive for residents with dementia
Area for improvement 3 **Ref:** Standard 35.18 **Stated:** First time **To be completed by:** 20 December 2017	The registered persons shall ensure that a robust system is put in place to manage urgent communications, safety alerts and notices. This relates particularly to, but is not limited to, the alerts regarding staff that had sanctions imposed on their employment by professional bodies. Ref: Section 6.7
	Response by registered person detailing the actions taken: Alerts are now sent to the Registered Manager and reviewed as appropriate

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care