Inspection Report

24 and 28 November 2023

Abbey View Care Home

Type of service: Nursing
Address: 48 Newtownards Road, Bangor, BT2 4BP
Telephone number: 028 9146 9644

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: MD Healthcare Ltd **Responsible Individual:** Lesley Catherine Megarity (acting)	**Registered Manager:** Ms Georgeana Tarabuta **Date registered:** 22 August 2023
Person in charge at the time of inspection: 24 November 2023 Ms Lauran Kane, Registered Nurse 10.00 am to 10.30 am Mr Sorin Simion, Deputy Manager 10.30 am to 5.45 pm 28 November 2023 Ms Georgeana Tarabuta, Manager	**Number of registered places:** 25
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. 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:** 25
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 25 patients. Patients' bedrooms are located over two floors. Patients have access to communal lounges and the dining room.	

2.0 Inspection summary

An unannounced inspection took place on 24 November 2023, from 10.00 am to 5.45 pm by a care inspector followed by an unannounced medicines management inspection on 28 November 2023, from 9.45 am to 12.45 pm by a pharmacist inspector.

The purpose of both inspections was to assess if the home was delivering safe, effective and compassionate care and if the home was well led in regard to care delivery and medicines management.

Evidence of good practice was found in relation to the patient dining experience, the provision of activities and maintaining good working relationships.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team with respect to medicines management.

One area for improvement has been identified in relation to contemporaneous records regarding wound care.

The home was found to be clean, tidy, well-lit, comfortably warm and free from malodour.

Staffing arrangements were found to be satisfactory and reviewed regularly by the manager in order to meet the assessed needs of the patients. Staff were seen to be professional and polite as they conducted their duties and told us they were supported in their role with training and resources.

Patients were observed to be well looked after regarding attention to personal care and appearance and staff provided care in a compassionate manner.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from patients, relatives and staff are included in the main body of this report.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience. Addressing the area for improvement will further enhance the quality of care and service in the home.

3.0 How we inspect

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

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

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

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

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

The medicines management part of the inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector also spoke to the manager and the two nurses on duty about how they plan, deliver and monitor the management of medicines in the home.

The findings of both inspections were discussed with the person in charge at the conclusion of the inspection.

4.0 What people told us about the service

Patients, patients' relatives and staff spoken with provided positive feedback about Abbey View Care Home. Patients told us that they felt well cared for, enjoyed the food, that staff were attentive and there are enough staff on duty to meet their needs. Staff told us that the manager was approachable and that they felt well supported in their role.

Patients' relatives told us they were very satisfied with the care provided by staff and the management. They confirmed they found the staff nice and had no issues or concerns but if they had they were confident any issues raised would be addressed.

Following the inspection we received three completed relative questionnaires indicating they were very satisfied that the care provided was safe, effective, compassionate and well led. No staff questionnaires were received within the timescale specified.

Cards and letters of compliment and thanks were received by the home. Comments were shared with staff. This is good practice.

The following comment was recorded:

'With grateful thanks to you all for the care and many kindnesses shown to our dear … It was such a difficult time and you helped us find our way through it.'

5.0 The inspection

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

The last inspection to Abbey View Care Home was undertaken on 12 January 2023 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. Review of records for a staff member evidenced that enhanced AccessNI checks were sought, received and reviewed prior to the staff member commencing work and that a structured orientation and induction programme was undertaken at the commencement of their employment. However, evidence was unavailable to view regarding employment history, that reasons for leaving previous employment and employment gaps had been explored and recorded during the recruitment process for the member of staff. This was discussed with the manager post inspection who advised that interview notes were held separately and confirmed that employment history, reasons for leaving previous employment and employment gaps had been explored and recorded in the interview notes. Recruitment will be reviewed again at the next inspection.

Staff said there was good teamwork and that they felt supported in their role. Staff also said that, whilst they were kept busy, staffing levels were satisfactory apart from when there was an unavoidable absence. The person in charge told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Examination of the staff duty rota confirmed this.

The provision of mandatory training was discussed with staff. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Review of the staff training and development plan for 2023 evidenced that staff had attended training regarding Deprivation of Liberty Safeguards (DoLS), adult safeguarding, first aid, moving and handling, infection prevention and control (IPC), control of substances hazardous to health (COSHH) and fire safety. The person in charge confirmed that staff training is kept under review and that staff had completed further training in relation to dysphagia awareness.

We discussed the Mental Health Capacity Act – Deprivation of Liberty Safeguards (DoLS) training. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

Staff told us they were aware of individual patient's wishes, likes and dislikes. It was observed that staff responded to requests for assistance promptly in an unhurried, caring and compassionate manner. Patients were given choice, privacy and respect.

5.2.2 Care Delivery and Record Keeping

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), the speech and language therapist (SALT) and dieticians.

However, deficits were identified regarding the management of wound care. Review of care records for two identified patients evidenced conflicting information to direct the assessed care required. This was discussed with the person in charge and it was agreed that the presence of such records was potentially confusing for nursing staff. An area for improvement under regulation was made.

There was evidence that patients' weight was checked at least monthly to monitor weight loss or gain. The person in charge advised that dieticians from the local Trust complete a regular, virtual ward round in order to review and monitor the weight of all patients in the home.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Staff attended a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable about individual patients' needs including, for example, their daily routine preferences. Staff respected patients' privacy and spoke to them with respect. It was also observed that staff discussed patients' care in a confidential manner and offered personal care to patients discreetly.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff.

We observed the serving of the lunchtime meal in the dining room on the ground floor. The daily menu was displayed on a white board showing patients what is available at each mealtime and tables were nicely set with condiments and flowers. Staff had made an effort to ensure patients were comfortable throughout their meal. A choice of meal was offered and the food was attractively presented and smelled appetising. The food appeared nutritious and was covered on transfer whilst being taken to patients' rooms. There was a variety of drinks available. Patients wore clothing protectors if required and staff wore aprons when serving or assisting with meals. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Adequate numbers of staff were observed assisting patients with their meal appropriately, in an unhurried manner and a registered nurse was overseeing the mealtime.

Patients able to communicate indicated that they enjoyed their meal.

Two patients spoken with said:

“The food is good and there’s always tea and coffee”.

“I enjoy the food. In fact they give you too much”.

5.2.3 Management of the Environment and Infection Prevention and Control

We observed the internal environment of the home and noted that the home was welcoming, well decorated, comfortably warm and clean throughout.

Patients’ bedrooms were personalised with items important to them. Bedrooms and communal areas were suitably furnished and comfortable. A variety of methods was used to promote orientation. There were clocks and photographs throughout the home to remind patients of the date, time and place.

In two identified bathrooms equipment and a skin cleansing product that had the potential to be shared communally was noted. This was discussed with the person in charge who addressed the matter immediately. This will be reviewed at the next inspection.

Equipment used by patients such as hoists and wheelchairs were noted to be effectively cleaned.

The treatment room, sluice room and the cleaning store were observed to be appropriately locked.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors and fire exits were clear from clutter and obstruction.

Observation of practice and discussion with staff confirmed that effective arrangements were in place for the use of personal protective equipment (PPE).

Personal protective equipment, for example, face masks, gloves and aprons were available throughout the home. Dispensers containing hand sanitiser were seen to be full and in good working order. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

5.2.4 Quality of Life for Patients

It was observed that staff offered choices to patients throughout the day which included preferences for what clothes they wanted to wear and where and how they wished to spend their time. Patients could have a lie in or stay up late to watch TV if they wished and they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of the time in their room and staff were observed supporting patients to make these choices.

Discussion with patients and staff evidenced that arrangements were in place to meet patients’ social, religious and spiritual needs within the home. The programme of activities was displayed on the noticeboard advising patients of forthcoming events.

Patients' needs were met through a range of individual and group activities such as armchair exercises, word and card games, arts and crafts. Patients were observed to enjoy playing bingo in the first floor lounge with staff.

Care records showed that staff discuss and observe patients' preferences for involvement in activity. Patients were given the opportunity to contribute their individual choices of preferred activities. Review of patients' activity records evidenced that a record is kept of all activities that take place, the names of the persons leading each activity and the patients who take part. Comments recorded showed that patients enjoyed the activities they attended.

Staff recognised the importance of maintaining good communication between patients and their relatives. Visiting arrangements were in place and staff reported positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

Since the last inspection there has been no change in the management arrangements. Discussion with staff, patients and their representatives evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the manager.

Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

A review of records and discussion with the manager confirmed that a process was in place to monitor the registration status of registered nurses with the Nursing and Midwifery Council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC).

Review of competency and capability assessments evidenced they were completed for trained staff left in charge of the home when the manager was not on duty.

It was noted that staff supervisions and appraisals had commenced. The person in charge confirmed that arrangements were in place to ensure that all staff members have regular supervision and an appraisal completed this year.

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

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, weight, care plans, the patient dining experience and IPC practices including hand hygiene.

It is required that the home is visited each month by a representative of the registered provider to consult with patients, their representatives and staff and to examine all areas of the running of the home. These reports were made available for review by patients, their representatives, the Trust and RQIA.

The reports of these visits showed that where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed.

Review of the complaints book evidenced that systems were in place to ensure that complaints were managed appropriately. Patients' relatives said that they knew who to approach if they had a complaint.

Review of records evidenced that patient, patient representative and staff meetings were held on a regular basis. Minutes of these meetings were available.

Staff confirmed that there were good working relationships and commented positively about the manager and described her as supportive and approachable.

5.2.6 Medicines Management

The audits completed at the inspection indicated that the medicines were being administered as prescribed.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments. The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they were written and updated to state that they were accurate.

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment. A sample of the medicines administration records was reviewed. The records were found to have been fully and accurately completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

The medicines storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines.

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission. The medicine records had been accurately completed.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct nurses on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If nurses record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient. The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed for two patients. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware of the factors that may be responsible. Records included the reason for and outcome of each administration.

The management of pain was discussed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place and reviewed regularly.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient. The management of thickening agents was reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was too low or too high.

The management of warfarin was reviewed. Warfarin is a high risk medicine and safe systems must be in place to ensure that patients are administered the correct dose and arrangements are in place for regular blood monitoring. Review of the warfarin administration records and the audit completed at the inspection identified satisfactory arrangements were in place for the management of warfarin.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plan. A written care plan was in place when this practice occurred.

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

Management and nurses audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Georgeana Tarabuta, Registered 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 12 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that wound care is delivered in accordance with best practice guidelines and that wound care records are reflective of patients' current needs and specialist advice. Risk assessments and evaluations should be regularly updated. Ref: 5.2.2
	Response by registered person detailing the actions taken: Following the inspection, additional training and education for all nurses has been provided in conjunction with the aligned clinical facilitator from the SEHCT. A nominated wound care champion has been named for the Home to ensure that wound care records are reflective of the residents' current needs and specialist advice and that risk assessments and evaluations are regularly updated. This will be closely monitored and audited by the Home Manager and Deputy Manager.

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

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