The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Rush Hall**

Provider: **Ann's Care Homes**

Date of Inspection: **19 September 2024**

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

1.0 Service information

Organisation:	Ann's Care Homes
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Mrs Carol Craig
Service Profile: This home is a registered nursing home which provides nursing care for up to 66 patients. The home is divided into four units. The Hunter and Broighter suites are situated on the ground floor and provide care for people living with dementia; the Binevenagh and Roe suites are situated on the first floor and provide general nursing care. Patients have access to communal lounges, dining rooms and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 19 September 2024, from 9.50 am to 5.15 pm by a care inspector.

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 13 June 2023; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection evidenced that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was established that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

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.

As a result of this inspection all of the previous areas for improvement were assessed as having been addressed by the provider and no new areas for improvement were identified. Details can be found in the main body of this report.

3.0 The inspection

3.1 How we Inspect

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patient's, relatives, staff or the commissioning trust.

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

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

3.2 What people told us about the service

Patients told us that staff offered choices to them throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time. The patients were happy to engage with the inspector and talk about their experience of living in Rush Hall, they told us; "The staff are lovely, I am very content, I enjoy going to the quizzes", "Everyone is very good to me.. too good" and "You couldn't get better staff even if you handpicked them yourself".

Relatives spoken with on the day of the inspection confirmed they were very happy with the care their loved one receives in Rush Hall; relatives described the care as "Absolutely magnificent", "First class" and "I can't speak highly enough about the staff". Three relatives completed and returned questionnaires; all the comments included were very positive, the staff were described as; "Kind, caring and attentive" and "Everyone is excellent". Other comments included "The staff go the extra mile to keep my mother happy and safe, she is in good hands" and "I am 100% confident my mother is well cared for" and "The care my mother receives is second to none, everyone does everything in their power to keep my mum comfortable and happy".

Staff spoken with said that Rush Hall was a good place to work, they felt supported and reported that teamwork was good. Staff also commented positively about the manager and described them as very supportive and approachable. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

There was a system in place to monitor that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC). Records showed that any nurse taking charge of the home had competency and capability assessments reviewed annually, to ensure they held the knowledge and skills required.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty and it was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients.

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patients' needs, their daily routine, wishes and preferences. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known.

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

At times some patients may require the use of equipment, require continuous supervision or live in a unit that is secure to keep them safe, these all could be considered restrictive. It was established that safe systems were in place to safeguard patients and to manage this aspect of their care.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs. It was observed that a number of airflow mattresses were not set correctly to the patients' current weight. This was discussed with the manager who provided assurance these would be altered immediately, following the inspection the manager provided evidence of the ongoing twice daily checks by the staff to ensure the airflow mattress are set appropriately. This will be followed up on the next care inspection.

Examination of care records and discussion with the manager confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. Review of records confirmed that staff took appropriate action in the event of a fall, for example, they commenced neurological observations and sought medical assistance if required.

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 and their diet modified.

The dining experience was an opportunity for patients to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. An identified mealtime champion co-ordinated the lunchtime meal to ensure each patient received the correct meal; this is particularly important for those patients who require a modified diet. It was evident that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

The importance of engaging with patients was well understood by the manager and staff. The home has dedicated activity staff employed; on the day of inspection the activity staff were on planned leave. However, the programme of activities was displayed and discussion with patients confirmed that they enjoy the activities provided by the home. The home was observed busy with visitors and one patient enjoyed an outing with their family to get an ice-cream. Other patients were observed in their bedrooms or communal lounges with their chosen activity such as reading, listening to music, chatting with others or watching television.

Patients' needs were met through a range of individual and group activities such as games, arts and crafts, hairdressing, one to one time and spending time outside.

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.

Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

3.3.4 Quality and Management of Patients' Environment Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. The home was warm, comfortable and welcoming. Patients' bedrooms were tidy and personalised with items of importance to each patient, such as family photos and sentimental items from home. Some areas of the home were seen in need of repainting; this was discussed with the manager who advised of an ongoing redecoration plan.

Review of records and discussion with the manager confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home's was safe to live in, work in and visit.

Corridors were clear of clutter. However, it was observed that staff whilst in the staff room having their break had propped the fire door open with a chair; this was immediately brought to the manager's attention and was addressed. The manager provided additional information to mitigate the risk of this reoccurring that a hold open device will be ordered and fitted to the door. In addition, it was identified that within the laundry room while staff were attending to the laundry that clothing trolleys were obstructing a fire door, this was discussed with the staff member and the manager who agreed to review the layout of the laundry. Confirmation was received from the manager as to how the laundry space is to be managed going forward. Both these areas will be reviewed at the next care inspection.

Review of records and observations confirmed that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.4 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Carol Craig has been the registered manager in this home since 15 May 2018.

Patients, relatives and staff commented positively about the manager described her as supportive, approachable and able to provide guidance. Relatives commented on how the manager's door is always open and they can approach her about anything.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Carol Craig, registered manager and Elaine McShane, regional manager, as part of the inspection process and can be found in the main body of the report.

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