Unannounced Care Inspection Report
05 February 2018

Meadowbank

Type of Service: Nursing Home (NH)
Address: 11a Trench Road, Londonderry, BT47 2DT
Tel No: 028 7134 7281
Inspector: Bridget Dougan

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.

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 35 adults living with a learning disability.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Maureen Claire Royston	**Registered Manager:** John Diamond – registration pending
Person in charge at the time of inspection: John Diamond	**Date manager registered:** John Diamond - application received - registration pending
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of registered places:** 35

4.0 Inspection summary

An unannounced inspection took place on 05 February 2018 from 11.00 to 17.00 hours.

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.

The inspection assessed progress with any areas for improvement identified during and 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.

There were good examples of practice found throughout the inspection in relation to staff recruitment; induction, training, adult safeguarding, risk management processes; care records; communication between patients, staff and other key stakeholders. There was also evidence of good governance and management systems.

No areas of improvement were identified at this inspection.

Patients and relatives said that they were satisfied with the care and services provided and described living in the home, in positive terms.

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 John Diamond, 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 24 May 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 24 May 2017. 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.

There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which may include information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with twenty patients, seven staff and four patients' visitors/representatives.

Questionnaires were given to the manager to distribute between service users (as appropriate) and their representatives. A poster was also displayed for staff inviting them to provide online feedback to RQIA. No service users or relatives returned questionnaires. Two members of staff provided online feedback, post inspection.

The following records were examined during the inspection:

- duty rotas for nursing and care staff
- staff training records
- a sample of incident and accident records
- complaints record
- compliments records
- three staff recruitment and induction files

- three patient care records
- supplementary care charts for example; repositioning charts, food and fluid charts, bowel records
- a selection of governance audits
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 24 May 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and was validated at this inspection.

6.2 Review of areas for improvement from the last care inspection dated 24 May 2017

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 (1) (a) and (b) **Stated:** First time	The registered persons shall ensure that registered nurses have oversight of the bowel records to ensure that gaps in recording are identified and acted upon. The system for recording bowel movements must also be reviewed to ensure that the records are accurate.	**Met**
	Action taken as confirmed during the inspection: There was evidence that bowel records had been well maintained. Registered nurses confirmed that they review patients' bowel records on a daily basis and record any actions taken in the patients daily progress notes.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 38 **Stated:** Second time	The registered persons should ensure that the recruitment and selection process is further developed to ensure that a record is maintained in regards to whether or not the AccessNI criminal checks received are clear.	**Met**
	Action taken as confirmed during the inspection: A review of three recruitment records evidenced that a record had been maintained and clearly stated the date an enhanced Access NI check was sought and received and the outcome of the check, prior to staff commencing work.	
Area for improvement 2 **Ref**: Standard 38.3 **Stated:** First time	The registered persons shall ensure that the recruitment processes are further developed to ensure explanations are recorded for any gaps in employment histories.	**Met**
	Action taken as confirmed during the inspection: The manager confirmed the recruitment processes had been reviewed and there was evidence that gaps in employment had been explored during interview.	
Area for improvement 3 **Ref**: Standard 39.1 **Stated:** First time	The registered persons shall ensure that induction records are retained in the home for inspection.	**Met**
	Action taken as confirmed during the inspection: Review of the induction records of three recently appointed staff confirmed that induction records were retained in the home for inspection.	

Area for improvement 4 **Ref**: Standard 4.5 **Stated:** First time	The registered persons shall ensure that patients' representatives' are involved in the care planning processes.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the care planning process included input from patients and/or their representatives, as appropriate. Care records provided evidence of regular communication with patients' representatives to inform them of any changes to patients' health or treatment plans. There was also evidence that patients' representatives had been invited to attend the home to review and discuss care plans and confirm their agreement with same.	
Area for improvement 5 **Ref**: Standard 4 **Stated:** First time	The registered persons shall ensure that the care staff booklets provide clear instruction for care staff on the frequency of repositioning required; and on the prescribed consistency of food and fluids.	**Met**
	Action taken as confirmed during the inspection: Supplementary care charts, including repositioning charts and food and fluid intake records were well maintained and evidenced clear directions for care staff on the frequency of repositioning required and on the prescribed consistency of food and fluids. Care staff confirmed they were knowledgeable in regards to the care needs of patients and that they could speak with the registered nurses or the manager if they required any clarification as to the patients care and treatment plans.	

Area for improvement 6 **Ref**: Standard 35.18 **Stated:** First time	The registered persons shall implement a robust system to manage alerts received in relation to medication, equipment and devices; and Chief Nursing Officer (CNO) alerts regarding staff who have sanctions imposed on their employment by professional bodies.	**Met**
	Action taken as confirmed during the inspection: The manager confirmed that the system to manage alerts had been reviewed and that all alerts were now received directly to the manager's e mail address. These are then printed and disseminated to staff as appropriate.	

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 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 manager informed the inspector that following a review of staffing levels, it was proposed to reduce the number of nurses and increase the number of care assistants on night duty, commencing in February 2018. It was confirmed that these proposals were made following a full assessment of the needs of all patients and that staffing levels would continue to be monitored by the manager. A review of the staffing rotas for weeks commencing 8, 15, 22 and 29 January 2018 evidenced that planned staffing levels were adhered to.

Staff confirmed that staffing levels met the assessed needs of the patients. Discussion with three patients evidenced that there were no concerns regarding staffing levels.

Observation of the delivery of care at the time of this inspection evidenced that patients' needs were met by the levels and skill mix of staff on duty.

A review of three recruitment records evidenced that they were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. The records confirmed that an enhanced Access NI check was sought, received and reviewed prior to staff commencing work.

The manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. A review of three staff induction programmes evidenced that these were completed within a meaningful timeframe.

The provision of mandatory training was discussed with staff and training records were reviewed for 2017. Training records evidenced good compliance. The registered manager confirmed that they had systems in place to facilitate compliance monitoring.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. Where any shortcomings were identified safeguards were put in place. It was identified that the home has reviewed and updated their policy and procedures to reflect information contained within the DHSSPS regional policy 'Adult Safeguarding Prevention to Protection in Partnership' issued in July 2015 and the Operational Procedures. There was a clear pathway to follow to refer any safeguarding concerns to the appropriate professionals and the organisation has an identified Adult Safeguarding Champion (ASC).

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Two staff provided online feedback post inspection. They identified they were "satisfied" regarding the question "is care safe" in this setting. They referenced the availability of staff; the care is protective and free from harm and the environment was safe and clean.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, adult safeguarding and the management of falls.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

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 tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning, bowel charts, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislation.

Review of three patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

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.

The manager confirmed that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered. There was evidence of regular monthly audits of a number of areas including care records, the management of falls, wounds and infection control. There was also evidence of weekly surveys of patients and/or relatives regarding the quality of care and services provided. Action plans had been developed and there was evidence that the actions had been embedded.

Discussion with the manager evidenced that patients and/or relatives meetings were not held on a regular basis. It was acknowledged that due to complex health needs, the majority of patients were unable to verbalise their views on the day to day running of the home. However, the manager stated his intentions to introduce meetings for those patients who were able and wished to attend and for their relatives.

Those patients who were able to verbalise their views and four relatives expressed their confidence in raising concerns with the staff and manager.

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. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that they enjoyed working in the home and with colleagues and if they had any concerns, they could raise these with the manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records and the culture of the home which promoted a sense of teamwork.

Areas for improvement

No areas for improvement were identified during the inspection

	Regulations	Standards
Total number of areas for improvement	0	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. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Observation of the lunchtime meal confirmed that patients were given a choice in regards to where they preferred to dine, food and fluid choices and the level of help and support requested. Staff treated patients with dignity and respect, affording patients adequate time to make decisions and choices and offered reassurance and assistance appropriately.

Patients who were able to communicate their feelings indicated that they enjoyed living in Meadowbank and that staff were caring and attentive.

Comments included:

"It's all good here."
"Everyone is very good. I enjoy going on holidays."
"I like going out for a cup of tea to the café. Staff are good and kind."

Discussion with the manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. The manager stated that the majority of patients have complex health needs and very few were able to verbalise their opinions. However, patients' choices and views were determined using non-verbal communication, pictures and other communication aids recommended by speech and language therapists. There was evidence that suggestions for improvement had been

considered and used to improve the quality of care delivered. A copy of the most recent annual report and action plan were available.

We spoke with four relatives during this inspection, all of whom were complimentary regarding the management, staff and the care provided to their loved ones. These are examples of some of the comments received from relatives:

"I am very happy with the care provided. The staff are all excellent, they keep me informed of any changes."
"This home is excellent. I have no concerns, it's a great place. My son has settled well and is now more content being hoisted than he was at home."
"Very happy with everything here.. Staff are excellent."

Two staff provided online feedback following the inspection. They identified they were "satisfied" regarding the question "is care compassionate" in this setting. They referenced that care was delivered in a person centred manner and staff communicate with patients with kindness, dignity and respect.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff awareness of patients' needs, wishes and preferences; patient and staff interactions.

Areas for improvement

No areas for improvement were identified 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.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

Three patients reported that they knew staff in the home; they could talk to staff or the manager if they were worried, or had a concern about their care and staff would help them resolve their concern.

Discussion with the manager and review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015. A copy of the complaints procedure was displayed in various locations within in the home.

A review of records evidenced that robust governance arrangements were in place. Areas audited included but were not limited to; trend analysis of accidents and incidents, care planning; supplementary care records, infection control and environmental audits. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was included within the report to address any areas for improvement and was reviewed at the next visit. Copies of the quality monitoring reports were available in the home.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and maintaining good working relationships.

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.

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