The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
16 June 2016

Meadowbank

Type of Service: Nursing Home
Address: 11a Trench Road, Londonderry BT47 2DT
Tel No: 02871347281
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Meadowbank took place on 16 June 2016 from 09.25 to 15.30 hours. The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence of positive outcomes for patients who were being assisted and responded to in a timely manner. The home was found to be warm, fresh smelling throughout. Staff clearly demonstrated the knowledge, skills and experience necessary to fulfil their roles and responsibilities. There was evidence of a structured orientation and induction for newly appointed staff and there were systems in place to monitor staff performance or to ensure that staff received support and guidance. The majority of staff had completed training in all mandatory areas. Staffing levels were subject to regular review to ensure that the assessed needs of the patients were met.

A recommendation has been made that the recruitment and selection process is further developed, to ensure that a record is maintained, to indicate whether or not the AccessNI criminal record check received was clear.

Is care effective?

A review of care records evidenced that patients' needs were assessed on admission and were reviewed as required. The assessments were used to inform the care planning process. Care plans were very person-centred and demonstrated an excellent understanding of the patients' needs. This is to be commended. The care planning process included input from patients and/or their representatives, as appropriate. Staff stated that there was effective teamwork in the home; each staff member knew their roles and responsibilities. Staff meetings were held on a regular basis and records were maintained. Patients and their representatives expressed their confidence in raising concerns with the home's staff/management.

Is care compassionate?

Staff interactions with patients were observed to be particularly compassionate, caring and timely and examples are given within the report. Patients were afforded choice, privacy, dignity and respect. Patients appeared content and relaxed in their environment. There was good provision of activities in the home and the staff ensured that patients were frequently able to attend external activities. Discussion with staff, relatives and patients and a review of compliments cards evidenced that staff cared for the patients and their representatives in a kind, caring and thoughtful manner.

Although the staff were commended in relation to the compassion displayed to patients on the day of the inspection, a requirement has been made to ensure that the meals in the Oakwood unit are maintained hot until ready to be served to patients.

Is the service well led?

There was a clear organisational structure within the home and evidence that the home was operating within the categories of care for which the home was registered. All comments received in regards to the responsiveness of the registered manger were very positive and all complaints were managed in accordance with legislation. Monthly monitoring visits, in respect of Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 were completed as required.

There was evidence that a range of audits had been completed on a regular basis; however, two requirements have been made in relation to the reporting of serious injuries sustained in the home; and the serving of hot food. Improvements in auditing these areas will further drive improvements in this domain.

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 Department of Health (DOH) Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with James, McCarron, Nurse in Charge, 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.

1.2 Actions/enforcement taken following the most recent medicines management inspection

The most recent inspection of the home was an announced medicines management inspection undertaken on 21 April 2016. There were no further actions required to be taken following this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection. There were no areas that required to be followed up in this inspection.

2.0 Service details

Registered organisation/registered provider: Four Seasons Healthcare Maureen Claire Royston	Registered manager: Claire Wilkinson
Person in charge of the home at the time of inspection: James McCarron	**Date manager registered:** 17 February 2016
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 35

3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients/reps/staff. The inspector also met with two patients, four care staff, one registered nurse and one patient's representative.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to adult safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 April 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector. There were no further actions required to be taken following this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 30 September 2015

Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 32.1 **Stated:** First time	The registered manager should ensure staff are knowledgeable of the reviewed policy and procedures in respect of palliative and end of life care, death and dying. **Action taken as confirmed during the inspection**: There was evidence that all staff had signed the newly issued policy and procedures in relation to palliative and end of life care.	**Met**

4.3 Is care safe?

The nurse in charge confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota commencing 6 June 2016 evidenced that the planned staffing levels were adhered to. Discussion with relatives and staff evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

There were safe systems in place for the recruitment and selection of staff. A review of two personnel files evidenced that these were reviewed by the registered manager and checked for possible issues. Where nurses and carers were employed, their PIN numbers were checked on a regular basis with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to validate their registration status. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and the reference number and date received had been recorded. A recommendation has been made to ensure that detail is recorded in regards to whether or not the Access NI checks received were clear.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. Newly qualified registered nurses were supported to develop their knowledge and skill through a preceptorship programme.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed 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 and this information informed the responsible persons' monthly monitoring visit in accordance with regulation 29. There were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The complaints and safeguarding records provided evidence of incidents. A review of the records identified that concerns had been logged appropriately. A review of documentation confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

A range of risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails and restraint, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate; assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. Where required, further assessments had been completed on an individual basis addressing issues such as behaviours that may challenge. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident, care management and patients' representatives were notified appropriately.

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

Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

A recommendation has been made that the recruitment and selection process is further developed, to ensure that a record is maintained, to indicate whether or not the Access NI criminal record check received was clear.

Number of requirements	0	Number of recommendations:	1

4.4 Is care effective?

A review of five patient care records evidenced that patients' needs were assessed on admission were reviewed as required. Examples of such risk assessments include moving and handling assessments, falls risk assessments, bedrails/lap belt risk assessments, pressure damage risk assessments and malnutrition/choke risk assessments. There was also evidence that risk assessments informed the care planning process.

The 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.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Patients who were identified as requiring a modified diet, had the relevant choke risk and malnutrition risk assessments completed and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

There was also evidence that the risk assessments and care plans were reviewed following any period of hospitalisation.

Care plans in relation to behaviours which challenge were detailed and included identified triggers and appropriate responses the staff should take in order to alleviate the patients' distress. Care plans were very person-centred and evidenced a good understanding of the patients' needs. For example, one care plan on a patient's elimination needs, included detail regarding a specific toilet, the patient preferred to use. A care plan for sleeping, also included detail regarding the patient's preference for having the curtains closed and a night light on, to ensure that they slept well. Consideration was also given to how a patient reacted to an episode of incontinence and included clear direction as to how staff should best deal with this, to ensure that the patient did not get upset. The level of person-centred detail within the care plans is to be commended. Further detail in regards to how staff managed communication difficulties is outlined in section 4.5.

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

A review of personal care records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. Totals of food and fluid received were recorded at the end of each day and there was evidence that the patients' fluid intake had been monitored regularly. Despite this, the system in place for recording patients' bowel movements was confusing, in that staff recorded patients' bowel movements on four separate forms. Bowel movements were recorded on the daily care sheet; the record of toileting; the bowel monitoring chart; and in the patients' daily progress notes. Given that there was evidence that patients' bowel patterns had been monitored, this matter was discussed with the nurse in charge, during feedback, who stated that this would be addressed with staff.

Discussion with staff confirmed 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. Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities; and that communication between all staff grades was effective.

Staff and relatives also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager. Information on advocacy services was not available to patients. Advocates can represent the views for patients/patients' representatives who are unable or not confident in expressing their wishes. However, registered nursing staff confirmed that advocacy services could be accessed via the patients' care management process, if required. Care staff consulted also stated that they felt they had a role to play in advocating for patients, in particular for those patients who did not have any relatives.

A review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. The registered manager also obtains feedback from three patients' representatives on a weekly basis, to ascertain their views on the home environment and the safety of the care provided in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Observation on the day of the inspection confirmed that patients were afforded choice, privacy, dignity and respect. Staff spoke to patients in a polite manner. Patients were consulted with regarding meal choices and were offered a choice of snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

A number of patients were identified as being unable to verbalise their feelings. Consultation with the staff confirmed that they felt they have the necessary skills to communicate effectively with the patients and that if additional support was required, they would get this from the manager.

One identified patient had a ‘communication passport’ which was used to assist staff in understanding their needs. This included information on how the patient displayed happiness or sadness and how staff should respond to these emotions. Other information recorded in the communication passport included: how the patient indicated yes or no to different situations; the expected mannerisms/behaviours which indicated their need to use the toilet, when they were hungry/thirsty; when they wanted to talk or to be alone; or to listen to music. Methods of communicating with the patient was also included, in terms of what the staff should say and what they should show/sign to the patient. This is to be commended.

Another patient was identified as having a visual impairment. Consultation with staff confirmed that they had a detailed knowledge of the patient’s needs. For example, one of the care staff described how the patient needed to hear the bath taps running, for them to be able to associate that the staff had a bath drawn for them.

Menus were displayed clearly throughout the building and were available in pictorial format to assist in making choices and to provide an awareness of the meal to be served. Although, the meals in the Oakwood dining room were covered, they were observed to be sitting on an unheated trolley. This meant that the main meals and deserts were not kept warm. This was discussed with the nurse in charge. A recommendation has been made in this regard.

We observed the lunch time meal in two dining rooms. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with tablecloths and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. One identified patient was observed sitting on the floor in the corridor. At lunch-time, one registered nurse was observed, sitting on the floor, beside the patient, whilst assisting the patient to eat. The manner in which this patient was assisted to eat was very compassionate and it was evident that the staff worked around the needs of the individual patients. This culture of care within the home is to be commended.

Patients were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. There was a list of activities displayed near the reception in order to assist patients to choose which to participate in. Discussion with staff also confirmed that the opportunities for patients to attend external activities were provided on a regular basis. Five staff members were available to drive the home’s minibus. This meant that patients could be brought out frequently. The activities coordinator also worked an evening shift one day per week, in order to escort one patient to the bowling alley. This is to be commended.

Patients’ bedrooms were observed to personalised, with pictures of family members and friends. Staff consulted with stated that they took pride in decorating the patients rooms.

There were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

As part of the inspection process, questionnaires were issued to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

"We give the highest possible standard of care that we can."
"We give 100 percent in everything we do. All the patients are well looked after."
"I have no concerns. It is good here."
"The manager is very good."

Patients

'I like it here alright'
'It's good'

Patients' representatives

"I have no concerns. The care is excellent and the manager would sort even the small things out."

Areas for improvement

A requirement has been made that the serving of meals is reviewed to ensure that the food is kept hot until served to patients.

Number of requirements	**1**	**Number of recommendations**:	**0**

4.6 Is the service well led?

There was a clear organisational structure within the home. Staff 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 was on annual leave on the day of the inspection; however, she made telephone contact with the inspector and also provided remote support to the nurse in charge throughout the day. Also, as discussed in sections 4.4 and 4.5, there was a culture of person-centred care within the home and all staff consulted with, spoke very highly of the registered manager.

Observation on the day of the inspection confirmed that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the nurse in charge and a review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients' representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Discussions

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

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts.

There were systems in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager completed the following audits in accordance with best practice guidance:

- falls
- wound management
- medicines management
- care records
- infection prevention and control
- environment audits
- complaints
- food and safety audit
- health and safety
- bedrails
- restraint
- dining experience audits
- human resource audits

The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis and there was evidence that the registered manager reviewed every incident. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. However, a review of the records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, identified that one serious injury had not been reported to RQIA, in keeping with regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been made in this regard.

As discussed in section 4.5, a recommendation has been made in regards to the need for the patients' meals to be kept hot, whilst waiting to be served. The food and safety audit reviewed only related to the food that was served in the kitchen/main dining room and did not include the serving of the meals in the dining room, in the Oakwood unit. Therefore, we were not assured of the effectiveness of this audit. A recommendation has been made to address this.

A review of records evidenced that Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. The monthly monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement.

Areas for improvement

A requirement has been made that every incident, wherein a head injury is sustained, RQIA must be notified.

The food safety audit should be further developed to ensure that there is regular monitoring of the food temperatures, served in the Oakwood unit. A recommendation has been made in this regard.

Number of requirements	1	Number of recommendations:	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with James McCarron, Nurse in charge as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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 (Insert Service Type). 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to nursing.team@rqia.org.uk for review by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Statutory requirements</td></tr>
<tr><td rowspan="2">Requirement 1

Ref: Regulation 13 (1)(a)

Stated: First time

To be completed by:
14 August 2016</td><td>The registered persons must review the serving of meals on the Oakwood unit, to ensure that the food is kept hot until served to patients.

Ref: Section 4.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Registered manager has completed a full review of the serving of meals. Supervisions have been conducted with catering, nursing and care staff advising that all meals should be kept hot until served to patients. This will be monitored by Registered Manager.</td></tr>
<tr><td rowspan="2">Requirement 2

Ref: Regulation 30 (1) (c)

Stated: First time

To be completed by:
14 August 2016</td><td>The registered person must ensure that any serious injury sustained in the home is reported to RQIA. This refers particularly to head injuries.

Ref: Section 4.6</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Registered manager has discussed the Scope of Notifications with Registered staff under supervison. This includes serious injuries sustained within the home.
Registered Manager will continue to monitor and quality assure that notifications are correctly reported.</td></tr>
<tr><td colspan="2">Recommendations</td></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 38

Stated: First time

To be completed by:
14 August 2016</td><td>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.

Ref: Section 4.3</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Registered Manager has implemented FSHC disclosure confirmation form to all personnel files and Access NI log form is in place allowing the outcome of the Access NI check to be clearly recorded.</td></tr>
</table>

Recommendation 2 **Ref**: Standard 35.4 **Stated:** First time	The registered persons should ensure that the food safety audit is further developed, to ensure that there is regular monitoring of the food temperatures, served in the Oakwood unit. **Ref: Section 4.6**
To be completed by: 14 August 2016	**Response by registered person detailing the actions taken:** The Registered Manager has discussed this with catering staff. The current food safety audit does allow for serving temperatures to be monitored. This will be completed on a regular basis and quality assured by the Registered Manager.

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews