Unannounced Care Inspection Report
23 and 24 May 2016

Magherafelt Manor

Address: 22 Pound Road, Magherafelt, BT45 6NR
Tel No: 028 7930 0284
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Magherafelt Manor took place on 23 and 24 May 2016 from 09:40 to 16:00 on day one; and 10:00 to 13:45 on day two.

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.

Throughout this report the term 'patient' is used to describe those living in Magherafelt Manor which provides both nursing and residential care.

Is care safe?

There was evidence of competent and safe delivery of care. Staff were required to attend mandatory training and the observation of care delivery evidenced that knowledge and skill gained, through training, was embedded into practice.

All grades of staff were commended for their professional and calm approach to events in the nursing home during the inspection. Staffs' approach and action ensured all patients were safe and as unaffected as possible.

There were no requirements or recommendations made.

Is care effective?

There was consistent evidence of positive outcomes for patients. All staff demonstrated a high level of commitment to ensuring patients received the right care at the right time.

There were no requirements or recommendations made.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

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

The level of engagement in activities from both patients and staff was evidently having a positive impact on the patients' experience in the home and was commended.

There were no requirements or recommendations made.

Is the service well led?

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

responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

Discussion with the registered manager and staff; and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. In addition to the organisation's governance programme short focused audits had also been implemented to assure the management of improvements implemented or training provided with outcomes shared with staff to drive improvements and to encourage learning.

As discussed in the report it was evident that the registered manager had implemented and managed systems of working within the home which were patient focused, impacted positively of the patient experience and involved and encouraged staff to participate in the home's life over and above their work commitment. The registered manager was available to patients and their relatives and operated an 'open door' policy for contacting her and she provided staff with a positive role model for their practice and attitude. This was commended.

There were no requirements or recommendations made.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with the registered manager, Mrs Siobhan Conway, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 9 May 2016. Other than the actions detailed in the QIP there were no further actions required. Enforcement action did not result from the findings of this inspection

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistleblowing and any other communication received since the previous care inspection

2.0 Service details

Registered organisation/registered person: Runwood Homes/Mr Nadarajah Logeswaran	**Registered manager:** Ms Siobhan Conway
Person in charge of the home at the time of inspection: Mrs Siobhan Conway	**Date manager registered:** 31 March 2015
Categories of care: NH-I, NH-PH, NH-PH(E), NH-DE, RC-DE A maximum of 22 patients in category NH-DE accommodated in the ground floor unit. A maximum of 30 residents in category RC-DE; 15 residents in ground floor unit and 15 resident in first floor unit. A maximum of 12 patients in categories NH-I, NH-PH and NH-PH(E) accommodated in first floor unit.	**Number of registered places:** 64

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events 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 plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection the inspector spoke with eight patients individually and with others in small groups, nine care staff, the deputy manager, one registered nurse, two catering staff, two staff from housekeeping and maintenance, an administrative support staff member and the activity therapist.

On day one the inspector spoke with one relative and greeted two other relatives visiting. A poster indicating that the inspection was taking place was displayed on the front door of the home which invited visitors/relatives to speak with the inspector.

In addition questionnaires were provided for distribution by the registered manager; 10 for relative/representatives; eight for patients and 10 for staff. At the time of issuing this report none had been returned within the timeframe specified.

The following information was examined during the inspection:

- three patient care records in full and one patient care plan pertaining to the management of bed rails
- four patient supplementary care charts such as repositioning and fluid intake records
- staff roster 16 – 29 May 2016
- staff training and planner/matrix for 2015 and 2016
- one staff recruitment record
- complaints record
- incident and accident records
- record of quality monitoring visits carried out on behalf of the responsible individual in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit
- records for checking nursing staff registration with Nursing and Midwifery Council (NMC) and checking with the Northern Ireland Social Care Council (NISCC) in relation to care staff
- evidence of consultation with staff, patients and representatives.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 9 May 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP will be returned to RQIA, in due course, and reviewed by the pharmacist inspector. The actions taken by the registered persons, as recorded, on the returned QIP will be validated at the next medicines management inspection. There were no issues to be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 23 November 2015

Last care inspection recommendations – no requirements resulted from the last inspection		Validation of compliance
Recommendation 1 **Ref**: Standard 4.8 **Stated:** Second time	The registered persons shall ensure that when recording bowel movements staff make reference to the type of stool passed in accordance with the Bristol Stool chart and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: Review of care records and discussion with staff confirmed that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 4.8 **Stated:** Second time	The registered person shall ensure that care plans pertaining to urinary catheters contain specific steps to ensure the safe management of the urinary catheter.	**Met**
	Action taken as confirmed during the inspection: Review of care records confirmed that this recommendation had been met.	
Recommendation 3 **Ref**: Standard 4.9 **Stated:** First time	Repositioning charts should be recorded accurately to reflect the care delivered in accordance with the patient's care plan.	**Met**
	Action taken as confirmed during the inspection: Review of care records confirmed that this recommendation had been met.	
Recommendation 4 **Ref**: Standard 22 **Stated:** First time	Falls risk and falls sustained are managed and records maintained in keeping with care standards and regional guidance on falls management.	**Met**
	Action taken as confirmed during the inspection: Review of care records and discussion with the registered manager confirmed that this recommendation had been met.	

Recommendation 5 **Ref**: Standard 35.3 **Stated:** First time	The auditing of care records should be reviewed to ensure it clearly identifies areas for improvement. Consideration should be given to the use of short focused audits.	**Met**
	Action taken as confirmed during the inspection: Review of records and discussion with the registered and deputy managers confirmed that this recommendation had been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. Review of the staffing rota evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels.

Staff consulted confirmed that staffing levels met the assessed needs of the patients. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff were mentored by an experienced member of staff during their induction. Records for one staff member were reviewed and found to be completed in full and dated and signed appropriately.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Staff training was delivered by combining an e-learning programme and face to face training in the home. Training outcomes for 2016, so far, indicated that the registered manager ensured mandatory training was completed. For example, 100% compliance had already been achieved in health and safety, medication awareness and other areas had compliance levels over 90%. This was commended. Staff consulted and observation of care delivery and interactions with patients clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice. Staff were confident in carrying out their role and function in the home. In 2015 compliance with mandatory training levels were approximately 95-98% compliant. The registered manager confirmed that 100% compliance had not been achieved due to staff on long term leave and the availability of student bank staff to attend updates when they lived elsewhere during 'term time'.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. A review of documentation confirmed that any potential safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were also notified appropriately.

On day one of the inspection staff were observed to respond to two serious patient safety events. Both events had the potential to have had serious consequences but staff acted promptly, professionally and with compassion to ensure patients were safe. Staff were calm and effective in their management of the situation. Staff worked together to ensure patients were as safe as possible and as unaffected as possible by the events. It was acknowledged that staff are required, at times, to respond to emergency situations. However, all grades of staff were observed to work together which was impressive. Staff were commended for their professional and caring manner.

Review of patient 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.

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 Home Regulations (Northern Ireland) 2005. Staff spoken with confirmed that nursing staff and senior care staff were knowledgeable of the actions to be taken in the event of an emergency. Review of accidents/incidents records confirmed that notifications were forwarded to RQIA appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients, their representatives and staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

Review of patient 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 registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. Risk assessments informed the care planning process. It was evident that 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 and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff also confirmed that regular staff meetings were held, that they could contribute to the agenda and the meeting and minutes were available. Nursing and senior care staff attended a 'heads of department' meeting at 11:00 hours every day, including weekends. Staff shared any concerns they had about their patients and discussed progress with other healthcare professionals or relatives as required. Staff felt this was beneficial as they were able to receive advice from more experienced colleagues. The registered manager said that the 11:00 meeting assisted her knowledge of issues in the home. In addition the registered manager came on duty before 08:00 to meet with night staff and she conducted a walk around the home at least twice daily to assure herself that care delivery was effective. For example, the registered manager said she walked around the home before she went home to assure herself that staff and patients' needs were and would be met over the evening and night duty shift. This is good practice and was commended.

Staff stated they knew they worked together effectively as a team because they communicated effectively and patients were their "top priority"; and staff stated they could raise their concerns with senior staff without fear or censure. As stated in section 4.3 the inspector observed how effective the team were in responding to events within the home to ensure patients safety, health and wellbeing. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

The registered manager informed the inspector that she knew that Magherafelt Manor was an "excellent" home because of the staff team and their professionalism and commitment to patients, relatives, her and each other. This was also evidenced through patient outcomes, for example, the reduction of challenging behaviours by increasing positive engagement in activities provided by staff.

The registered manager also had appointed a 'home ambassador' who was a relative who volunteered for this role. Information on who the person was and their role was displayed on the relatives' board in the foyer. The registered manager confirmed that the ambassador walked around the home on a regular basis to observe the units and to meet and greet relatives. Any concerns were fedback to the registered manager or nurse in charge immediately. Feedback was also provided to the home manager on a more formal basis at the monthly meeting between her and the ambassador. Records were maintained.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

There was information available to staff, patients, representatives in relation to advocacy services.

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

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

Examples of staff knowledge of their patients included the observation of one patient who was attempting to walk unaided. Staff approached this patient with a cup of tea and a biscuit and the patient settled again and enjoyed their midmorning snack with other patients. Staff later confirmed that they knew this patient did not need anything other than the cup of tea because they had provided personal care earlier and they knew the patient's routine and preferences. Other patients in the dementia units were observed to benefit from 'doll therapy' which was appropriately managed by staff. The activity therapist also explained and provided examples of how staff and relatives had made 'twiddle cuffs and muffs'. These were knitted and enabled items of interest or special significance to be attached for patients to hold or handle. The cuffs were unobtrusive and could be easily removed by patients. For example, rosary beads had been attached to a cuff to ensure they were not lost. The 'twiddle muff' were for patients who were nursed in bed and again provided a level of engagement and activity which had a positive impact on levels of anxiety.

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

The inspector was impressed by the level of engagement in meaningful activities by staff throughout the home. Discussion with the home's activity therapist evidenced that she had taken up post in August 2015 and had been a senior care assistant in the home prior to this. The main obstacle to providing activities in the home was the question "can we do this". Over time staff and families have been encouraged to initiate and participate in activities with the patients. Some examples of this are:

- 'cookie jar activity' – this is an activity that staff can initiate and consists of them going to the unit's 'cookie jar' and pulling a patients name from it and then spending 10-15 minutes with that patient on a one to one activity which could be a walk in the garden or choosing their outfit for the next day. The staff member then records the activity and the effect it had for the patient. Use of the cookie jar is kept under review by the activity therapist and the registered manager. All grades of staff are encouraged to participate in this activity process.
- picnics in the garden – families had asked if this was possible and with some forward planning with catering and care staff –it was agreed that it was.
- 'Manor Memories' – was a way for patients, families and staff to get involved in the development of the garden. A shrub, tree or other item could be donated to the garden. For example, if you loved red roses then you could purchase/donate a red rose tree to the garden. A special discount had been arranged for the home at the local garden centre to help with this activity and local school children were donating their time to help.
- garden owls – patients and staff were making these from rounds of tree trucks and these owls would help decorate the fencing until the trees covered it.

There were many other examples provided by the activity therapist and staff.

Staff and the registered manager's aim was to 'normalise' activities in the home and that activities were viewed as being as important in providing care as the medicine round.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Views and comments recorded were analysed and an action plan was developed and shared with staff, patients and representatives. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Consultation with patients individually, and with others in smaller groups, confirmed that living in Magherafelt Manor was a positive experience.

Patient comments to the inspector included:
"I really love the garden."
"I like to eat my meals in the dining room but prefer my own company the rest of the time."
"I would prefer to be at home but I enjoy it here, the staff are very good to me – nothing is a bother to them."

In addition 10 relative/representatives; 10 patient and eight staff questionnaires were provided by RQIA to the registered manager for distribution. At the time of issuing this report none had been returned within the timeframe specified. Any questionnaires received will be dealt with under separate cover as required.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed. Discussion with the registered manager and observations evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and 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. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients and representatives confirmed that they were confident that staff and management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was and referred to her as Siobhan.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. A review of notifications of incidents to RQIA since the last care inspection in November 2015 confirmed that these were managed appropriately.

Discussion with the registered manager and staff; and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints and incidents/accidents. 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. In addition to the organisation's governance programme, short focused audits had also been implemented to assure the management of improvements implemented or training provided. The outcomes were shared with staff to drive improvements and to encourage learning. For example, the registered manager or deputy would audit the care records of a patient recently admitted or of a patient who had been seen by their GP to ensure records were reflective of the patients care needs, regulatory and professional requirements. This is good practice.

Discussion with the registered manager and review of records for March and April 2016 evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives. 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.

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

As discussed in the preceding sections it was evident that the registered manager had implemented and managed systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff to participate in the home's life over and above their work commitment. The registered manager was available to patients and their, relatives and operated an 'open door' policy for contacting her and she provided staff with a positive role model for their practice and attitude. This was commended.

Areas for improvement

No areas for improvement were identified during the inspection.

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

5.0 Quality improvement plan

No requirements or recommendations resulted from this inspection.

Please provide any additional comments or observations you may wish to make below:

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

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