The Regulation and Quality Improvement Authority

Inspection Report

7 and 8 September 2021

Magherafelt Manor Nursing Home

Type of Service: Nursing Home
Address: 22 Pound Road, Magherafelt, BT45 6NR
Tel No: 028 7930 0284

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

1.0 Service information

Organisation/Registered Provider: Kathryn Homes Ltd **Responsible Individual:** Mrs Andrea Feeney	**Registered Manager:** Mrs Siobhan Conway **Date registered:** 31 March 2015
Person in charge at the time of inspection: Mrs Siobhan Conway, Registered Manager	**Number of registered places:** 37
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 37
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 37 patients. The home is divided in two units situated on the ground floor. There is a Residential Care Home which occupies the first floor and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on the 7 September 2021 from 9.30 am to 6.30pm by two care inspectors and continued on 8 September 2021from 9.25 am to 1.30 pm by a pharmacist inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The home was clean, tidy and welcoming on the day of inspection. The patients were observed in their rooms and the communal lounges if they preferred.

It was evident that staff promoted the dignity and well-being of patients through respecting their personal preferences and choices throughout the day. Discussion with staff identified that they had a good knowledge of patients' needs and had relevant training to deliver safe and effective care. Staff provided care in a compassionate manner and were sensitive to patients' wishes.

Review of medicines management found that patients were being administered their medicines as prescribed. There were robust arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management.

Areas requiring improvement were identified regarding management of unwitnessed falls, effective cleaning of equipment and care planning.

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.

RQIA were assured that the delivery of care and services provided in Magherafelt Manor was safe, effective, and compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services in the home.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

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

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

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

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

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

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

The findings of the inspection were discussed with the manager at the conclusion of the inspection.

4.0 What people told us about the service

Five patients were consulted during the inspection. They told us they were happy with the service provided. Comments included; “I am happy, everyone is friendly I get on well” and “they do their best”. Patients were positive about the cleanliness of the home and the care provided. The meal provision was described as “good, but can be repetitive”.

Four staff members were spoken with during the inspection, they said they were happy working in the home.

All comments from patients and staff were passed to the manager for consideration and action as necessary.

No completed questionnaires were received following the inspection and there was no response from the on-line staff survey.

A record of compliments received about the home was kept and shared with the staff team.

5.0 The inspection

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

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Areas for improvement from the last inspection on 04 March 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 27 (4)(d)(iii) **Stated:** First time	The registered person shall ensure that the corridors in the home are maintained free from any clutter or obstruction that would impede in the event of an evacuation of the home.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was met as stated.	

Area for improvement 2 **Ref**: Regulation 14 (2) (a) (b) and (c) **Stated:** First time	The registered person shall ensure as reasonably practicable unnecessary risks to the health or safety of patients is identified and so far as possible eliminated. This is stated with regards but not limited to: • Access to the kitchen area in the Sycamore unit • Access to and inappropriate storage of toiletries and creams in the hairdressers room	**Partially met**
	Action taken as confirmed during the inspection: The hair dressing room was observed to be locked; however, the kitchen area in the sycamore unit was accessible. This will be discussed further in section 5.2.3 This area for improvement was partially met and will therefore be stated for a second time.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 46 **Stated:** First time	The registered person shall ensure that the IPC training in the use of PPE is embedded into practice.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was met as stated.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that supplementary care records are accurately recorded and the nursing staff evaluates the effectiveness of this care. This is stated with specific reference to the detailing on the food and fluid charts and the recording of the bowel charts.	**Not met**
	Action taken as confirmed during the inspection: A sample of records reviewed did not fully reflect the patients intake for the day and the oversight of the bowel monitoring records by the registered nurses was inconsistent. This area for improvement will be stated for a second time.	

Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure a sufficiently detailed care plan is in place for those patients who require to be repositioned.	**Not Met**
	Action taken as confirmed during the inspection: A review of records evidenced for one patient who required to be repositioned no record or recording chart was in place. In another record the equipment in use was not clearly documented. This area for improvement will be stated for a second time.	

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence in recruitment records that the applicants reason for leaving prior employment was not always documented, this was discussed with the manager who agreed to address this.

There were systems in place to ensure staff were trained and supported to do their job. Staff said that team work was good and everyone worked well together. The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty.

Staff told us that staffing levels in the home were usually good; however, due to the ongoing pandemic and short notice absences these were not always achieved. Staffing was discussed with the manager who advised us of the system in place to manage short notice sickness and recruitment was ongoing. All comments from staff were passed to the manager for consideration or action as necessary.

Review of governance records provided assurance that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or Northern Ireland Social Care Council (NISCC) and that these registrations were effectively monitored by the manager on a monthly basis.

Staff responded to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day. For example' staff supported patients' who wished to spend time in the communal areas of the home and those who wished to remain in their own rooms.

It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Patients said staff were friendly and it was evident that they knew the patients well.

5.2.2 Care Delivery and Record Keeping

Staff were observed to be prompt in recognising those patients who had difficulty in making their wishes or feelings known. Staff responded to patients requests for assistance and were knowledgeable about their daily routines.

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. In addition, patient care records were maintained which accurately reflected the needs of the patients. Staff were knowledgeable of individual patients' needs and their daily routine.

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.

A sample of care plans were reviewed; these evidenced risk assessments were completed on admission and reviewed thereafter. Care plans were developed to direct staff on how to meet patients' needs, however, it was observed that some had not been updated with sufficient detail to direct the required care. This was observed in records relating to mobility, nutrition and, as discussed in section 5.2.6, pain management. This was discussed with the manager and an area for improvement was identified.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink; however, in some it was observed that the snacks offered to patients were not recorded. Daily records were kept of how each patient spent their day however there was a lack of oversight of the supplementary care records for example the bowel records by the registered nurses. This was discussed with the manager and an area for improvement was stated for a second time.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, aids such as alarm mats, crash mats or bedrails were in use, patient areas were free from clutter, and staff were seen to support or supervise patients with limited mobility. Staff also conducted regular checks on patients throughout the day and night. Those patients assessed as being at risk of falling had care plans in place.

Records confirmed that in the event of a patient falling, a post falls protocol was in place. A review of records evidenced, for one fall, the post falls observations had not been consistently recorded. An area for improvement was identified.

Patients who are less able to mobilise require special attention to their skin care. These patients were assisted by staff to change their position regularly. A sample of records were reviewed, in one the pressure relieving equipment in use was not clearly documented and a further record had no care plan or recording chart in place. An area for improvement identified at the previous inspection will therefore be stated for a second time.

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. The serving of lunch was observed and found to be pleasant, social and unhurried experiences for patients. The food looked and smelled appetising and portion sizes were generous. Patients told us they enjoyed their meal.

5.2.3 Management of the Environment and Infection Prevention and Control

Observation of the home's environment evidenced that in general the home was clean, tidy and well maintained.

Patients' rooms were tastefully decorated and patients said they were happy with their rooms. Patients' rooms were personalised with items of memorabilia which was important to them. Patients said "they keep my room clean".

Some of the equipment reviewed was not effectively cleaned such as wheelchairs, commodes and shower chairs. Hairdressing equipment was observed inappropriately stored in the kitchen and mops and buckets in the communal bathrooms. This was discussed with the manager and an area for improvement was identified.

The door of the kitchen in the Sycamore unit and cupboards in the Hawthorne unit were unlocked and items such as cleaning chemicals and thickening agents was accessible. This was discussed with the manager and an area for improvement was partially met and stated for a second time.

The patients' kitchen area contained tea and coffee making materials and snacks and drinks were available for those who requested them.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients, staff and Care Partners and any outbreak of infection was reported to the Public Health Authority (PHA).

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures had been provided.

Visiting arrangements were managed in line with DoH and IPC guidance.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

It was observed that staff offered choices to patients throughout the day which included preferences for what clothes they wanted to wear and where and how they wished to spend their time.

Patients' needs were met through a range of individual and group activities, such as art, music activities and movies. Staff spoken with discussed the development of the activity programme and ideas to include a variety of different activities such as doll therapy and individualised rummage boxes. These ideas were shared with the manager who agreed to discuss these further with staff. Both staff and the manager described how the ongoing pandemic had recently impacted the activity programme. Activities will be further reviewed at the next inspection.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted patients to make phone calls. Visiting was in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

There was no change of management since the last inspection. Mrs Siobhan Conway has been the Registered Manager in this home since 31 March 2015.

There was evidence of a robust system of auditing in place to monitor the quality of care and other services provided to patients. There was evidence of auditing across various aspects of care and services provided by the home.

Each service has an adult safeguarding champion appointed, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Patients said that they knew how to report any concerns and said they were confident that their concerns would be addressed.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

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

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed; where action plans for improvement were put in place.

5.2.6 Medicines Management

The audits completed at the inspection indicated that the patients had received their medicines as prescribed

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

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

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. The records inspected showed that medicines were available for administration when patients required them.

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another. The management of medicines for two patients who had been admitted to this home were reviewed. Staff had been provided with a list of prescribed medicines from either the hospital or GP practice. The patients' personal medication records had been accurately written. Medicines had been accurately received into the home and administered in accordance with the prescribed directions.

Medicines must be stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error. The medicines storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. Records were maintained of the disposal of medicines.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in a controlled drug record book. Robust arrangements were in place for the management of controlled drugs. The controlled drugs record book had been maintained to the required standard.

The records of three patients who were prescribed regular analgesia were reviewed; each patient did not have a pain management care plan. An area for improvement has been made in relation to care planning as discussed in section 5.2.2.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and its effect. The records belonging to four patients were reviewed. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available. The reason for and effect of administration were recorded.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals to manage weight loss. The records belonging to three patients' who were prescribed thickening agents for addition to fluids and food were reviewed. For each patient, a speech and language assessment report and care plan was in place. Records of prescribing and administration were maintained; however, they did not always include the recommended consistency level; this matter was rectified during the inspection.

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out.

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. The audit system in place in this home helps staff to identify medicine related incidents.

6.0 Conclusion

The home was clean, bright and welcoming. Staff engaged positively with patients and chatted in a friendly manner about daily life in the home.

The staff were seen to be responsive to patients' requests and had a good knowledge of their individual needs, likes and dislikes.

The staff worked well as a team and were aware of their roles and responsibilities in regard to the care of patients.

RQIA was assured that the patients were being administered their medicines as prescribed by their GP.

Based on the inspection findings three new areas for improvement were identified. Compliance with these areas for improvement will further enhance the service provided in Magherafelt Manor.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015)

	Regulations	Standards
Total number of Areas for Improvement	2*	4*

* The total number of areas for improvement includes one under the regulations and two under the standards that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Siobhan Conway, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a)(b) and (c) **Stated:** Second time **To be completed by:** Immediately and ongoing	The registered person shall ensure as reasonably practicable unnecessary risks to the health or safety of patients is identified and so far as possible eliminated. This is stated with regards but not limited to: • Access to the kitchen area in the Sycamore unit • Access to and inappropriate storage of toiletries and creams in the hairdressers room. Ref: 5.2.1 and 5.2.3
	Response by registered person detailing the actions taken: The Kitchenette door is closed, and this is spot checked by the Home/Deputy Manager. The hairdressers room is locked when not in use and no toiletries/creams are stored there.
Area for improvement 2 **Ref:** Regulation 13 (1) (b) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that all unwitnessed falls are managed in line with best practice guidance and that neurological observations are consistently recorded.
	Response by registered person detailing the actions taken: Home Manager has addressed this with staff and all staff are to ensure that all Post falls observations have been consistently recorded. Neurological observations are checked by the Home/Deputy Manager.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 30 November 2021	The registered person shall ensure that supplementary care records are accurately recorded and the nursing staff evaluates the effectiveness of this care. This is stated with specific reference to the detailing on the food and fluid charts and the recording of the bowel charts. Ref: 5.2.1 and 5.2.2
	Response by registered person detailing the actions taken: All food and fluid charts are checked by the Home/Deputy Manager to ensure all snacks given to the residents are recorded. Staff Nurse records in daily observation notes residents Bowel activity and actions taken.

Area for improvement 2 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 30 November 2021	The registered person shall ensure a sufficiently detailed care plan is in place for those patients who require to be repositioned. Ref: 5.2.1 and 5.2.2
	Response by registered person detailing the actions taken: Addressed with staff and Care plans are now in place for residents that require pressure relief and repositioning. All care plans include the pressure relieving equipment required and frequency of repositioning, and the charts are in place and reflect this.
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 30 November 2021	The registered person shall ensure that the assessment, planning and monitoring of patient care is robust and care needs are accurately assessed and care planned accordingly. This is stated in respect of but not limited to: • mobility/manual handling • up to date multi-disciplinary recommendations e.g. dietician and SLT • pain management Ref:5.2.2 and 5.2.6
	Response by registered person detailing the actions taken: All residents who are prescribed pain relief have a care plan in place. All care plans regarding SLT/Dietitian recommendations are recorded and reviewed as appropriate.Moving and Handling risk assessments in place and reviewed monthly as a minimum. All care plans include the pressure relieving equipment required and repositioning charts are in place and reflect this.
Area for improvement 4 **Ref:** Standard 46 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered manager shall ensure that the environmental and infection prevention and control issues identified during the inspection are addressed. Ref: 5.2.3
	Response by registered person detailing the actions taken: Cleaning chart in place for for equipment such as wheelchairs, Shower chairs and commodes and staff must sign to state this is completed. Home/Deputy manager will carry out spot checks. Hairdressing equipment removed from the cupboard and all cupboards locked.

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

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