Unannounced Care Inspection Report
25 May 2017

Apple Mews

Type of service: Nursing Home
Address: 95 Cathedral Road, Armagh, BT61 8AB
Tel no: 028 3751 7840
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Apple Mews took place on 25 May 2017 from 10.40 to 16.00 hours.

The inspection was undertaken in response to information received by RQIA on 16 May 2017 from a concerned individual. The information was also shared with the adult safeguarding team of the Southern Health and Social Care Trust in keeping with regional protocols.

The purpose of this inspection was to seek assurances that the care and welfare of patients living in Apple Mews was in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes, July 2015.

The concerns raised were in relation to the quality of nursing care, staffing arrangements and management and governance arrangements for the home. The issues raised in relation to the quality of nursing care included; the quality of food; management of accidents and incidents and activities which were having a negative impact on patients health and welfare.

During this inspection, the inspector reviewed services and care provided in all five bungalows within Apple Mews.

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection was unable to evidence the specific concerns raised by the individual and found no significant areas of concern. However, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

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	*1	0

*The above includes one requirement made at the previous care inspection which was not met and has been stated for a second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Amanda Leitch, registered manger, and Gavin Hughes, peripatetic manager, 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 inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 27 February 2017. Other than those actions detailed in the QIP there were no further actions required to be taken.

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.

2.0 Service details

Registered organisation/registered person: Parkcare Homes No2 Ltd Nicola Cooper (Acting responsible individual, registration pending)	**Registered manager:** Amanda Leitch
Person in charge of the home at the time of inspection: Amanda Leitch	**Date manager registered:** 22 December 2016
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 30

3.0 Methods/processes

Information was received by RQIA on 16 May 2017 which raised concerns in relation to the quality of nursing care; staffing arrangements and the management and governance arrangements within the home.

It is not the remit of RQIA to investigate complaints or safeguarding allegations made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate actions is required; this may include an inspection of the home. Following discussion with senior management at RQIA, it was agreed that an inspection would be undertaken to review the following areas:

- staffing arrangements
- the quality of nursing care with specific focus on the quality and quantity of food; management of accidents and incidents; and the provision of activities
- overview of management and governance arrangements

Prior to the inspection we analysed the following information:

- the registration status of the home
- written and verbal communication received by RQIA since the last care inspection
- the previous care inspection report
- the returned QIP from the previous care inspection
- notifications received since February 2017

The following methods and processes used in this inspection include the following:

- a discussion with the registered manager
- discussion with staff
- observation during an inspection of the five bungalows
- a review sample of staff duty rotas
- staff training and induction records
- a review of care records
- supplementary care records
- accident and incident records
- a sample of Menus
- monthly monitoring reports for April & May 2017

The majority of patients were observed in each of the five bungalows, some of whom were resting in bed or seated in the day lounges. All registered nurses on duty were spoken with and a sample of care staff from each bungalow. There was no opportunity to speak with relatives as none were present at the time of the inspection. Questionnaires for patients, staff and relatives were left in the home for completion and return to RQIA.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 27 February 2017

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector. This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 1 February 2017

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time	The registered person must ensure that the treatment and care provided to each patient meets their identified assessed needs and reflects their plan of care in relation to the management of pressure damage and / or wounds. This should include the completion of all documentation pertaining to this area of practice.	**Not Met**
	Action taken as confirmed during the inspection: A review of one patient's care record pertaining to wound management evidenced that this requirement was not met. Refer to section 4.3.3. This requirement was not met and is restated.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 39 **Stated:** First time	The registered provider should ensure that staff receive "awareness training" in the interim period until formal training is provided. A record should be kept of the training and information provided.	**Met**
	Action taken as confirmed during the inspection: A discussion with staff and a review of induction and training records evidenced that this recommendation was met. The registered manager advised that the induction process to include records had been reviewed and was more robust. Staff completing their induction were spoken with at the time of the inspection and confirmed that the systems and processes in place were adequate to provide them with the knowledge to fulfil their roles and responsibilities.	

4.3 Inspection findings

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4.3.1 Staffing arrangements

Information received by RQIA indicated that staffing arrangements were not adequate and were not being effectively managed. A discussion with the registered manager, staff and a sample review of duty records for the five bungalows evidenced that in the majority planned staffing levels were adhered to. Staffing levels adhered to those determined by the commissioning trust however, the home aims to roster additional care staff over the 24 hour period. The duty records reviewed were maintained in accordance with legislative requirements and care standards guidance. Contingency arrangements were in place and records were available to evidence the implementation of same.

Discussions held with staff regarding staffing arrangements for the home were positive. Staff stated that staffing levels had improved since the new management. Staff advised that it was very seldom that registered nurses and care staff had to cover more than one bungalow. A review sample of duty rotas for all bungalows confirmed this information. Ten staff questionnaires were issued to staff; six were returned prior to issue of this report. One of the questions included in the questionnaire was; "Are there sufficient staff to meet the needs of the patients?" All respondents answered "yes." No concerns were identified at this inspection.

4.3.2 Quality of food and fluids

Information received by RQIA, indicated concerns regarding the quantity and quality of food provided to patients and weight loss management. From a review of the menu it was evident that choice was available and demonstrated that food choices were available for patients who required modified diets. The food observed for the serving of the lunch time meal was consistent with the menu displayed.

A discussion with catering staff evidenced that they were knowledgeable in regards to patient's dietary needs to include arrangements for therapeutic diets. Nursing and care staff confirmed that food was provided in accordance with patients' preferences and therapeutic needs. Discussion with staff indicated that the menu was varied and there was always plenty of food available to include the provision of snacks and alternative food choices. Each bungalow completed a weekly food order which included a range of snacks, cereals, and other food choices which reflected patient's individual preferences. One staff member spoken with felt that portion sizes was not adequate for all patients. The staff member was advised to discuss this with catering staff and management. This information was shared with management during inspection feedback. No other concerns were raised.

During the inspection staff were observed assisting and encouraging patients with food and fluids. Records for food and fluid intake were maintained for all patients. A sample review of charts for all five bungalows evidenced that these were maintained to a satisfactory standard. Records reviewed reflected meals and fluids refused. There was evidence that the 24 hour fluid intake received was totalled and this information was recorded within the patient's daily progress notes. There was evidence that the information was monitored by registered nurses and that appropriate actions had been taken as deemed necessary. Patients spoken with commented positively about the food they received.

A review of information evidenced that patients' weights were being monitored and recorded accordingly. Records reviewed identified any weight loss and/or gain and subsequent actions taken. Quality audits were also undertaken by the registered manager to ensure that this area of care was safe and effective. No concerns were raised in this area of care delivery.

4.3.3 Care records and care delivery

Again, information received by RQIA indicated that the care delivered was neither safe nor effective.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with three patients individually confirmed that patients were afforded choice, privacy, dignity and respect. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Patients' personal care was observed and delivered according to their own individual preferences. Personal care records were maintained to a satisfactory standard and where a patient refused care, there was evidence that this was recorded on the personal care record and was reflected in the patient's care plan.

A review of six patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. These included; moving and handling, skin integrity, nutrition and continence management. Risk assessments informed the care planning process. There was evidence that the care and treatment provided was reflective of that outlined in the care plan. Where applicable, specialist healthcare professionals were involved in prescribing care for example; Speech and Language Therapist (SALT), Dietician and Occupational Therapist (OT). Any recommendations made were included in the care plan. Discussion with staff confirmed that they could access patients' care records to update their knowledge regarding patients' needs.

The omissions identified at the last care inspection in regards to wound management were still evidenced. The review of wound care management in a patient's care record did not evidence that a systematic and robust strategy was in place. The care plan in place did not include the regime of care required therefore it was difficult to determine if the care delivered was appropriate to meet the patient's needs. A review of wound care records evidenced that the delivery of care and treatment was inconsistent. This was discussed with the registered manager and the registered nurse who gave assurances and agreed to address this shortfall immediately. A requirement made at the previous inspection was not met and has been stated for a second time.

A review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last inspection confirmed that these were appropriately managed. Falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately. 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.

4.3.4 Provision of Activities

The information received also included concerns regarding the management of activities in the home, indicating that patients' choices were not respected. A discussion with registered nurses, staff and patients and a review of records was undertaken to seek assurances regarding the provision of activities in the home. A dedicated member of staff is employed to take the lead for this area of practice and is supported by other staff in delivering same. Information provided and reviewed evidenced that all patients have an individual activity programme. Records were maintained to evidence activities that took place and also demonstrated where patients did not wish to participate. A discussion with staff demonstrated their understanding of how to deliver meaningful, appropriate and enjoyable activities whilst recognising patient's decision to participate or not. There was evidence that the provision of activities was flexible to accommodate the daily preferences and choices of the patients.

At the time of the inspection a number of activities were observed these included; hand manicures; walks, playing games and a group of patients were attending a "Fit for You" class at the local leisure centre. Patients who attended expressed their enjoyment and desire to attend again. A training session on the provision of activities was taking place at the time of the inspection and staff who attended advised that the home were trying to further develop a programme of activities which was more suited to the category of care for which they provided. A discussion with the registered manager and a review of information evidenced that the activity lead completes an analysis of activities on a monthly basis. This is to ensure that the programme and the individual activities therein are evaluated to ensure that they are appropriate to each patient's needs.

4.3.5 Governance and Management

Concerns were also expressed by the individual to RQIA about the management and leadership of the home indicating that the service was not 'well led'.
The registered manager commenced employment in the home, September 2016. During this time, there is evidence that they have driven and made quality improvements.

Staff advised that there was a clear organisational structure within the home and systems were now in place to ensure that the care delivered was safe and effective. Discussion with the registered manager and a review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

Discussion with staff confirmed that working relationships had improved since the change of management and that management were responsive to any suggestions or concerns raised.

Staff spoken with described the registered manager in positive terms; comments included:
“Amanda is great, very approachable.”
“Good support from management, would feel comfortable raising any concerns, have had conversations with management, very open and approachable.”
“Overall staff morale on the site is improving and getting better. The support from management is brilliant.”

Opinions regarding the management and leadership of the home were also sought via questionnaires. Ten questionnaires were issued for staff and relatives and three were issued to patients for completion and return. Six staff and one relative returned their questionnaires within the timescale specified for inclusion within this report. No responses were received from patients.

The responses received from all six staff members were positive and indicated that they were either ‘very satisfied’ and/or ‘satisfied’ with the care provided across the four domains and that the service was well led.

One additional written comment included:
“Manager and house managers are really helpful. I have always found them to follow up on the things I have said. Team get on well.”

No concerns were raised.

The response received from the relative was also positive indicating that they too were either ‘very satisfied’ or ‘satisfied’ with the care and services provided.

There was no evidence available to support the concerns raised in the information received by RQIA.

Areas for improvement

No new areas for improvement were identified during the inspection.

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

5.0 Quality improvement plan

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

The registered provider/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 nursing home. 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 The 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 provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** Second time **To be completed by:** Immediately from the date of the inspection	The registered person must ensure that the treatment and care provided to each patient meets their identified assessed needs and reflects their plan of care in relation to the management of pressure damage and/or wounds. This should include the completion of all documentation pertaining to this area of practice. **Ref: Section 4.2 & 4.3.3**
	Response by registered provider detailing the actions taken: Tissue viability care plan in place. Audit process enhanced re tissue viability records.

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

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