Unannounced Care Inspection Report
1 February 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 1 February 2017 from 10:00 to 16:15.

The inspection sought to assess progress with any issues raised during and since the last 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 competent and safe delivery of care on the day of inspection. Staff were required to attend training and the observations of care delivery evidenced that the knowledge and skills gained through training, were embedded into practice. Staff confirmed that there were good communication systems and teamwork in the home, including; staff appraisal and supervisions. Staff advised that the registered manager was very supportive and approachable and any concerns raised were dealt with effectively.

The home was found to be warm, fresh smelling and clean throughout. The standard of décor within the bungalows was maintained to a satisfactory standard.

Is care effective?

There was evidence of positive outcomes for patients living in Apple Mews. All staff demonstrated a high level of commitment ensuring patients received care to meet their identified needs. Each staff member understood their role, function and responsibilities.

In the majority, care records were maintained to meet the needs of the patients however; a requirement has been made in regards to the delivery of care and management of documentation for wound care.

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.

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.

Is the service well led?

Discussion with the registered manager and staff advised that there was a clear organisational structure within the home.

Discussion with the registered manager and staff; and a review of records evidenced that systems were in place to monitor and report on the quality of nursing care and other services provided.

It was evident that the registered manager managed systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff to deliver care appropriately to meet the assessed needs of patients. This was commended.

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	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Amanda Leitch, Registered Manager, 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 announced enforcement compliance inspection undertaken on 4 October 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. 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, whistle blowing and any other communication received since the previous care inspection.

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

2.0 Service details

Registered organisation/registered person: Parkcare Homes No2 Ltd/Mrs Sarah Hughes	**Registered manager:** Mrs 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) A maximum of 6 patients to be accommodated in each of the 5 bungalows.	**Number of registered places:** 30

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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 plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection reports
- 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. The inspector met with two patients individually and the majority of others were observed and/or greeted in small groups. Five registered nurses, eight care staff, ancillary staff and the homes administrator were consulted.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staff duty rotas for weeks commencing 23 January and 30 January 2017
- a sample of training records
- recruitment files for two staff
- staff supervision and appraisal schedule
- complaints and compliments records
- incident and accident records
- sample of quality audits
- records of meetings; staff, patient and relatives
- three patient care records
- reports of monthly monitoring visits undertaken in accordance with Regulation 29

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 04/10/16

The most recent inspection of the home was an announced enforcement compliance care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 04/10/16

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 14 (4) **Stated:** Second time	The registered person shall ensure that patients who have made an active choice to rise early (prior to 07.00) are assisted to do so. These decisions must be in the patient's best interest. Care plans should be detailed to include the rationale for this practice and be reviewed at regular intervals.	**Met**
	Action taken as confirmed during the inspection: A discussion with staff and a review of care records evidenced that care plans included information to reflect patients' daily routine to include "rising times". A summary report for day and night hours was also available and included information on patients sleep pattern and rising times.	
Requirement 2 **Ref:** Regulation 20 (1)(c)(iii) **Stated:** First time	The registered person must ensure that training is provided to all relevant staff in respect of cleaning practices and its documentation. This area should be closely monitored to ensure that the training is embedded into practice and that the kitchen is maintained clean. Records should be retained of the monitoring process.	**Met**
	Action taken as confirmed during the inspection: A discussion with staff and a review of records evidenced that training had been provided for staff in regards to "cleaning practices". Since the last inspection a "head house keeper" has been appointed and audits were available in relation to the cleanliness of the environment and associated records management. The registered manager advised that the home had achieved a rating of "5" as a result of an Environmental Health Inspection carried out in January 2017. An observation of the environment to include kitchen areas evidenced that these were clean and tidy.	

Requirement 3 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time	The registered person must undertake a review of all accidents and incidents to include the incident identified at this inspection. Evidence should be retained of any actions taken to ensure the health and welfare of patients.	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager, staff and a review of records evidenced that the incident identified at the last care inspection had been reviewed and appropriate actions had been taken to ensure the health and welfare of the identified patient. A further review of accident and incident records evidenced that a review and analysis is carried out. Risk assessments and care plans are reviewed and updated accordingly. There was evidence that referrals had been made to the appropriate healthcare professionals to ensure that all relevant measures were in place to ensure the patients wellbeing.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 23 **Stated:** Second Time	It is recommended that repositioning charts should contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning and the actual positional change is recorded. Records should reflect the care delivered/not delivered.	**Met**
	Action taken as confirmed during the inspection: A review sample of repositioning charts evidenced that these were being maintained in accordance with best practice guidelines.	

Recommendation 2 **Ref:** Standard 4 Criteria 7 **Stated:** First Time	It is recommended that registered nurses ensure that care plans are evaluated using meaningful statements and information and any changes in regards to the treatment and care are recorded accordingly.	**Met**
	Action taken as confirmed during the inspection: A review of three care records evidenced that in the majority care plans were evaluated using meaningful statements and any changes in regards to the treatment and care were recorded accordingly. Shortfalls identified in one care record can be referred to in section 4.4. However, the inspector was satisfied that this recommendation had been met overall and the shortfalls identified in the record referred to have been raised in a requirement made at this inspection.	
Recommendation 3 **Ref:** Standard 4 Criteria 9 **Stated:** First Time	It is recommended that a record is developed and maintained for any patient who requires additional levels of supervision and monitoring to ensure that the patients assessed need is met in accordance with their plan of care.	**Met**
	Action taken as confirmed during the inspection: A record has been developed for any patient that requires additional levels of supervision and monitoring. A review sample of these records evidenced that they were being maintained appropriately and reflected the level of supervision required as outlined in the care plan.	
Recommendation 4 **Ref:** Standard 12 Criteria 1 **Stated:** First time	The menu should be reviewed to ensure that patients are provided with a nutritious and varied diet, which meets their individual dietary needs and preferences. A record should be retained of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.	**Met**
	Action taken as confirmed during the inspection: A discussion with staff and an observation of the menu displayed confirmed that the menu had been reviewed November 2016. The menu reflected best practice guidelines and the Care Standards for Nursing Homes, 2015. Records were maintained and available to evidence all foods offered, taken and/or refused.	

Recommendation 5 **Ref:** Standard 39 Criteria 4 **Stated:** First Time	The registered person should provide training for staff commensurate with their roles and responsibilities in the management of accidents and incidents to include head injuries. Records should be kept of training.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that staff had been provided with training in this area of practice. A review sample of accident and incidents records evidenced that appropriate actions had been taken and/ or medical advice had been sought. The registered manager advised that a protocol for the management of head injuries was currently being developed. A copy of the protocol discussed was submitted to RQIA, 14 February 2017 by email confirming that it had been circulated to all relevant staff.	

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. A review of the staffing rota from 23 January to 5 February 2017 evidenced that the planned staffing levels were adhered to on the majority of occasions. Contingency arrangements for staff cover were in place and maintained appropriately. The staff duty rota was managed in accordance with Care Standards for Nursing Homes, DHSSP's, 2015.

A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.

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 supported and mentored by an experienced member of staff during their induction. The induction records were signed and dated appropriately for all areas of induction completed.

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).

Discussion with staff and a review of records confirmed that arrangements were in place for staff supervision and appraisals.

A review of training records indicated that training was planned to ensure that mandatory training requirements were met. A training matrix was available in each bungalow and the house managers had good oversight of training requirements for staff. Staff training was delivered by combining an e-learning programme and face to face training in the home.

Discussion with staff indicated that more training opportunities were now available and training compliance was more closely monitored by both the house managers and the registered manager. Staff advised that the training and guidance provided to them had enhanced their knowledge, understanding and the rationale for carrying out care practices. A discussion with the registered manager and staff confirmed that arrangements were in place for staff to undertake training called "My Home Life" jointly facilitated by the University Of Ulster. Staff expressed an enthusiasm as to how this new knowledge could positively affect the life of the patients living in the home. This is commended.

A discussion with a member of staff recently employed identified that they had not received training in some mandatory areas for example; moving and handling and adult safeguarding. A discussion with the registered manager demonstrated that no provision was made for any awareness training/systems to support staff in the interim period until formal training could be completed. A recommendation has been made.

The registered manager and staff spoken with clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities, in general and specifically 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 notified appropriately.

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 records pertaining to accidents, incidents and notifications forwarded to RQIA since the last inspection confirmed that these were managed appropriately. Audits of falls and incidents were maintained and clearly evidenced analysis of the data to identify any emerging patterns or trends and action plans were in place as required. Audit outcomes regarding falls and incidents informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

A review of all five bungalows was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. All of the bungalows had been repainted and a number of furnishings had been replaced at the time of the last inspection. The improvements made have been maintained to a satisfactory standard. The bungalows were warm, fresh smelling and clean throughout.

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

A recommendation has been made in relation to the provision of training for new staff.

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

4.4 Is care effective?

Review of three patient care records evidenced improvement and progress in the majority of records examined. A range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that the risk assessments informed the care planning process. Where applicable, specialist healthcare professionals were involved in advising and prescribing treatment and care interventions.

Two of the three care records reviewed accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare and medical professionals. One care record examined had not been updated following a review carried out by a tissue viability nurse specialist (TVN). A further review of records pertaining to wound management evidenced that the dressings were not carried out in accordance with the prescribed frequency and on one occasion there was no evidence available to validate that the dressings had been changed for up to and including 12 days. This was very concerning given that the treatment plan advised that the dressing (s) were to be renewed on alternate days. In addition there were inconsistencies in regards to the recording of information. These concerns were discussed with the registered manager as the identified shortfalls could have a direct impact on the delivery of safe and effective care.
A requirement has been made.

Supplementary records such as repositioning; food and fluid intake records as discussed earlier evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Discussion with the registered manager, house managers and staff confirmed that staff meetings were held on a regular basis and records were maintained. Staff advised that they could access the minutes of the meetings if they were unable to attend. The review of the minutes of staff meetings evidenced that the registered manager had held general staff meetings and subsequent meetings with the individual groups of staff. Staff confirmed that they found the level of communication from the registered manager to be very good. Staff also stated that the registered manager was very receptive and encouraged their ideas.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager and these were dealt with appropriately.

Areas for improvement

A requirement has been made in relation to the management of wounds and/or pressure damage and records pertaining to this area of practice.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Staff spoken with were knowledgeable regarding the patients' likes and dislikes and individual preferences. This ensured the safe, effective and compassionate delivery of care.

We observed numerous occasions when staff offered patients choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time.

Two patients who had the ability to verbalise their views commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be suitably dressed and were relaxed and comfortable in their surroundings.

In addition questionnaires were provided by RQIA to the registered manager for distribution. These included 10 questionnaires for staff and relatives/patient representatives and two for patients. At time of issuing this report, one patient, three staff and four relatives returned their questionnaires within the identified timeframe. All responses received indicated that they were very satisfied and/or satisfied across all four domains.

Additional written comments were received in the returned staff questionnaires as follows:
"Excellent leadership provided."
"All service users care interventions are discussed @MDT meetings and 'best interest decisions' made on the residents behalf."

One questionnaire returned by a relative had a letter appended. The respondent advised that their relative had lived in a long term care hospital setting for over 50 years. Initially having had some reservations about the transfer to Apple Mews, they advised that they would never move their relative even though it is 70 miles away because of the "love and the joy the staff give."

Areas for improvement

No areas for improvement were identified.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

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 a review of patient information evidenced that the home was operating within its registered categories of care.

The registered manager has been in post since September 2016. Staff consulted spoke in very positive terms in relation to the registered manager and their confidence in her management and leadership skills. Discussion with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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.

Discussion with the registered manager 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, 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.

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.

Discussion with the registered manager and review of records 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.

The reports reviewed did not include a review of all matters identified in the action plan from the previous monitoring visit and the progress made. This matter was discussed with the registered manager who agreed to address same with the relevant personnel. Post inspection, a revised template for recording Regulation 29 monitoring visits was submitted to RQIA, which has been reviewed to include this information in reports going forward. Copies of the reports were available for staff, patient representatives and Trust representatives.

Based on the inspection findings detailed in the preceding domains, review of records, systems and processes; and comments from staff it was evident that improvements and progress have been made in Apple Mews across all domains. The registered manager, clearly demonstrated how she and the senior management team ensured the delivery of safe, effective and compassionate care and that this was an integral part of the day to day operational control of the home. This was commended.

Areas for improvement

No areas for improvement were identified.

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

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:** First time **To be completed by:** 1 February 2017	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 4.4**
	Response by registered provider detailing the actions taken: Audit system reviewed and updated to include pressure damage and wound care.
Recommendations	
Recommendation 1 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 1 March 2017	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. **Ref Section 4.3**
	Response by registered provider detailing the actions taken: Review of induction processes will include an interim training plan for new staff.

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

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