Unannounced Care Inspection Report
13 February 2020

County Care Home

Type of Service: Nursing Home (NH)
Address: 42 Tempo Road, Enniskillen, BT74 6HR
Tel No: 028 6632 3845
Inspector: Heather Sleator

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 52 patients.

3.0 Service details

Organisation/Registered Provider: EBBAY Ltd **Responsible Individual:** Patrick Anthony McAvoy	**Registered Manager and date registered:** Caroline McCrea Registration pending
Person in charge at the time of inspection: Caroline McCrea	**Number of registered places:** 52
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. A maximum of 21 patients in category NH-DE. The home is also approved to provide care on a day basis to 5 persons. There shall be a maximum of 1 named resident receiving residential care in category RC-I and 1 named resident receiving residential care in category RC-PH	**Number of patients accommodated in the nursing home on the day of this inspection:** 51

4.0 Inspection summary

An unannounced inspection took place on 13 February 2020 from 09.50 hours to 17.15 hours.

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.

Evidence of good practice was found in relation to staff attentiveness to patients and the delivery of care which took into account personal choice for patients. Patients were enthusiastic and informed of the planned activities. Staff were knowledgeable of the needs of the patients and worked well as a team to deliver the care patients' required. The environment was homely and comfortable. Effective systems were in place to provide the manager with oversight of the services delivered.

There were no areas for improvement identified during the inspection.

Patients described living in the home as being a good experience/ in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others/with staff.

Comments received from patients, people who visit them, other professionals and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Caroline McCrea, Manager, 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.

4.2 Action/enforcement taken following the most recent inspection dated 22 October 2019

No further actions were required to be taken following the most recent inspection on 22 October 2019.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including estates and pharmacy, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from 1 to 13 February 2020
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records
- reports of the monthly quality monitoring reports from November 2019 to February 2020
- complaints record
- accident and incident records
- compliments received
- RQIA registration certificate
- selected policy documentation

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspection

There were no areas for improvement identified as a result of the last care inspection.

6.2 Inspection findings

6.2.1 Staffing arrangements and care practice

A system was in place to identify staffing levels to meet the patients' needs. A review of the staff rotas for the period 1 to 13 February 2020 confirmed that the staffing numbers identified by the manager were consistently provided. Staff spoken with told us that there were sufficient staff to meet the physical, emotional and social needs of the patients. We spoke with the relatives of four patients, comments received included; "staff are very good, very helpful and would do anything for you." However relatives also commented that they felt there could be more staff on duty. The comments received from relatives were discussed with the manager who stated that the staffing arrangements would remain under review.

We discussed the provision of staff for any patients who required additional supervision. The manager has a clear understanding that staff required to provide increased supervision would be in addition to the number of staff required to meet the overall needs of the patients. Staff confirmed that they received a report when commencing duty and had a clear plan for the day's activity. Staff also confirmed that they were supported by management through the process of bi annual supervision and staff appraisal. We reviewed the minutes of staff meetings and this confirmed that there was a planned approach to the frequency of staff meetings, patients meetings and relatives meetings.

We discussed the arrangements for the nominated person in charge of the home in the absence of the manager. The manager stated that a registered nurse on duty the person in charge in her absence and this person was identified on the duty rota. A review of the duty rota and the completed competency assessments confirmed a robust system was in place.

In discussion with the manager and staff it was confirmed that arrangements were in place for the completion of the Mental Capacity Act/Deprivation of Liberty Standards training for staff. Care staff are completing level 2 training and senior registered nurses will be completing levels 3 and 4.

We were advised that the use of potential restrictive practices was very limited, for example, the use of bedrails or alarm/pressure mats when and where there is assessed need. We reviewed a patient's care records regarding the use of bedrails. Evidence of a risk assessment was present and a corresponding care plan regarding the use of bedrails which monitored the continued safe use of this type of equipment. Evidence was also present of consultation with the patient's representative in respect of the need for bedrails. We spoke with a visiting professional during the inspection who stated; "anything I ask the staff to do, they do." Care records also confirmed that staff had diligently assessed, planned and consulted with other professionals, where applicable, regarding the management of weight loss and pain management.

The care records reviewed for persons living with dementia evidenced that staff have implemented a person centred approach to care planning with the assistance of life story work. The aim of this being, to assist staff in supporting patients in a meaningful and personal manner. The information is completed on admission by a registered nurse and is retained in the patients care records and also in their activities file. The manager stated that consideration is being given to developing a life story booklet which could be given out at the pre-assessment stage to allow family to complete the booklet and then give to the nurse on admission.

6.2.2 Environment

The home was clean and fresh smelling. The manager confirmed that the cleaning routines in the home have recently been reviewed and schedules put in place to ensure that all areas of the home are regularly attended to.

The manager stated that the environment is being monitored monthly and any remedial work identified. In discussion, it was stated it was anticipated that a programme to refurbish the general nursing unit was being considered. The dementia unit on the lower ground floor was bright and attractive with an extended lounge/garden room for patients to enjoy.

We saw that fire safety measures were in place to ensure patients, staff and visitors to the home were safe. No issues were observed with fire safety. The access to fire escapes was clear.

6.2.3 Patients' and relatives views

We arrived in the home at 09:50 hours and were met immediately by staff who offered assistance. Patients were present in the lounge, dining room or in their bedroom, as was their personal preference. Observations of interactions throughout the day demonstrated that patients were relating positively to staff and to each other

Activities are planned by staff however this may change on a daily basis depending on what patients' state they would prefer. Activities are a mixture of small group activities and one to one activity. There was a wide range of activities available for patients including crafts, board games, quizzes and musical entertainers coming into the home. Both of the nursing units have a designated activities leader and their own programme. There is a weekly service in the home to facilitate the spiritual needs of the patients.

We viewed a number of thank you cards received from patients and or their representatives. The comments written were very complimentary and included:

- "XXX has been in many care homes over the years but the County Care Home was unique. The care was second to none and the respect and relationship the staff had for the residents was amazing." Friend of patient -November 2019.

We met with four patients' representatives who were very positive regarding the care afforded by staff and commented:

- "Staff are very good, very helpful and would do anything for you."
- "Staff are very nice, very helpful, always offering you a cup of tea."
- "Think staff look after my (relative) very well."
- "Could do with more staff, always seem very rushed."
- "Definitely think they could do with more staff."

There were no questionnaires returned to RQIA relatives.

No issues were raised by staff. Staff felt the staffing arrangements were generally satisfactory and that there was good teamwork in the home. There were no questionnaires completed and returned to RQIA from staff.

6.2.3 Serving of lunch

We observed the serving of lunch in the dementia care unit. Patients were assisted to the table in timely manner before the serving of lunch. The menu was displayed in a pictorial format for patients' information. Staff were present throughout the meal to provide assistance and reassurance as required. Assistance given by staff was sensitive, not time limited and institutive, for example; a patient was eating their meal and some of the food was going onto the table. A care assistant observed this and went and got a plate guard so as the patient could continue to eat their meal independently. Lunch is served over two sittings. Meals were plated individually and served directly to the patients. Staff told us that as they plate the meals they can adjust meals and portion sizes in response to patients' preferences and individual need.

We observed the serving of the mid afternoon tea and snack. Patients who required a modified diet were observed to be getting cake moistened with tea. We discussed this with staff and the manager and queried as to whether there was any other alternative available to these patients. The manager emailed RQIA following the inspection and stated that she had consulted with a speech and language therapist who confirmed that cake moistened with tea was a suitable and nutritious snack for patients who required a modified diet. The manager also stated that kitchen staff would also provide other suitable alternatives for patients so as choice was available.

6.2.4 Management and governance arrangements

The manager, Caroline McCrea, had worked in the home for a number of years prior to being appointed as manager. It was agreed that an application for registration would be submitted to RQIA. The manager facilitated the inspection and demonstrated a good understanding of the relevant regulations, care standards and the systems and process in place for the daily management of the home. A wide range of documentary evidence to inform the inspection's findings, including minutes of staff meetings, monitoring reports, audit records, patients care records and staffing information. Feedback and discussion took place at the conclusion of the inspection with the manager and areas of good practice were identified.

The manager has implemented a range of monthly audits to assist her with reviewing the quality of services delivered. The manager was knowledgeable of the auditing process and explained that the action required to achieve any improvements are shared with the relevant staff and rechecked by the manager to ensure the action has been completed. Areas audited included for example; the environment, accidents, incidents, complaints and care records.

A monthly quality monitoring visit was undertaken in accordance with Regulation 29. Records of the past three months were reviewed. The reports included the views of patients, relatives and staff, a review of records, for example accident reports, complaints records and a review of the environment. The reports of these visits were available in the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff attentiveness to patients and the delivery of care which took into account personal choice for patients. Patients were enthusiastic and well informed of the planned activities. Staff were knowledgeable of the needs of the patients and worked well as a team to deliver the care patients' required. The environment was homely and comfortable.

Effective systems were in place to provide the manager with oversight of the services delivered.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

The Regulation and Quality Improvement Authority

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