Unannounced Care Inspection Report
22 October 2019

County Care Home

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

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:** 49

4.0 Inspection summary

An unannounced inspection took place on 22 October 2019 from 10.15 hours to 17.15 hours.

The term ‘patient’ is used to describe those living in County Care Home which provides nursing care and residential care to two named patients.

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

There were no areas for improvement in respect of the most recent estates or pharmacy inspections.

Evidence of good practice was found in relation to the provision and training of staff, staffs attentiveness to patients and patient safety. The environment was safely managed. There were examples of good practice found throughout the inspection in relation to the assessment of patients’ needs and the planning of how these need would be met. Patients were attended to by their GP and other healthcare professionals as they required. Staff were well informed of the needs of the patients and worked well as a team to deliver the care patients’ required.

We saw that staff supported patients to make daily choices and that the culture and ethos of the home supported patient dignity and privacy.

There were stable management arrangements with systems in place to provide management with oversight of the services delivered.

There were no areas requiring improvement identified as a result.

Patients described living in the home as being a good experience/ in positive terms. Residents 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 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 patients' 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 and Sharon Loane, Operations 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 9 January 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 9 January 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included registration information, and any other written or verbal information received. For example serious adverse incidents.

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 and 'Have We Missed You' cards 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.

The following records were examined during the inspection:

- duty rota for all staff from week commencing 14 & 21 October 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- five patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- a sample of governance audits/records
- complaints record
- compliments received
- reports of monthly visits completed on behalf of the registered provider
- RQIA registration certificate

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

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(s)

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that where patients are assessed as requiring a hoist, the type and size of hoist sling should be identified in the care records.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that this area for improvement has been met.	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

In order to determine if care was delivered safely we talked with a number of the patients. Patients told us that staff attended to them promptly and if they were in their bedrooms staff came as quickly as they could when they called them. The patients said that staff were pleasant and attentive to them. Patients said:
“Staff come as quickly as they can.”
“The staff are very good at looking after us.”
“The staff are very good.”

A system was in place to identify appropriate staffing levels to meet the patient’s needs. A review of the staff rotas for week commencing 14 & 21 October 2019 confirmed that the staffing numbers identified were provided. There were sufficient staff available to ensure that catering and housekeeping duties were undertaken. Activity co-ordinators were also employed to deliver a range of recreational and diversional activities.

We provided questionnaires in an attempt to gain the views of relatives, patients and staff who were not available during the inspection. Unfortunately there were no responses received.

We discussed the recruitment of staff with the registered manager and reviewed the recruitment records. The records confirmed that the appropriately checks had been completed with applicants to ensure they were suitable to work with older people. Newly appointed staff completed a structured induction to enable them to get to know the patients, working practices and the routine of the home.

Review of training records confirmed that staff had undertaken a range of training annually relevant to their roles and responsibilities.

We discussed how patients are protected from abuse. Staff receive training annually on the safeguarding and protection of patients and how to report any concerns they have; this is also included in the induction programme for staff. The manager confirmed that the home had a safeguarding champion to support the adherence to the safeguarding policies and procedures.

Staff providing care in a nursing home are required to be registered with a regulatory body. For nurses this is the Nursing and Midwifery Council (NMC) and for care staff it is the Northern Ireland Social Care council (NISCC). The manager is responsible for ensuring all staff are registered appropriately. We observed that checks were being completed monthly.

Assessments to identify patients' needs were completed at the time of admission to the home and were reviewed regularly. Where a risk to a patient was identified, for example a risk of falls or poor nutrition, a plan of care to minimise each risk was put in place. We observed that some patients had bedrails erected or alarm mats in place; whilst this equipment had the potential to restrict patients' freedom we were satisfied that these practices were the least restrictive possible and used in the patient's best interest. Patients, were possible, their relatives and the healthcare professionals from the relevant health and social care trust were involved in the decision to use restrictive practice.

If a patient had an accident a report was completed at the time of the accident. We saw from the care records that the circumstances of each fall were reviewed at the time and the plan of care altered, if required. The manager reviewed the accidents in the home on a monthly basis to identify any trends and consider if any additional action could be taken to prevent, or minimise the risk of further falls. Patients' relatives, the manager and the appropriate health and social care trust were informed of all accidents. RQIA were also appropriately notified.

We observed staff and looked at the environment to determine if there was good practice to minimise the risk of the spread of infection. Gloves and aprons were available throughout the home and we noted that staff used these appropriately. Hand washing facilities, liquid soap and disposable hand towels were widely available and well utilized through the home. Hand sanitising gel was available in the reception area as you entered the home and at a variety of locations throughout the home as an additional resource to support good hand hygiene.

The environment in the home was warm and comfortable and provided homely surroundings for the patients and those that visit them. The majority of patients choose to spend their day in the company of others in the main lounges of the home. The home was clean and fresh smelling throughout.

No issues were observed with fire safety. The access to fire escapes was clear and fire doors in place were secured with magnetic hold open devices.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the provision and training of staff, staffs attentiveness to patients and patient safety. The environment was safely managed.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total numb of areas for improvement	0	0

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

We spoke with seven patients individually who were very happy with the care they were receiving. They confirmed that staff arranged visits from healthcare professionals, for example their GP, podiatry, opticians and dentists when they needed them. If they were required to attend hospital appointments the staff made the necessary arrangements for them to attend.

As previously discussed a range of assessments, to identify each patient's needs, were completed on admission to the home. From these, care plans, which prescribed the care and interventions required to support the patient in meeting their daily needs were produced.

We reviewed the management of nutrition, patients' weight and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Arrangements were in place to identify patients who were unable to mobilise or move independently and therefore at greater risk of skin breakdown. Pressure relieving care was recorded on repositioning charts. These charts evidenced that the patients were assisted by staff to change their position regularly.

We reviewed how patients' needs in relation to wound prevention and care were met. Records confirmed that wounds care was in keeping with the care plan instructions. Records also evidenced that where necessary advice on the management of wounds was sought from healthcare professionals in the local health and social care trust. For example podiatry and tissue viability nurses (TVN).

Patients' nutritional needs were identified through assessment and appropriate care planning to identify the specific support required by each patient. Patients' weights were kept under review and checked a minimum of monthly to identify any patient who had lost weight. Referrals were made to dietetic services as required and details were recorded in the patient's care records. Food charts were maintained where there was an identified need to record patient's daily intake. The archiving arrangements of the completed supplementary charts were commended; charts were well ordered and easy to retrieve.

We observed the serving of lunch in the dementia unit where lunch is served over two sittings. There was a relaxed atmosphere in the dining rooms and the tables were nicely set for lunch . There was a choice of two dishes at each meal time. The meals served looked and smelt appetising. Patients told us the meals were tasty. Staff were present in the dining rooms to ensure that the patients were happy with their meal, to remind and encourage the patients to eat and to provide assistance to those patients who required help with their meal. One patient told us "The food is good, they know how to cook."

We reviewed the prevention and management of falls. Care records evidenced that a post falls review was completed within 24 hours of the patient sustaining a fall to identify the possible reason for the fall and take any preventative action necessary. We reviewed the accident book and can confirm that recorded accidents were appropriately managed with medical advice sought as required.

Patient care was discussed at the beginning of each shift in the handover report. All of the staff spoken with were knowledgeable of individual patient need and of each patient's routine.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the assessment of patients' needs and the planning of how these need would be met. Patients were attended to by their GP and other healthcare professionals as they required. Staff were well informed of the needs of the patients and worked well as a team to deliver the care patients' required.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 10:15 hours and were met by the manager. We walked round the home mid-morning; the majority of patients choose to spend their day in the lounge areas of the home. A selection of armchairs were available in the lounges alongside space for patients who sat in their own specialised seating. Patients had a comfortable chair and, where they wanted, a table within easy reach to hold everyday things that they need such as newspapers, books , tissues, drinks and sweets. The atmosphere in the home was relaxed and quiet.

Patients told us that they were supported to make daily choices, for example, where to spend their day, have their meals and what time they liked to go to bed. They told us:
"I'm very happy, they are all good to me."
"If you don't feel like getting up they'll bring your breakfast to you."
"I've no complaints."
"I'm very happy here."

As previously discussed we provided questionnaires in an attempt to gain the views of relatives, and staff who were not available during the inspection; unfortunately there were no responses received.

Staff told us about the range of activities available and how the activity co-ordinators worked to make sure that each patient enjoys meaningful pastimes, crafts and religious services. Patients said that they enjoyed the activities on offer.

The home has received numerous compliments, mainly in the form of thank you cards. The most recent cards were displayed throughout the home for patients and visitors to see. These are some of the comments included:
"We as a family cannot put into words how very grateful we are to you all."
"Thanks especially for your patience and kindness."
"Thank you so much for the care you all gave my … he was so content and happy in the short time he had with you."

We discussed how patient and relative opinion was sought on the day to day running of the home. The manager explained that questionnaires were provided annually to relatives in an attempt to gain their opinion on behalf of their loved one; these were due to be issued shortly for 2019. The operations manager explained that they are currently considering an easy read version of the questionnaires in an attempt to gain the opinion of all patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy and the provision of activities.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

There were stable management arrangements in the home. The manager, who has responsibility for the day to day operation of the home, has been in post since May 2018 and was knowledgeable of her responsibility with regard to regulation and notifying the appropriate authorities of events. They are supported in their role by the operations manager, the owners of the home and a team of registered nurses who were present throughout the inspection and knowledgeable of the day to day running of the home and patient care. An application for the manager to register with RQIA has been received.

The manager reviews the services delivered by completing a range of monthly audits. Areas audited included the medications, care records and accidents and incidents.

The owner of the home is required to checks the quality of the services provided in the home. This is done by the operations manager during monthly unannounced visits to the home; a report is made of the outcome of these visits. 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.

A complaints procedure was available in the home. Records were available of any complaints received. The records included the detail of the complaint, the outcome of any investigations, the action taken, if the complainant was satisfied with the outcome and how this was determined.

Examples of compliments received have been provided in section 6.5 of this report.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the management arrangements and the systems to provide management with oversight of the services delivered.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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