Inspection Report

13 September 2022

Mullaghboy

Type of service: Nursing
Address: 86 Warren Road, Donaghadee, BT21 0PQ
Telephone number: 028 9188 3596

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: Mullaghboy Limited **Responsible Individual** Mr Robert Maxwell Duncan	**Registered Manager:** Mrs Anne Dugan **Date registered:** 1 April 2005
Person in charge at the time of inspection: Mrs Anne Dugan, Manager	**Number of registered places:** 32
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 30
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 32 patients. Patients' bedrooms are located over two floors. Patients have access to a communal lounge, the dining room and the garden.	

2.0 Inspection summary

An unannounced inspection took place on 13 September 2022 from 09.50 am to 5.45 pm by a care inspector.

The inspection assessed progress since the last 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 maintaining good working relationships.

Six areas for improvement have been identified in relation to submission of notifiable events to RQIA, the duty rota, staff training, completion of repositioning charts and that the daily menu is displayed in a suitable format for patients showing what is available at each mealtime. The total number of areas for improvement includes one regulation and one standard that is stated for a second time.

The home was found to be clean, tidy, well-lit, comfortably warm and free from malodour.

Staffing arrangements were found to be satisfactory and reviewed regularly by the manager in order to meet the assessed needs of the patients. Staff were seen to be professional and polite as they conducted their duties and told us they were supported in their role with training and resources.

Patients were seen to be well looked after regarding attention to personal care and appearance and staff provided care in a compassionate manner.

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.

Comments received from patients, relatives and staff are included in the main body of this report.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience. Addressing the areas for improvement will further enhance the quality of care and service in the home.

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 registration information, and any other written or verbal information received from patients, 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 Mrs Anne Dugan, Manager, at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke with four patients individually, small groups of patients in the dining room, two patients' relatives and eight staff. Patients told us that they felt well cared for, enjoyed the food and that staff were attentive. Patients' relatives said they were happy with the standard of care their loved one received. Staff said that the manager was approachable and that they felt well supported in their role.

Following the inspection we received no patient, patient representative or staff questionnaires within the timescale specified.

Cards and letters of compliment and thanks were received by the home. The following comment was recorded:

"Just to say a big thank you for caring for my dear … She was always happy and content.''

5.0 The inspection

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

Areas for improvement from the last inspection on 1 February 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (1) (b) **Stated:** First time	The registered person shall ensure that all unwitnessed falls are managed in line with current best practice and that neurological observations are completed for 24 hours as per post fall protocol.	**Met**
	Action taken as confirmed during the inspection: Review of records evidenced that unwitnessed falls are managed in line with current best practice and that neurological observations are completed for 24 hours as per post fall protocol.	
Area for Improvement 2 **Ref:** Regulation 13 (1) (a) **Stated:** First time	The registered person shall ensure to promote and make proper provision for the health and welfare of patients. This relates specifically to the management of falls within the home and the appropriate reporting to the patients' General Practitioner regarding a head injury or a suspected head injury.	**Met**

	Action taken as confirmed during the inspection: Review of records evidenced that falls within the home were appropriately reported to the patients' General Practitioner regarding a head injury or a suspected head injury.	
Area for Improvement 3 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that appropriate notifications are submitted to RQIA without delay. This relates specifically to falls within the home resulting in injury including head injury.	**Not met**
	Action taken as confirmed during the inspection: Review of a selection of notifications showed that not all falls within the home resulting in injury including head injury were submitted to RQIA. This area for improvement has not been met and is stated for a second time. See section 5.2.5 for details.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 38 **Stated:** First time	The registered person shall ensure that records regarding recruitment of staff are at all times available for inspection in the home by any person authorised by the RQIA. This relates specifically to pre-employment health assessment.	**Met**
	Action taken as confirmed during the inspection: Review of staff recruitment records evidenced that a pre-employment health assessment is in place.	

Area for improvement 2 **Ref:** Standard 37.5 **State** First time	The registered person shall ensure that staff duty rotas are not altered using white adhesive paper in order that the previous records can be read in accordance with best practice in record keeping.	**Not met**
	Action taken as confirmed during the inspection: Review of staff duty rotas evidenced that this area for improvement has not been met and will be stated for a second time. See section 5.2.1 for details.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. Review of records for a staff member evidenced that a pre-employment health assessment was in place and enhanced AccessNI checks were sought, received and reviewed prior to the staff member commencing work. A structured orientation and induction programme was undertaken at the commencement of their employment. The manager advised that recruitment is ongoing and that arrangements have been made for newly appointed staff to commence post within the next month.

Staff said there was good team work and that they felt supported in their role. Staff also said that, whilst they were kept busy, staffing levels were generally satisfactory apart from when there was an unavoidable absence. The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Examination of the staff duty rota confirmed this. It was noted that white adhesive paper was used to correct the duty rota. This was discussed with the manager who advised she had used white adhesive dots when she had been making changes to the original rota. Staff duty rotas are not to be altered by using correction fluids or white adhesive paper in order that the previous records can be read in accordance with best practice in record keeping. An area for improvement was identified for a second time.

We discussed the provision of mandatory training with staff. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Review of staff training records for 2022 evidenced that staff had attended training regarding first aid, moving and handling, infection prevention and control (IPC) and fire safety. The manager advised that training has been arranged for staff to attend adult safeguarding, dementia awareness, falls prevention, health and safety and control of substances hazardous to health (COSHH). However, a training and development plan was unavailable to view to reflect the training needs of individual staff. This was discussed with the manager and an area of improvement was identified.

We discussed training in relation to the Mental Health Capacity Act – Deprivation of Liberty Safeguards (DoLS) level 2. Staff told us they were unsure if they had completed DoLS training but were confident that they could report concerns about patients' safety and poor practice. The manager advised that only trained staff had completed DoLS training. All employed staff should complete the Mental Health Capacity Act – Deprivation of Liberty Safeguards (DoLS) level 2 training. An area of improvement was identified.

Staff told us they were aware of individual patients' wishes, likes and dislikes. It was observed that staff responded to requests for assistance promptly in an unhurried, caring and compassionate manner. Patients were given choice, privacy, dignity and respect.

5.2.2 Care Delivery and Record Keeping

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them.

Care records regarding mobility and pressure relief were reviewed and evidenced that they were clearly documented and well maintained to direct the care required and reflect the assessed needs of the patient. Appropriate risk assessments and evaluations had been completed.

Review of a selection of supplementary charts for patients who require to be assisted by staff to reposition, in order to provide pressure relief, evidenced there were gaps in the recording in accordance with their care plan. An area for improvement was identified.

Records reviewed regarding patients' food and fluid intake were found to be satisfactory.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example bed rails and alarm mats. Care plans were in place for the management of bed rails. In order that people feel respected, included and involved in their care, it is important that where choice and control is restricted due to risk assessment understanding, restrictions are carried out sensitively to comply with legislation.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), the speech and language therapist (SALT) and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), SALT or the Dietician.

Review of a patients' annual care review by their care manager from the local Health and Social Care Trust, showed a record of the meeting, including any actions required and involvement by the multidisciplinary team in order to support the person with their individual care needs.

Staff attended a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff members were knowledgeable about individual patients' needs including, for example, their daily routine preferences. Staff respected patients' privacy and spoke to them with respect. It was also observed that staff discussed patients' care in a confidential manner and offered personal care to patients discreetly.

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.

We observed the serving of the lunchtime meal in the main dining room. Staff had made an effort to ensure patients were comfortable throughout their meal. A choice of meal was offered and the food was attractively presented and smelled appetising. The food appeared nutritious and was covered on transfer whilst being taken to patients' rooms. There was a variety of drinks available. Patients wore clothing protectors if required and staff wore aprons when serving or assisting with meals. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. However, a menu was not on display outlining what was available at each mealtime for patients. The daily menu is required to be displayed in a suitable format, in a suitable location showing what is available at each mealtime. This was discussed with the manager and an area of improvement was identified.

The cook told us all food including scones and shortbread is home cooked. Patients able to communicate indicated that they enjoyed their meal.

5.2.3 Management of the Environment and Infection Prevention and Control

On arrival to the home we observed contractors working on the new extension at the front of the building. The manager informed us that the work is planned to be completed within the next month.

We observed the internal environment of the home and noted that the home was comfortably warm, fresh smelling and clean throughout.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were suitably furnished and comfortable. Patients could choose where to sit or where to take their meals and staff were observed supporting them to make these choices. A variety of methods was used to promote orientation. There were clocks and photographs throughout the home to remind patients of the date, time and place.

The treatment room and the sluice room/cleaner's store were observed to be appropriately locked.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors and fire exits were clear from clutter and obstruction.

All visitors to the home had a temperature check and a health declaration completed when they arrived at the home.

Observation of practice and discussion with staff confirmed that effective arrangements regarding infection prevention and control (IPC) measures and the use of Personal Protective Equipment (PPE) were in place.

Personal protective equipment, for example face masks, gloves and aprons were available throughout the home. Dispensers containing hand sanitiser were seen to be full and in good working order. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

Visiting and Care Partner arrangements were managed in line with DOH and IPC guidance. There were systems in place to manage the risk of infection and to ensure that guidelines regarding the current COVID-19 pandemic were adhered to.

5.2.4 Quality of Life for Patients

It was observed that staff offered choices to patients throughout the day which included, for example, preferences for what clothes they wanted to wear and food and drink options. Patients could have a lie in or stay up late to watch TV if they wished and they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of the time in their room and staff were observed supporting patients to make these choices.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. The manager advised that patients recently enjoyed a music event and a visit from the ice cream van.

Staff recognised the importance of maintaining good communication between patients and their relatives, especially whilst visiting is disrupted due to the COVID-19 pandemic. Staff assisted patients to make phone or video calls. Visiting arrangements were in place and staff reported positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

Since the last inspection there has been no change in management arrangements. Discussion with staff, patients and their representatives evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff members were able to identify the person in charge of the home in the absence of the manager.

Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the Nursing and Midwifery Council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC).

The manager advised that staff supervision had commenced for 2022 and arrangements are in place that all staff members have regular supervision and an appraisal completed this year.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding complaints and infection prevention and control (IPC) practices, including hand hygiene.

Deficits were found in relation to the reporting of notifiable accidents/incidents to RQIA in keeping with regulation. A review of records of accidents and incidents which had occurred in the home regarding unwitnessed falls, found that residents who had fallen and sustained a possible head injury, there was evidence of appropriate onward referral as a result of the post falls review to their General Practitioner (GP). Accidents and incidents were notified, if required, to patients' next of kin and their care manager. Neurological observation charts for patients who had unwitnessed falls were recorded for a period of twenty-four hours in line with post fall protocol and current best practice. However, RQIA were not notified accordingly. This was discussed with the manager and the outstanding notifications were requested and received post inspection, from the manager. This area for improvement has not been met and is stated for a second time.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager, Mrs Anne Dugan was identified as the appointed safeguarding champion for the home. Staff members spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

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 in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

Review of complaints records evidenced that systems were in place to ensure that complaints were managed appropriately. Patients and staff said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

The manager advised that staff meetings had been difficult to arrange due to disruption during the COVID-19 pandemic and that a staff meeting would be scheduled to take place within the next month.

Correspondence from the manager on 10 October 2022 confirmed a staff meeting had been held.

Staff confirmed that there were good working relationships and commented positively about the manager and described her as supportive and approachable.

6.0 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	1*	5*

* the total number of areas for improvement includes one regulation and one standard that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Anne Dugan, 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 30 **Stated:** Second time	The registered person shall ensure that appropriate notifications are submitted to RQIA without delay. This relates specifically to falls within the home resulting in injury including head injury. Ref: 5.1 and 5.2.5
To be completed by: Immediate action required	**Response by registered person detailing the actions taken:** All nurses reminded of process for reporting.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 37.5 **State** Second time **To be completed by:** Immediate action required	The registered person shall ensure that staff duty rotas are not altered using white adhesive paper in order that the previous records can be read in accordance with best practice in record keeping. Ref: 5.1 and 5.2.1
	Response by registered person detailing the actions taken: This practice has now ceased.All changes to original rotas are initialled.

Area for improvement 2 **Ref:** Standard 39 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure there is a robust written training and development plan that is kept under review and is updated at least annually to reflect the training needs of individual staff. Ref: 5.2.1
	Response by registered person detailing the actions taken: Ongoing.Face to face training sessions have been held in October and further planned for early November
Area for improvement 3 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 23 December 2022	The registered person shall ensure that all employed staff complete mandatory training in Mental Health Capacity – Deprivation of Liberty Safeguards (DoLS) and that a record of training is kept and closely monitored. Ref: 5.2.1
	Response by registered person detailing the actions taken: DOLS and safeguarding training on line and in house sessions are planned
Area for improvement 4 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** Immediate action required	The Registered Person shall ensure that repositioning charts are consistently completed to evidence that patients are assisted in accordance with their care plan. Ref: 5.2.2
	Response by registered person detailing the actions taken: To be monitored and followed up monthly at time of monthly reviews of care plans.
Area for improvement 5 **Ref:** Standard 12 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that a daily menu is on display in a suitable format and in an appropriate location, showing patients what is available each mealtime. Ref: 5.2.2
	Response by registered person detailing the actions taken: A menu board has been ordered for the dining room.This will be erected in a suitable place where it can be clearly seen by residents.

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

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