Unannounced Care Inspection Report
17 May 2017

Mullaghboy

Type of Service: Nursing Home
Address: 86 Warren Road, Donaghadee, BT21 0PQ
Tel no: 028 91 883596
Inspectors: Sharon McKnight

1.0 Summary

An unannounced inspection of Mullaghboy took place on 17 May 2017 from 10:15 hours to 16:15 hours.

The inspection sought to assess progress with any issues raised during and 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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment.

Observation of the delivery of care and discussion with patents and staff evidenced that patients' needs were met by the levels and skill mix of staff on duty. The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. Infection prevention and control measures were adhered to. Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no areas for improvement identified in this domain.

Is care effective?

A review of three patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

We reviewed the management of wound care for one patient and were assured that prescribed dressing regimes were adhered to. Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. There was evidence within the care records of regular, ongoing communication with relatives.

Care management reviews for patients receiving long term care were arranged by the relevant health and social care trust. These reviews could be held in response to a change to patient need and as a minimum annually.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting and that staff were aware of the importance of handover reports in ensuring effective communication.

There were no areas for improvement identified in this domain.

Is care compassionate?

We arrived in the home at 10:15. There was a calm atmosphere and staff were busy attending to the needs of the patients. The majority of patients were in their bedrooms as was their personal preferences; some patients remained in bed, again in keeping with their personal preference. All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. A number of their comments are included in the report.

Ten relative questionnaires were issued by RQIA; one was returned. The relative was very satisfied with the care provided across the four domains.

Ten questionnaires were issued to nursing, care and ancillary staff; four were returned prior to the issue of this report. The staff members were very satisfied or satisfied with the care provided across the four domains.

There were no areas for improvement identified in this domain.

Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.

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.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the responsible person. A copy of the quality monitoring reports was available in the home.

There were no areas for improvement identified in this domain.

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	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Anne Dugan, registered manager and Robert Duncan, responsible person, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 22 November 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.

2.0 Service details

Registered organisation/registered person: Mullaghboy Limited Robert Maxwell Duncan	**Registered manager:** Anne Dugan
Person in charge of the home at the time of inspection: Anne Dugan	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 32

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with seven patients individually and with the majority in small groups, two registered nurse, one senior care staff, the housekeeper, one domestic and one patient's visitors/representative.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from relatives and staff not on duty. Ten staff and relative questionnaires were left for completion.

The following information was examined during the inspection:

- duty rota for all staff for the week of the inspection
- 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 files
- competency and capability assessments of nurses
- staff register
- three patient care records
- record of staff meetings
- patient register
- complaints and compliments record
- record of audits
- RQIA registration certificate
- certificate of public liability
- monthly monitoring reports

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 22 November 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 22 November 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 14(2)(c) **Stated:** First time	The security of cleaning chemicals and the need for signage on the bedroom door where oxygen cylinders are available must be reviewed to ensure that, as far as is reasonably practicable unnecessary risks to health and safety of patients are identified and so far as possible eliminated	**Met**

	Action taken as confirmed during the inspection: Observations made throughout the inspection evidenced that sluice rooms were locked ensuring cleaning chemicals were securely stored. Signage was appropriately displayed on the bedroom door where oxygen cylinders were available. This requirement has been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 21.6 **Stated:** First time **To be completed by:** 20 December 2016	It is recommended that where a risk is identified with the use of footrests a documented risk assessment is completed.	**Met**
	Action taken as confirmed during the inspection: Patients at the time of this inspection were being transferred with the use of footrests. Registered nurses spoken with were aware of the need to ensure that where a risk was identified with the use of footrests a documented risk assessment would be completed. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 15 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Observation of the delivery of care and discussion with patients evidenced that their needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; four were returned following the inspection. Whilst all of the respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?" a comment was made that an additional care staff in the morning would help when the dependency of patients is higher. This comment was shared with the registered manager.

Patients and a relative spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in timely manner. We sought relatives' opinion on staffing via questionnaires; one was returned in time for inclusion in the report. The relative was satisfied that there was sufficient staff to meet the needs of their loved one.

A nurse was identified to take charge of the home when the registered manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

A review of two staff recruitment records evidenced that they were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records confirmed that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

A record of staff including their name, address, contact number, position held, contracted hours, date of receipt of Access NI certificate, date commenced and date position was terminated (where applicable) was held and provided an overview of all staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager. A review of the records of NMC registration evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The record of the checks of care staff registration included the expiry date of their registration with NISCC.

The registered manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe.

We discussed the provision of mandatory training with staff and reviewed the training records for 2016/2017. Training records evidenced good compliance; for example 77% of staff had completed training in safeguarding and 74% in infection prevention and control in the past 12 months. In 2017 93% of staff have completed training in fire awareness. Mandatory training compliance was monitored by the registered manager.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the responsible person and registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The responsible individual confirmed that both they and the registered manager had attended training on the role of the safeguarding champion in February 2017. Following discussion we were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

Review of three 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 January 2017 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. Infection prevention and control measures were adhered to. We spoke with two members of housekeeping staff who were knowledgeable regarding the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

We discussed the management of fire safety with the registered manager who confirmed that fire checks were completed weekly. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

No areas for improvement were identified with the delivery of safe care.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

A review of three patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

We reviewed the management of wound care for one patient. Care plans contained the grade and size of the wound, the prescribed dressing regime and the frequency dressing were recommended for renewal. An assessment of the wound was recorded after each dressing change. A review of wound care records for the period 10 February to 17 May 2017 evidenced that prescribed dressing regimes were adhered to. The patient was well informed of the prescribed treatment regime and when the podiatrist and tissue viability nurse were due to visit.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Care management reviews for patients receiving long term care were arranged by the relevant health and social care trust. These reviews could be held in response to a change to patient need and as a minimum annually. They could also be requested at any time by the patient, their family or the home. There was evidence within the care records of regular, ongoing communication with relatives.

Discussion with the registered manager and staff 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.

The registered manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting held was with all staff on 5 May 2017.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

No areas for improvement were identified with the delivery of effective care.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

We arrived in the home at 10:15. There was a calm atmosphere and staff were busy attending to the needs of the patients. The majority of patients were in their bedrooms as was their personal preferences; some patients remained in bed, again in keeping with their personal preference.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. 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. Discussion with patients individually and with others in smaller groups, confirmed that living in Mullaghboy was a positive experience.

All of the patients spoke highly of the staff. Patients and staff confirmed that when they raised a concern or query, they were taken seriously and their concern/query was responded to appropriately.

The following are examples of comments provided:

"Good food, good staff, good care."
"The staff are very approachable and always have a smile."
"I would have no hesitation incoming here again."

We reviewed the provision of activities and observed that the activity programme for the week of the inspection was displayed in the home. Activities were provided by the care staff. Discussion with staff evidenced that they valued the role activities had in the lives of the patients and the importance of ensuring there was time to deliver the planned activities. On the afternoon of the inspection patients enjoyed a game of bingo in the main lounge. It was good to note that a number of patients who generally stayed in their bedroom during the day joined the others in the lounge for the bingo.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. The registered manager explained that as they work as a registered nurse and a variety of shifts over seven days a week they have regular contact with the patients and relatives. They confirmed that a satisfaction survey was conducted annually by the home. The registered manager explained that surveys were due to be sent out in June 2017; the results would then be collated and displayed in the home. The outcome of this engagement with patients and their representatives will be reviewed at a future care inspection.

As previously discussed ten relative questionnaires were issued; one was returned within the timescale for inclusion in this report. The relative was very satisfied with care provided across the four domains.

We issued ten questionnaires to nursing, care and ancillary staff; four were returned prior to the issue of this report. Staff were either very satisfied or satisfied with the care provided across the four domains.

Any comments from relatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas for improvement

No areas for improvement were identified with the delivery of compassionate care.

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

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.

Discussion with the registered manager and review of the home's complaints records evidenced that systems were in place to ensure 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.

The registered manager confirmed that monthly audits were completed, for example care records. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

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.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the responsible person. An action plan was included within the report to address any areas for improvement. The action plan was reviewed at the next visit. A copy of the quality monitoring reports were available in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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