The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
30 September 2016

Strangford Court (Millar Suite)

Type of Service: Nursing Home
Address: Millar Suite, 26 Strangford Road, Downpatrick, BT30 6SL
Tel No: 028 4461 2481
Inspector: Donna Rogan

1.0 Summary

An unannounced inspection of Strangford Court Care Home (Millar Suite) took place on 30 September 2016 from 10.00 to 16.15 hours. The inspection sought to assess progress with any issues raised during and since the previous 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 were safe systems in place for the recruitment and selection of staff. New staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs and there were systems in place to monitor staff performance. The staffing levels for the home were subject to regular review to ensure the assessed needs of the patients were met. Training had been provided in all mandatory areas and this was kept up to date. The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding and a review of records confirmed that any potential safeguarding concern was managed appropriately. Risks to patients' safety were assessed on a regular basis and there was evidence that any falls sustained in the home were managed appropriately. The home was found to be clean, tidy, well decorated and warm throughout. The corridors in the home were being painted on the day of the inspection. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Is care effective?

The care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals. There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with patient representatives within the care records, in relation to any changes in the patients' condition. Personal care records evidenced that personal care was delivered in line with their care plans. Patients' confidentiality was respected by staff and the staff consulted confirmed that communication between all staff grades was effective. Staff, patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely and the patients confirmed that they were afforded choice, privacy, dignity and respect. The mealtime experience was found to be tranquil and all patients were assisted to eat their meals in a respectful manner. Patients consulted with also confirmed that they were able to maintain contact with their families and friends and there was a range of activities available for patients to choose from. Patients' religious needs were well met when requested. A system was in place to obtain life histories of patients, which enables more person-centred care to be delivered. Patients and representatives' views were ascertained and this information was used to inform future service planning. The comments received from patients and their representatives were very positive and a number of comments have been included in the report.

Is the service well led?

There was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. Complaints were managed appropriately. There were systems in place to monitor and report on the quality of nursing and other services provided. 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 also 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. All incidents had been managed appropriately and reported in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. Monthly monitoring visits were also completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives.

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 DHSS 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 Claire Quail, registered 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 25 August 2016. There were no requirements or recommendations made during the most recent medicines management inspection. There were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered provider: Four Seasons Healthcare Dr Maureen Claire Royston	Registered manager: Claire Quail
Person in charge of the home at the time of inspection: Claire Quail	**Date manager registered:** 10 March 2011
Categories of care: NH-DE	**Number of registered places:** 22

3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report
- 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 also met with 10 patients, two care staff, the deputy manager and one patient's representative.

The following information was examined during the inspection:

- staffing arrangements in the home
- three patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to adult safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent medicines management inspection dated 25 August 2016

The most recent inspection of the home was an unannounced medicines management inspection. There were no issues required to be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 18 November 2015

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

There were safe systems in place for the recruitment and selection of staff. A review of two personnel files evidenced that these were reviewed by the registered manager and checked for possible issues. Where nurses and carers were employed, their pin numbers were checked monthly with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC) if applicable, to ensure that their registration status was current. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with Access NI and a record was maintained which included the reference number and date received.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. This ensured that they had the basic knowledge needed to begin work.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed training on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adults safeguarding. Observation of the delivery of care evidenced that training had been embedded into practice. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota commencing 26 September 2016 and 3 October 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The registered manager demonstrated good knowledge regarding adult safeguarding and confirmed that any potential safeguarding concern would be managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures and that RQIA would be notified appropriately. There were no ongoing safeguarding issues in the home.

A range of risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails and restraint, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate; assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were updated following each incident, care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. The areas reviewed were found to be clean, tidy, well decorated and warm throughout. The corridors were being painted on the day of inspection. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

Patients' needs were assessed on admission. Care plans were developed and reviewed on a regular basis. A review of three patient care records evidenced that risks to patients were assessed. Examples included moving and handling assessments and risk of falls; bedrails and other restraints; risk of developing pressure damage and assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

The care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records, in relation to any changes in the patients' condition.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

Where patients required the use of a lap belt, whilst seated in their chairs, the review of records evidenced that these were checked and released on a regular basis, in line with the care plan.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to discussing patients' details in front of other relatives.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and it provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Staff meetings are held on a regular basis. Consultation with staff confirmed 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. Information leaflets were available for patients or relatives they were displayed in the front entrance of the home. Advocates or patient representatives can represent the views for patients who are unable or not confident in expressing their wishes.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon. Four Seasons Health Care (FSHC) have introduced a' Quality of Life' programme which provides patients, relatives and visitors an opportunity to have their say about their experiences regarding the home. The manager also informed the inspector that she formally seeks views from two patients and relatives at least weekly. The findings are recorded in the home's 'TRaCA system'.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with 10 patients both individually and in small groups, confirmed that they were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their choices were listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Menus were displayed clearly throughout the building and were correct on the day of inspection. We observed the lunch time meal in the dining room. We saw that the atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with tablecloths and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal.

The registered manager stated that a second activities coordinator had recently been appointed in the Oakland Suite and that the activity therapist was now specifically employed to assist patients in the Millar Suite with their activities. There was a hairdresser who visits weekly and there was also evidence that music and entertainment was a regular occurrence in the schedule of activities.

Staff confirmed that the spiritual needs of patients were catered for and there was evidence of regular visits by ministers of different faiths.

A review of patient care records confirmed information about patient's background. Each patient had a (Life Story) record, displayed in their bedrooms, which aimed to provide information about their life and interests, before they came to live in the home.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. The complaints procedure was displayed in the reception area of the building. From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

- "I love working here"
- "I think patients are very well cared for, I would recommend it"
- "We attend training to keep ourselves up to date"
- "The home is well run; I feel we are listened to"
- "This is a great place to work"

Patients

- "I like it here"
- "I enjoy the food"
- "Yes, the staff are very kind"
- "I'm happy enough"

Patients' representatives

- "I feel my relative is very well cared for"
- "I think this is a very good home"

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed at least every three years. Staff confirmed that they had access to the home's policies and procedures.

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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Relatives were aware of who the manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- wound management
- medicines management
- care records
- infection prevention and control
- environment audits
- complaints.

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. For example, an audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

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. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement. Discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

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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