Unannounced Care Inspection Report
17 August 2016

Ben Madigan Nursing Home

Type of Service: Nursing Home
Address: 36 Mill Road, Newtownabbey, BT36 7BH
Tel No: 028 9086 0787
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Ben Madigan Nursing Home took place on 17 August 2016 from 09:10 to 1730 hours.

The inspection sought to assess progress with 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 was evidence that systems and processes were in place and monitored to ensure the safe and competent delivery of care and other services. A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, and clean throughout. Housekeeping staff were commended for their efforts.

Staff consulted and observation of care delivery and interactions with patients clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice. Staff were confident in carrying out their role and function in the home.

One requirement was made in this domain regarding the awareness of staff to ensure fire exits are maintained clear from obstruction.

Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process. There was evidence registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. It was evident that the majority of patient care records reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals.

All staff spoken with demonstrated knowledge and understanding of their role and function to ensure patients received the right care at the right time.

There was evidence of positive outcomes for patients in relation to the appropriate and timely delivery of care and in particular during the lunchtime meal which was commended to the registered manager. Refer to section 4.4 for details.

A recommendation was made regarding the accurate recording of supplementary care charts such as repositioning charts.

Is care compassionate?

Patients were afforded choice, privacy, dignity and respect. Interactions between patients and staff were positive, caring and kind. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

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.

Observations and discussion with patients and staff confirmed that a comprehensive and varied programme of activities was provided.

There were no requirements or recommendations made in this domain.

Is the service well led?

Comments from patients, relatives and staff confirmed that the home was well led.

As discussed in the preceding sections it was evident that the registered manager had implemented systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff to deliver care appropriately to meet the assessed needs of patients. The registered manager was available to patients, their relatives and operated an 'open door' policy for contacting her. This was commended.

Compliance with the requirement and recommendation made will further enhance the patient experience and service provision.

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	1	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Jillian Campbell, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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 23 March 2016. Other than those actions detailed in the previous QIP there were no further actions required. 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: Priory Care Homes Number 2 Ltd/ Mrs Caroline Denny	**Registered manager:** Mrs Jillian Campbell
Person in charge of the home at the time of inspection: Mrs Jillian Campbell	**Date manager registered:** 21 March 2016
Categories of care: NH-DE, I, PH, PH(E) and TI A maximum of 34 patients within category of care NH-DE and located within the dementia unit.	**Number of registered places:** 64

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 the inspector spoke with nine patients individually and with others in small groups, one relative, five care staff, the deputy manager, two registered nurses, the hairdresser, two maintenance staff, the home's administrator and the home's activity/social lead.

In addition questionnaires from RQIA were provided for distribution by the registered manager; 10 for relatives/representatives; 10 for patients and seven for staff not on duty during the inspection. None were returned.

The following information was examined during the inspection:

- three patient care records
- five patients' care charts such as repositioning, food intake and fluid intake records
- staff duty rosters 8 – 21 August 2016
- staff training and planner/matrix for 2016
- one staff recruitment record
- complaints record
- a selection of incident and accident records including audit processes

- record of quality monitoring visits carried out on behalf of the responsible individual in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit and governance relating to management of falls and complaints
- records pertaining to the management of adult safeguarding concerns
- records for checking nursing staff registration with Nursing and Midwifery Council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC).

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 23 March 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. Details of the care inspector's validation of the QIP can be viewed in the next section.

4.2 Review of requirements and recommendations from the last care inspection dated 23 March 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:** 31 May 2016	Registered nurses admitting patients to the home, should evidence that they have undertaken a comprehensive and holistic assessment of nursing needs their assessment of the patient's nursing needs on the day of admission and complete it within five days.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of patient care records confirmed that this recommendation had been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. For example, a 'twilight shift' had been introduced from 16:00 to 22:00 hours following a review of patients' needs. This shift was in place most evenings. In addition to the twilight shift the deputy manager confirmed that she had commenced working from 09:00 to 21:00 hours rather than the traditional '8 to 8 shift'. This enabled the deputy manager to liaise with and support night staff. The deputy manager confirmed that this liaison was useful to the management team and to night staff. In addition during discussion it was confirmed that the

registered manager had worked on night duty to support the induction of new staff. This is good practice.

Review of the staffing rota from 8 to 21 August 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients confirmed that they had no concerns regarding staffing levels although some patients did comment that staff 'were very busy'.

Staff consulted confirmed that planned staffing levels met the assessed needs of the patients. However, on occasions, due to short notice sick leave, the staffing levels would be 'short'. Staff described that on these occasions they had to work well as a team to ensure patients did not notice any difference to their day. Some staff stated that staff were 'borrowed' from one floor to support staffing levels on the other floor. Staff said this was frustrating. Specific and individual concerns were discussed with the inspector and staff advised to discuss their concerns with the registered manager.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. For example, the serving of the lunchtime meal on both floors confirmed that patients' needs were met by the staff in a timely, considerate and caring manner.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff were mentored by an experienced member of staff during their induction period. Recruitment records for one staff member were reviewed and found to be completed in full and in accordance with legislative requirements. For example pre employments checks were undertaken and two references received prior to the person's start date. Staff induction records were also in place.

Discussion with the registered manager and staff evidenced that a system was in place to ensure staff attended mandatory training. Review of the training matrix/schedule for 2016 indicated that training was planned to ensure that mandatory training requirements were met. Training outcomes for 2016, so far, indicated that 95.7% of staff were compliant with mandatory training requirements. Staff consulted and observation of care delivery and interactions with patients clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice. Staff were confident in carrying out their role and function in the home. The registered manager and staff demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. RQIA were assured that 100% compliance in mandatory training requirements was the objective of management. The level of staff compliance with training requirements, so far this year, was commended.

Some staff raised concerns about the lack of face to face training in comparison to electronic learning/training and additional training to enable them to fulfil their role and function in the home. The registered manager confirmed that since she had commenced managing the home she had concentrated on ensuring all staff were complaint with the mandatory training requirements first and was planning additional training for the rest of 2016. As stated previously in regard to concerns raised about staffing levels; staff were advised to raise their specific concerns about training requirements with the registered manager.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff with Nursing and Midwifery Council (NMC and care staff with the Northern Ireland Social Care Council (NISCC) were appropriately implemented and managed.

Review of 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 management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Information from the falls audit, and other audits, informed the responsible individual's monthly monitoring visit in accordance with the Nursing Home Regulations (Northern Ireland) 2005 - regulation 29.

Staff spoken with confirmed that nursing staff and care staff were knowledgeable of the actions to be taken in the event of an emergency. Review of accidents/incidents records confirmed that notifications were forwarded to RQIA appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, and clean throughout. Housekeeping staff were commended for their efforts.

Observations at the beginning of the inspection indicated that the storage of equipment was not appropriately managed in two of the stairwells. The final exit doors at the foot of the stairwells were partially obstructed by a zimmer walking frame in one and a BBQ in another. This was brought to the attention of the maintenance staff and the registered manager. All other fire exits were clear and unobstructed. Observations later in the day confirmed that the registered manager had ensured the obstructions had been removed. However, a requirement was made in relation to staff awareness of fire safety measures.

Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

A requirement was made to ensure that all staff are aware of the importance of ensuring fire exits and fire exit routes are maintained free from obstruction at all times.

Number of requirements	1	**Number of recommendations**	0

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process. There was evidence registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. It was evident that the majority of patient care records 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.

However, the review of five patients' supplementary care charts such as repositioning and food and fluid intake records evidenced that these records were not maintained accurately. For example, 'gaps' in the delivery of care to prevent the development of pressure ulcers, particularly from the late evening period and overnight were observed. Fluid records reviewed

also evidenced gaps and on occasions staff did not always 'total' the daily fluid intake. In addition it was also evident from review of evaluations of care delivered, that registered nurses' (RN's) had not reviewed the charts prior to recording their evaluation. Observations of care delivery and discussion with patients and staff did assure RQIA that care was delivered, as prescribed. Details were discussed with the registered manager and deputy manager. A recommendation was made.

Review of three patient care records and care planning evidenced that care was patient centred and relevant to ensure patients' assessed needs were met. However, advice was provided to the registered manager regarding the content of one care plan relating to the management repositioning. As stated previously, discussion confirmed that the right care was delivered. There was evidence that the care planning process included input from patients and/or their relatives, if appropriate. There was evidence of regular communication with relatives and representatives from the Trust within the care records.

Discussion with staff confirmed that all nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff also confirmed that regular staff meetings were held and minutes were made available. The registered manager kept records of any meeting she had with staff. For example, there was evidence that a meeting with staff had taken place on 27 July 2016 and a meeting with department heads on 7 June 2016 had also taken place. However, advice was given that meeting agendas should be available in advance of meetings to enable staff to prepare and/or contribute to the agenda and that formal minutes with an action plan should be produced following the meeting and made available to participants.

The registered manager also confirmed that a staff survey had been undertaken in February 2016 and the outcomes/results had been forwarded to the registered manager from head office.

Minutes of residents' meetings were reviewed for May and June 2016. The registered manager and activity therapist conducted the meeting on a monthly basis. Minutes were made available with outcomes recorded of any actions taken.

Staff stated they knew they worked together effectively as a team because they communicated effectively and patients 'came first'. Staff stated that they felt proud to be able to make a difference to patients' quality of life. Staff confirmed they could raise any concerns with senior staff and were confident of support and, if required, confidentiality. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

As discussed in section 4.3 observation of care delivery was found to meet patient needs. Staff were observed during the lunch time period to provide assistance on a one to one basis in accordance with best practice guidance. One example of effective care delivery during the lunch time was particularly noteworthy; a staff member was observed to respond to a patient in a caring and discreet manner. This approach ensured that the patient was not distressed and would continue to eat their meal when ready to do so. The details were discussed with the registered manager and the staff member's actions commended.

Patients spoken with expressed their confidence in raising concerns with the home's staff and/or management. Patients were aware of who their named nurse was and knew the registered manager.

There was information available to staff, patients and relatives in relation to advocacy services.

Areas for improvement

A recommendation was made that registered nurses and care staff ensure records of the care delivered are accurate and recorded contemporaneously.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. It was evident that there were good relationships between patients and 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 and staff and review of care records evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with patients and review of the information displayed in the foyer confirmed that a variety of 'activities' were available in the home. example, every Tuesday they had a visit from some dogs, the game Bocce was to recommence in September and helped create some competition between units, baking and cooking demonstrations, Bingo – because the ladies 'love to win something' and various church services.

Discussion with the activity therapist demonstrated a detailed awareness of the need to adapt and develop the activities offered to meet specific needs of patients and an enthusiasm for the role. For example, an assessment of the patients likes and dislikes regarding activities and socialising alongside their participation ability was undertaken on admission to the home. Staff and patients said they enjoyed activities and described various activities at the fete that had been held the previous weekend for patients, staff and their families. The activity therapist and patients also discussed the breakfast and lunchtime clubs. These clubs provided for smaller groups of patients to come together in a quieter environment than the main dining rooms. Patient enjoyed the groups and could relaxed and enjoy the chat and 'craic'.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Patients and their relatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Consultation with patients individually, and with others in smaller groups, confirmed that living in Ben Madigan Care Home was a positive experience.

Patient comments to the inspector included:

- "I'm great, girls and boys all lovely, I'm content…staff are good"
- "good criac with staff"
- In relation to living in Bed Madigan and the staff – "Okay here, girls good"

In addition, eight patient questionnaires were provided by RQIA for distribution by the registered manager. None were returned.

One relative spoken with was very positive in relation to the care delivered, the environment, staff attitude and management of the home. In addition, 10 relative/representatives' questionnaires were provided by RQIA to the registered manager for distribution. At the time of issuing this report none had been returned.

Comments made by staff during the inspection are included throughout the report. In addition, 10 staff questionnaires were provided by RQIA for distribution, by the registered manager, to staff not on duty during the inspection. At the time of issuing this report none had been returned.

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 were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern. Staff were able to identify the person in charge of the home when the registered manager was not on duty.

Staff, patients and relatives were complimentary in relation to how the registered manager led and managed the home and supported them on a daily basis. For example, staff commented that the registered manager was observed out on the floor and she was aware of staff and patients' needs.

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

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. Patients and relatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/relatives confirmed that they were confident that staff and management would manage any concern raised by them appropriately.

Staff were knowledgeable of the complaints and adult safeguarding process commensurate with their role and function. A review of notifications of incidents to RQIA April 2016 confirmed

that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

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. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents/accidents. Records also evidenced that the results of audits had been analysed and appropriate actions taken to address any shortfalls identified.

There was an effective system in place to ensure nursing staff were registered with the NMC; and that care staff were registered with NISCC. Care staff not registered with NISCC were required and supported to register.

Review of reports and discussion with the registered manager evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and trust representatives.

As discussed in the preceding sections it was evident that the registered manager had implemented and managed systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff to deliver care appropriately to meet the assessed needs of patients. The registered manager was available to patients, their relatives and operated an 'open door' policy for contacting her. This was commended. Compliance with the requirement and recommendation made will further enhance the patient experience and service provision.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jillian Campbell, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref**: Regulation 27 (4) **Stated:** First time **To be completed by:** Immediate action required.	The registered provider must ensure that all staff are aware of the importance of ensuring fire exits and fire exit routes are maintained free from obstruction at all times.
	Response by registered provider detailing the actions taken: Immediate action was taken on the day of inspection to remove the obstructing items from the fire exits / stairwells. All staff undertake H&S training as part of induction and also have a one to one fire safety session on the first day of induction. All staff have received supervision which details the findings on the day of the inspection and the actions to be taken - all staff have been updated about their responsibility in relation to H&S and fire safety. The maintenance person completes a full Home walk round at the start of each shift and will raise any issues necessary with the appropriate persons/staff members.

Recommendations	
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that registered nurses and care staff record of the care delivered accurately and contemporaneously.
	Response by registered provider detailing the actions taken: Registered nurses - the care records were reviewed and 3 residents care plans were updated to include their repositioning requirements as their needs had changed. The updated care plans were forwarded to RQIA the day after the inspection. Care staff are now completing their records accurately and contemporaneously. Systems have been implemented to ensure that Senior Care staff on each shift check this is completed.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

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