Ben Madigan Care Home
RQIA ID: 1398
36 Mill Road
Newtownabbey
BT36 7BH

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Unannounced Care Inspection
of
Ben Madigan Care Home

23 March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 23 March 2016 from 10:05 to 15:00 hours.

This inspection was carried out to follow up on information received by RQIA from a relative on 16 February 2016. Further information is available in sections 3 and 5 of the report.

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 26 August 2015.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

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

2. Service Details

Registered Organisation/Registered Person: Priory Care Homes Number 2 Ltd Caroline Denny – Responsible Individual	**Registered Manager:** Jillian Campbell
Person in Charge of the Home at the Time of Inspection: Registered Manager – Jillian Campbell	**Date Manager Registered:** 21 March 2016
Categories of Care: NH – I, PH, PH(E), TI and DE A maximum of 34 patients within category of care NH-DE within the Dementia Unit.	**Number of Registered Places:** 64
Number of Patients Accommodated on Day of Inspection: 60	**Weekly Tariff at Time of Inspection:** £623 - £750

3. Inspection Focus

Information was received by RQIA on 16 February 2016 from a relative in relation to the standard of care within Ben Madigan Nursing Home. This information was also forwarded by the relative, to the Northern Health and Social Care Trust's (NHSCT) care manager aligned to the named patient. On 22 February 2016, RQIA were informed by the Trust that following a meeting with the relative and the receipt of further written information, the complaint was being investigated under the DHSSPS complaints process and the safeguarding of vulnerable adults protocols.

It is not the remit of RQIA to investigate complaints or safeguarding allegations made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Following discussion with senior management, it was agreed that an inspection would be undertaken to review the following areas:

- staffing
- management of behaviours that challenge
- provision of activities
- management of falls
- management of notifiable events
- management of medical emergencies
- transfer of patients to and from hospital
- management of fluids
- privacy, dignity and respect
- governance/quality assurance systems pertaining to inspection focus

The inspection also sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/Process

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

- discussion with the registered manager
- discussion with the registered nurses
- discussion with care staff
- discussion with patients
- a general tour of the home and review of a random selection of patients' bedrooms, bathrooms and communal areas
- examination of a selection of patient care records
- examination of a selection of records pertaining to the inspection focus
- observation of care delivery
- evaluation and feedback.

During the inspection, the inspectors spoke with three patients individually and with the majority of others in smaller groups; six care staff, two registered nurses and three relatives.

Prior to inspection the following records were analysed:

- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the returned quality improvement plan (QIP) from the last care inspection
- the previous care inspection report.

The following records were examined during the inspection:

- duty rotas for nursing and care staff week commencing 14 and 21 March 2016.
- records relating to governance/quality assurance systems for:
    - falls
    - staffing levels/patient dependency
    - notifiable events
- four patient care records including fluid intake and repositioning charts.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced medicines management inspection dated 12 November 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection on 26 August 2015.

Last Care Inspection Statutory Requirements		**Validation of Compliance**
There were no requirements made		
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 4 **Stated:** First time	The registered person should ensure that care plans clearly demonstrate how staff are to meet the assessed needs of the patients.	**Met**
	Action taken as confirmed during the inspection: Review of four patient care plans evidenced that care plans were generally reflective of patient's assessed needs. Care plans were regularly reviewed. Advice was provided regarding the inclusion of the pressure ulcer risk assessment score within one care plan. Another care plan in respect of end of life care was discussed and the content was described as 'exemplary' and commended by inspectors.	

5.3 Staffing

Observations of the delivery of care and review of nursing and care staff duty rotas confirmed that the planned number of staff on duty was adhered to.

Staff were observed responding to calls for assistance in a timely manner as required. Staff demonstrated that their knowledge of the patients' needs and the staffing levels enabled staff to anticipate patients' need and provide effective support.

Discussion with the registered manager and review of records confirmed that when reviewing staffing levels, that patient dependency levels were considered alongside pattern and trend analysis of accidents and incidents and the skill mix of staff. This ensured that patients' needs were met over 24 hours a day and seven days a week.

Areas for Improvement

There were no areas for improvement identified.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.4 Management of behaviours that challenge

Observation of the delivery of care and the interactions between patients requiring reassurance and staff, was caring, effective and compassionate. Efforts were made by staff to determine how patients felt, particularly when patients were unable to articulate their feelings or concerns.

Discussion with staff and review of care records confirmed that referrals were made appropriately to support services within the Trust, such as sensory and dementia services.

Since taking up post the registered manager had implemented a 'supervised lounge' within both units. Staff confirmed that the lounge was supervised 'at all times' which included during handover to night staff and until patients were assisted to bed. Staff allocated to the supervised lounge, were required to call for assistance rather than leave the lounge. Examples of this included, when a patient required to use the bathroom or when a patient wished to go for a walk and required support. Staff spoken with were also aware that the recent reduction in the number of incidents and falls in home had been attributed to the introduction of the 'supervised lounge'.

Care plans reviewed in relation to specific behaviours that challenged, were found to meet the patients' assessed need and that the care plans were reviewed regularly.

Areas for Improvement

There were no areas for improvement identified.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.5 Provision of activities

Within the dementia unit it was observed that staff were actively seeking patients' views as to which activity they would like to participate in. These activities were in addition to the activities provided by the home's activity therapist. Options available included watching a movie/DVD; listening to music; reading newspapers/magazines and the use of 'rummage boxes'.

Patients in one lounge were observed to discuss at length which movie to watch and patients were heard instructing staff how to get the best picture. The interactions between patients and staff were observed to be caring, effective, compassionate and fun. It was obvious that good relationships existed.

Areas for Improvement

There were no areas for improvement identified.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.6 Management of falls

As discussed in section 5.4 staff spoken with were aware that the recent reduction in the number of incidents and falls in home had been attributed to the introduction of the 'supervised lounge'.

This was confirmed through discussion with the registered manager and a review of the governance arrangements for monitoring and analysing falls.

Discussion with staff evidenced that when a patient experienced a fall, the patient's care plan and risk assessment were reviewed, post fall, to ensure the care delivered was still relevant. There was evidence of referral to other healthcare professionals including in the event of an emergency.

One relative spoken with confirmed that if their loved one experienced a fall or any other type of incident, they were informed.

Areas for Improvement

There were no areas for improvement identified.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.7 Management of notifiable events

Registered nurses and the registered manager were aware of the requirements for reporting of events to both RQIA and the Trust.

Review of notifications submitted to RQIA, in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005, since the previous care inspection, indicated that incidents were notified appropriately.

Areas for Improvement

There were no areas for improvement identified.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.8 Management of medical emergencies and transfer of patients to and from hospital

Care staff confirmed that when a patient was found to have fallen or when a patient became unwell, that the registered nurses responded immediately and that "they [the nurses] knew what they were doing".

Discussion with registered nurses and review of records confirmed that when a patient became unwell the appropriate nursing care would be delivered and timely referrals made to the relevant healthcare professional, such as the patient's own GP. In the event of a medical emergency, nursing staff would respond appropriately and someone would be directed to call '999'.

If a patient was to transfer to hospital information regarding the patient's nursing needs and their medication would be provided by means of the 'transfer/discharge record'.

When a patient returned to the home from hospital a 'return from hospital assessment' was undertaken by the nurse receiving the patient back into the home.

Areas for Improvement

There were no areas for improvement identified.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.9 Management of fluids

Observations of the serving of the lunch time meal confirmed that patients were offered a choice of drinks. Drinks were also observed to be available to patients in their bedrooms and in the lounges. However, it was not obvious how drinks were provided, in that there were no jugs of juice or fresh water in these areas.

This was discussed with registered manager who confirmed that she had instructed staff to keep the jugs of juice and water in the unit's refrigerators to ensure the juices were cool and as fresh as possible. Discussion took place regarding the visual prompt of a jug of juice.

A review of three patients' fluid intake charts evidenced that fluids were provided on a regular basis and the patients' fluid intake was totalled and recorded by nursing staff in the daily notes.

Discussion did take place in regard to one entry on a fluid intake chart, in which the staff member had recorded 'fluid x 2' meaning two glasses of fluid had been drunk rather than recording the amount of fluid taken in millilitres. However, inspectors acknowledged that the accumulated intake of fluid recorded was correct.

Areas for Improvement

There were no areas for improvement identified.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.10 Privacy, dignity and respect

Observation of care delivery, patient's clothing and personal appearance and discussion with patients, relatives and staff evidenced that patients' were treated with dignity and respect and afforded privacy.

For example, one relative said that at times their loved one's clothing would have food stains but that this was due to the patient's eating habits. The relative said that as they usually visited just after mealtimes they assisted the changing of their loved ones clothing. However, they were confident that staff would do this if they were not there.

Relatives spoken with were positive regarding the attitude of staff and the attention to the detail of personal care. It was mentioned, by relatives, that the recent change of the manager had brought about improvements.

Relatives also said that in the past they had raised concerns/complaints with management which were addressed and that they felt confident in doing so again should the need arise.

One patient did discuss a number of concerns they had regarding staff attitude and their care and treatment. The patient agreed for the details to be feedback to the registered manager. The registered manager agreed to inform the Trust as some of concerns expressed would need to be reviewed under the adult safeguarding procedure. RQIA received emailed confirmation following the inspection that the referral had been made to the appropriate person in the Trust.

Areas for Improvement

There were no areas for improvement identified.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

6. Additional Areas Examined

Environment

The home had undergone a refurbishment programme during the summer of 2015. Improvements made to the environment and furnishings had been maintained.

The home was found to be warm, clean, tidy and free from odours. Patients were observed relaxing in their bedroom or one of the home's lounge or seating areas, as was their wish.

Infection prevention and control measures were being adhered to and housekeeping staff were commended, by inspectors, for their efforts in maintaining the cleanliness of the home.

Assessment of nursing needs

When reviewing the care records, it was noted that an assessment of nursing need was carried out prior to the patient's admission to the home. This assessment was based on the Roper, Logan and Tierney model of nursing and included risk assessments in relation to prevention of pressure ulcers and nutrition. On the day of admission to the home additional risk assessments were completed and care plans developed to manage and direct the care and treatment. However, there was no evidence that a comprehensive and holistic assessment of nursing need had commenced on the day of admission to the home.

Discussion took place during feedback. It was acknowledged that the risk assessments and care plans provided by the commissioning Trust along with the pre admission assessment undertaken by the home; informed the development of the care planning process on admission. However, as these documents were recorded prior to admission and a period of time had elapsed when the patient's needs could have changed, a recommendation was made.

Areas for Improvement

It was recommended that registered nurses, admitting a patient to the home, should evidence that they have undertaken a comprehensive and holistic assessment of nursing needs on the day of admission and this completed within five days.

Number of Requirements:	**0**	**Number of Recommendations:**	**1**

7. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager, Jillian Campbell, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

7.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

7.2 Recommendations

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

7.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

Quality Improvement Plan	
Recommendations	
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. Ref: Section 6
	Response by Registered Person(s) Detailing the Actions Taken: Following the inspection, the Director of Quality was contacted and a discussion was held regarding how best to document the day of admission assessment. Work had already been initiated to reinstate an amended version of a document used previously that the inspector had sight of on the day of inspection. To date the renewed version of the admission day assessment has not been finalised but the nurse completing the admission of a new resident now completes "admission care plan check sheet" when the resident arrives - this sheet contains areas to be assessed within time frames ranging from 6 hours - 72 hours from arrival. The Trust care plan will also be in place at the time of admission.

Registered Manager Completing QIP	Jill Campbell	**Date Completed**	11.05.16
Registered Person Approving QIP	Caroline Denny	**Date Approved**	07.06.16
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	16/06/16

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.