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

Inspector: Lyn Buckley
Inspection ID: IN021975

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Unannounced Care Inspection of Ben Madigan Care Home

26 August 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 26 August 2015 from 12:10 to 17:00 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of 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 16 and 17 July 2014.

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 acting manager, Nora Curran, 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 person	Registered Manager: see box below
Person in Charge of the Home at the Time of Inspection: Initially deputy manager Frank Mundie until the arrival of the acting manager Nora Curran at approximatley14:00 hours.	**Date Manager Registered:** Acting manager Nora Curran in post since June 2015.
Categories of Care: NH – I, PH, PH(E), TI and DE. Maximum of 34 persons in NH-DE	**Number of Registered Places:** 64
Number of Patients Accommodated on Day of Inspection: 61	**Weekly Tariff at Time of Inspection:** £623 - £750

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the returned quality improvement plans (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre-inspection assessment audit.

During the inspection the delivery of care and care practices were observed. A review of the general environment was also undertaken. The inspection process allowed for consultation/interaction with six patients individually and with others in small groups, four care staff, four registered nurses, two ancillary staff and three relatives/visitors.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes
- training records
- staff induction templates
- competency and capability assessment template for the nurse in charge of the home in the absence of the manager
- compliment records
- complaints record
- three patient care records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 16 and 17 July 2014. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 5.6 **Stated:** First time	It is recommended that contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures carried out in relation to each patient. These records include outcomes for patients.	**Met**
	Action taken as confirmed during the inspection: Review of three patient care records including care charts evidenced that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 6.2 **Stated:** First time	It is recommended that all entries to case records are contemporaneous; dated, timed and signed.	**Met**
	Action taken as confirmed during the inspection: Review of three patient care records including care charts evidenced that this recommendation had been met.	

Recommendation 3 **Ref**: Standard 6.3 **Stated:** First time	It is recommended that any alterations or additions [to patient records] are dated, timed and signed, and made in such a way that the original entry can still be read. Refer also to NMC guidelines on record keeping.	**Met**
	Action taken as confirmed during the inspection: Review of three patient care records including care charts evidenced that this recommendation had been met.	
Recommendation 4 **Ref**: Standard 6.4 **Stated:** First time	It is recommended that records maintained in relation to wound care should clearly evidence the delivery of care. Consideration should be given to how registered nurses effectively utilise the ongoing wound assessment charts and daily progress notes.	**Met**
	Action taken as confirmed during the inspection: Review of two records relating to the management of wounds evidenced that this recommendation had been met	
Recommendation 5 **Ref**: Standard 12.1 **Stated:** First time	A recommendation is made that the registered manager considers setting the breakfast tables (in particular) with milk jugs, self- serve sugar, jams and toast; to assist care staff when serving this meal and promote independence for patients able to serve themselves. How to promote independence during any meal time should also be considered.	**Met**
	Action taken as confirmed during the inspection: The timing of this inspection did not allow for a review of the breakfast meal time. However, observations in both dining rooms during the serving of the lunchtime meal evidenced that patients had access to condiments on each of the dining tables. Discussion with one of the catering team confirmed that patients were enabled to be as independent as possible during mealtimes and the setting of tables correctly was important. Therefore based on the available evidence, RQIA are satisfied that this recommendation has been met.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice. Guidance was also available on 'Breaking Bad News'. Discussion with staff confirmed that they were knowledgeable regarding this policy and procedure.

Information regarding the guidance from DHSSPSNI 'Breaking Bad News' was available within a resource file held in each of the nursing offices.

A sampling of training records evidenced that staff had or were required to complete training in relation to communicating effectively with patients and with families/representatives. The manager confirmed that additional e-learning sessions were planned to cover the inspection theme/focus.

Is Care Effective? (Quality of Management)

Care records reviewed included reference to the patient's specific communication needs and actions required to manage barriers such as, language, culture, cognitive ability or sensory impairment. There was also evidence, from records and discussion with patients and relatives, that patients and their representatives were included in discussions regarding communication and for treatments options, where appropriate.

Observation of patient and staff interactions and discussion with 10 staff clearly demonstrated the staff's ability to communicate sensitively with patients and/or representatives.

Is Care Compassionate? (Quality of Care)

Observation of care delivery and interaction between patients and staff clearly demonstrated that communication was compassionate and considerate of the patient's needs. Patients were treated with dignity and respect and responded to in a timely manner.

The inspection process allowed for interaction with six patients individually and with others in small groups. Patients who could verbalise their feelings on life in Ben Madigan Nursing Home commented positively in relation to the care they were receiving. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

Discussion with three relatives confirmed that staff were professional, caring, and attentive and kept them informed of any and all changes in the care of their loved one. Positive comments were also viewed in letters and cards received by the home from relatives.

Areas for Improvement

There were no requirements or recommendations made.

Number of Requirements:	0	Number of Recommendations:	0

5.3 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home. Best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects were also available.

Training records evidenced that staff were trained in the management of serious illness/deteriorating patient and what to do when death occurred. The manager confirmed that the organisation was developing a foundation for growth (FFG) e- learning session relating to palliative and end of life care. Training specific to the use of syringe drivers had been delivered to registered nurses within the last year. Bereavement and dignity training for staff had been organised in conjunction with a local funeral directors.

A resource file was available to staff.

Discussion with the manager and nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with nursing staff and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or drugs was in place and discussion with registered nurses confirmed their knowledge of the protocol.

Is Care Effective? (Quality of Management)

A review of care records evidenced that where required patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements were appropriate.

A document entitled 'end of life wishes' had been developed and recently introduced to assist staff when discussing and care planning for end of life care.

Discussion with the manager and staff evidenced that management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Staff confirmed that relatives were supported with tea, coffee, meals and advice as required.

A review of notifications of death to RQIA during the previous inspection year confirmed that any death occurring in the home was notified appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. Staff consulted demonstrated an awareness and detailed knowledge of patients' expressed wishes and needs as identified in their care plan.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes; for family/friends to spend as much time as they wish with the person.

From discussion with the manager, staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient. Some examples of comments made by relatives included:

'thank you so much to each and every member of staff for taking care of my …The love, kindness and support you all gave myself (and family) at the time of …death was lovely.'

'I thank you all very much for the care you gave…'

'Warmest appreciation for the care you gave…'

'Everyone [in Bed Madigan] treated …with kindness, dignity, patience and care which was outstanding.'

Discussion with the manager and a review of the complaints record evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death.

Areas for Improvement

There were no requirements or recommendations made.

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

5.4 Additional Areas Examined

5.4.1 Consultation with patients, staff and patient representative/relatives

Patients

The inspector met and spoke with six patients individually and with others in small groups. Patients were complimentary regarding the standard of care they received, the attitude of staff and the food provided. There were no concerns raised with the inspector.

Six questionnaires for patients were left with the manager for distribution none were returned.

Staff

In addition to speaking with 10 staff on duty six questionnaires were provided for staff not on duty. The manager agreed to forward these to the staff selected. At the time of writing this report none had been returned.

There were no concerns raised by staff spoken with.

Representatives/relatives

Discussion with three relatives visiting during the inspection evidenced that relatives were complimentary regarding the care provided, communication with the home and the attitude of staff. Relatives said that they felt their loved one was safe and well cared for in the home.

Six questionnaires were provided for patient representatives/relatives. At the time of writing this report none had been returned.

5.4.2 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms and bathrooms on each floor. The home was found to be warm, well decorated, fresh smelling and clean.

Since the past care inspection a major refurbishment plan had been completed. Patients and relatives consulted commented positively regarding the home's environment.

5.4.3 Record keeping

Review of three patient care records, including care charts evidenced that generally the standard of record keeping was of a good standard and that records were maintained in accordance with professional requirements. As detailed in section 5.2, improvements in relation to record keeping had been made and sustained since the last care inspection in July 2015.

However, across all three care records it was evidenced that care planning could be improved in relation to specific and individualised details. For example, discussion with staff regarding non-verbal cues prompted a wealth of information shared with the inspector which the care plan reviewed did not include. Another care plan stated 'management of symptoms' as an action but did not specify the symptoms that may occur. Registered nurses also recorded a care plan action that 'they' should liaise, determine or treat symptoms without specifying exactly what they meant by this statement or what exactly was required.

Details in relation to the care records reviewed were discussed with the manager during feedback. A recommendation was made.

5.4.4 Management arrangements

RQIA were informed in April 2015 that there would be changes to the management in the home in June 2015. During this inspection the inspector was informed that the home had recruited a new manager who would commence employment week beginning 31 August 2015. The manager confirmed that she would remain in a support role for a period of time to ensure a smooth induction and handover to the new manager.

Areas for Improvement

A recommendation was made that care plans clearly demonstrate how staff are to meet the assessed needs of the patients.

Number of Requirements:	0	Number of Recommendations:	1

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the acting manager, Nora Curran, 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.

6.1 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.

6.2 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.

6.3 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.

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 within this report do not absolve the registered person/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 person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be Completed by:** 30 September 2015.	The registered person should ensure that care plans clearly demonstrate how staff are to meet the assessed needs of the patients. **Ref: Section 5.4.3**
	Response by Registered Person(s) Detailing the Actions Taken: Section 5.4.4 - recommendation that care plans clearly demonstrate how staff are to meet the assessed needs of the residents. This has been addressed with all clinicaal staff in the form of 1:1 or group supervision. Continued auditing by Clinical staff, Home Manager, Regional Project Manager and MD. Will be a focus on monthly Reg 29 visits.

Registered Manager Completing QIP	Nora Curran	**Date Completed**	28/09/15
Registered Person Approving QIP	Caroline Denny	**Date Approved**	1/10/2015
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	01/10/2015

Please provide any additional comments or observations you may wish to make below:

***Please complete in full and returned to RQIA nursing.team@rqia.org.uk ***