Unannounced Care Inspection Report
13 March 2017

Ben Madigan Care 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 13 March 2017 from 10:10 to 15:15 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There were no concerns raised regarding staffing levels for nursing and care staff. Patients and relatives confirmed that they were satisfied with the care delivered and that it was safe.

A review of the home's environment, review of cleaning records and discussion with staff evidenced concerns in relation to the overall cleanliness of the home and the effectiveness of infection prevention and control measures. The day following the inspection RQIA were also notified that an outbreak of infection had been declared with the Public Health Agency (PHA).

Due to these concerns a meeting was held at RQIA on 28 March 2017 and assurances were provided that the concerns had either been addressed in full or would be addressed within a specific timeframe.

A requirement has been made regarding infection prevention and control measure and a recommendation made to review the staffing levels for cleaning staff.

Is care effective?

Care records evidenced that at the time of admission a comprehensive assessment of need and a range of validated risk assessments were completed. Care records reflected that referrals were made to healthcare professionals appropriately.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with patients, relatives and their colleagues.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

A recommendation was made regarding the care planning and evaluation of daily fluid intake targets/requirements.

Is care compassionate?

We arrived in the home at 10:10 hours. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were either finishing off their breakfast, sitting in one of the lounges or in their bedrooms as was their personal preference. Staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day.

Patients spoken with commented positively in regard to the care they received. Those patients unable to verbalise their opinion were observed to be relaxed and comfortable with staff.

We spoke with three relatives who commented positively with regard to the standard of care and communication in the home.

Is the service well led?

Discussion with the nurse in charge and staff evidenced that there was a clear organisational structure within the home. Discussions with staff confirmed that there were good working relationships and that management were available and responsive.

A review of records and observations confirmed that the home was operating within the categories of care registered.

There were no areas for improvement identified within this domain.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Karen McIlherron, regional manager, as part of the inspection process. Details were also discussed with Ms Jillian Campbell, registered manager, by telephone on the 16 March 2017. The timescales for completion commence from the date of inspection.

As a result of the inspection findings the registered persons were asked to attend a serious concerns meeting in RQIA to provide assurances that the areas of concern would be addressed. Following this meeting, on 28 March 2017, RQIA were provided with assurances that the concerns had either been addressed in full or would be addressed within a specific timeframe.

Enforcement action resulted 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 12 December 2016. There were no further actions required to be taken following the most recent inspection. 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 Limited/ Mrs Caroline Denny	**Registered manager:** Mrs Jillian Campbell
Person in charge of the home at the time of inspection: Clinical Lead Nurse Christine Banjo	**Date manager registered:** Mrs Jillian Campbell
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E) and NH-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 we spoke with six patients individually and with others in small groups, three relatives, three care staff, two registered nurses, two staff from housekeeping and one staff member from catering.

We also undertook a review of the home's environment which included a review of a number of communal bath/shower and toilets, dining rooms, lounges and patients' bedrooms.

The following information was examined during the inspection:

- three patient care records including care charts such as repositioning and fluid intake records
- staff duty rotas from 6 March to 19 March 2017
- staff training records
- a selection of housekeeping cleaning records
- infection prevention and control audit for January 2017

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 December 2016

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 12 December 2016. There were no further actions required to be taken following the most recent inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 17 August 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 27(4) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Observation of stairwells and fire exit routes and discussion with staff evidenced that this requirement had been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time	The registered provider should ensure that registered nurses and care staff record of the care delivered accurately and contemporaneously.	**Met**
	Action taken as confirmed during the inspection: Discussion staff and review of three patient care records including care charts such as reposition, food intake and fluid intake evidenced that this recommendation had been met.	

4.3 Is care safe?

The nurse in charge confirmed the planned daily staffing levels for the home. A review of the nursing and care staff duty rota from 6 – 19 March 2017 evidenced that planned staffing levels were adhered to. In addition to nursing and care staff, the registered manager confirmed that administrative, catering, domestic and laundry staff were also on duty daily.

Patients and relatives spoken with commented positively regarding the staff and care delivery. No concerns regarding staffing provision within the home were raised during discussions with patients. No concerns were raised by care staff with regard to staffing.

A general inspection of the home was undertaken to examine a number of patients' bedrooms, lounges, communal bathrooms and toilets. The following was observed:

- domestic trolleys and cleaning equipment were observed to be heavily soiled
- a significant number of patient bedrooms were in need of thorough cleaning to remove debris behind doors, under beds and along skirting boards and door thresholds
- door handles and other touch points throughout the home were observed to be dirty
- equipment used by patients including wheelchairs, bedside tables and dining tables were observed to be in need of cleaning
- pressure relief cushions were observed to be stained and some were torn
- a review of communal bath/shower/toilets evidenced that the underside of wash hand basins, soap dispensers and hand towel dispensers were dirty. Waste sack holder frames were also in need of cleaning.

Concerns were identified in relation to the overall cleanliness of the home and the impact on infection prevention and control measures within the home. A requirement was made.

A review of domestic/housekeeping duty rotas confirmed that three housekeeping staff were on duty daily with one allocated to the laundry and one staff member on each floor to provide cleaning services. Concerns were raised with the regional manager, during feedback, regarding the adequacy of the staffing levels for housekeeping given the inspection findings. Rotas also indicated that housekeeping staff had been reduced, on occasions, due to leave. A recommendation was made regarding the review of housekeeping/cleaning hours.

The day following this inspection RQIA were notified that an outbreak of infection had been declared with the Public Health Agency (PHA). Consultation with PHA confirmed that the home had declared four infectious outbreaks since 26 November 2016.

Based on the inspection findings, the information from PHA and the potential impact on patients, a meeting was held with RQIA senior management on 21 March 2017. The registered persons were asked to attend a serious concerns meeting in RQIA to discuss the inspection outcomes and to provide RQIA with assurance that the areas of concern would be addressed. Following this meeting, on 28 March 2017, RQIA were provided with assurances that the concerns had either been addressed in full or would be addressed within a specific timeframe.

Areas for improvement

A requirement was made in relation to infection prevention and control measures being effectively implemented in accordance with regional guidelines and legislative requirements.

It was recommended that the housekeeping/cleaning hours for the home be reviewed to ensure they are adequate to maintain hygienic standards of cleanliness throughout all areas of the home in accordance with regional infection prevention and control requirements.

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

4.4 Is care effective?

A review of three care records evidenced that at the time of admission a comprehensive assessment of need was completed for each patient. A range of validated risk assessments were also completed as part of the admission process.

Care records reflected that referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians as required. Care records were regularly reviewed and updated, as required, in response to patient need.

Staff were of the opinion that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with patients, relatives and their colleagues.

Care charts such as repositioning and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. However, care plans pertaining to the management of dehydration did not include a daily target and nursing staff did not evaluate the effectiveness of daily fluid intakes as recorded on the fluid intake charts. A recommendation was made.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

Areas for improvement

It was recommended that where a patient is deemed at risk of dehydration, care plans and fluid intake charts indicate a daily fluid intake target, in accordance with regional nutritional guidelines and best practice. In addition nursing staff should evaluate the effectiveness of the care delivered and any action taken, by them, when a deficit is identified.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

We arrived in the home at 10:10 hours. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were either finishing off their breakfast, sitting in one of the lounges or in their bedrooms as was their personal preference. Staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day. Some ladies were gathered near the hairdresser's rooms and were looking forward to having their hair done.

Patients spoken with commented positively in regard to the care they received. Those patients unable to verbalise their opinion were observed to be relaxed and comfortable with staff.

We spoke with three relatives who commented positively with regard to the standard of care and communication in the home.

One staff member was observed to assist a patient out of their chair inappropriately in relation to good practice in moving and handling and in ensuring the patient's dignity. This was discussed with the nurse in charge of the home who agreed to address the matter with the identified staff member through a formal supervision session. Training records confirmed that 89.5% of staff had completed their moving and handling training; both the theory and practical sessions. There was also evidence that attendance at mandatory training was effectively managed with update training planned for the end of March 2017. Observations of all other moving and handling of patients was observed to be appropriate and conducted in a dignified manner.

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 nurse in charge and staff evidenced that there was a clear organisational structure within the home. Discussions with staff confirmed that there were good working relationships and that management were available and responsive.

A review of records and observations confirmed that the home was operating within the categories of care registered.

In relation to infection prevention and control we asked to review the last infection control audit undertaken. The report provided was dated 4 January 2017. During the serious concerns meeting in RQIA on 28 March 2017 the registered manage, who was on leave at the time of the inspection, confirmed that she had undertaken audits in February and March 2017 but that these were not filed and therefore staff were not aware of where to find them. RQIA were assured by the registered manager in relation to the governance arrangements around the standards of hygiene and cleanliness of the home.

A requirement has been previously made in relation to infection prevention and control measures. Refer to section 4.3.

Areas for improvement

No new 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 Ms Karen McIlherron, regional manager, as part of the inspection process. Details were also discussed with Ms Jillian Campbell, registered manager, by telephone on the 16 March 2017. 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 13 (7) **Stated:** First time **To be completed by:** Immediate action required.	The registered provider must ensure that infection prevention and control measures are effectively implemented and maintained in accordance with, regional guidelines and legislative requirements. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Following the inspection an action plan was compiled to address the issues raised. This was discussed with RQIA during the concerns meeting. A detailed housekeeping schedule has been devised and daily auditing has been put in place until standards have improved- it will move to weekly once standards are acheived. All Housekeeping staff have been updated on Public Health guidance for cleaning during an outbreak. The Home has undergone a full terminal clean with each area being signed off once completed. This is in accordance to Public Health Guidance followiing an outbreak. Additional staffing has been utilised from other sites to enable the terminal clean to be carried out in a more timely manner. The Home has had four infectious outbreaks since November 2016 - additional face to face training has been completed for all staff grades in all departments which included training on outbreak procedures, and Public Health Guidance. All Staff were advised on what to report as potential outbreak and what the reporting procedure is. Relatives have been been issued with a letter advising them not to visit when unwell and a leaflet on Public Health Hand Hygiene Technique was included.
Recommendations	
Recommendation 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** Immediate action required.	The registered provider should ensure that the housekeeping/cleaning hours for the home are reviewed to ensure they are adequate to maintain hygiene standards of cleanliness throughout all areas of the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Housekeeping staffing levels have been reviewed. Senior management have assessed the budgeted hours and if all posts are appointed the budgeted hours are sufficient to ensure the housekeeping needs are met. Recruitment had been addressed previously but no interest had been shown for bank work positions. We have now successfully recruited a new part time housekeeper who has commenced in post and two new bank housekeepers have also been successful at interview - awaiting Access NI checks. The housekeeping department is now fully staffed as per budgeted hours and all annual leave and sick leave will be covered as far as is possible.

	Daily housekeeping audits have been conducted in the first instance and will move to weekly once standards have been achieved.
Recommendation 2 **Ref**: Standard 4.8 **Stated:** First time **To be completed by:** 30 April 2017	The registered provider should ensure that where a patient is deemed at risk of dehydration, care plans and fluid intake charts indicate a daily fluid intake target, in accordance with regional nutritional guidelines and best practice. Nursing staff should evaluate the effectiveness of the care delivered and any action taken, by them, when a deficit is identified. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: An additional hydration care plan has been added to all care files which identifies the daily fliud intake target for each individual. Care assistant files for each resident already contain a chart for optimal fluid intake and consistency of fluids, for each individual - this has been updated for each resident and all care staff have been made aware of this. Nurses will evaluate the additional hydartion care plan as part of their monthly care plan evaluations.

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
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews