The Regulation and Quality Improvement Authority

Inspection Report

7 and 9 June 2022

Meadowbank Care Home

Type of Service: Residential Care Home
Address: 2 Donaghanie Road, Omagh, BT79 0NR
Tel No: 028 8224 2868

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Age NI **Registered Person/s OR Responsible Individual:** Ms Linda Robinson	**Registered Manager:** Mrs Clare Lafferty **Date registered:** 27 April 2020
Person in charge at the time of inspection: Mrs. Clare Lafferty	**Number of registered places:** 25
Categories of care: Residential Care (RC) DE – Dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 25
Brief description of the accommodation/how the service operates: This home is a registered Residential Care Home which provides health and social care for up to 25 residents. The home is divided in three units over one floor. Each unit has its own lounge and dining communal areas and are connected by a central corridor. An enclosed garden is available and accessible for all residents in each of the units.	

2.0 Inspection summary

An unannounced inspection took place on 15 June 2022, from 9.20am to 2.30pm by a care inspector and an unannounced medicines management inspection took place on 7 June 2022, from 9.40am to 12.55pm. This was completed by a pharmacist inspector.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed.

Staff promoted the dignity and well-being of residents with kind, caring interactions.

Residents in large were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Two areas of improvement were identified during this inspection. These were in relation to detailing the spiritual care of residents and the home's most recent fire safety risk assessment.

The findings of this report will provide the management team with the necessary information to improve staff practice and the residents' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with residents, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Mrs Clare Lafferty at the conclusion of the inspection.

4.0 What people told us about the service

During this inspection all 25 residents were met with. In accordance with their capabilities all confirmed that they were happy with their life in the home, their relationship with staff and the provision of meals. Two residents made the following comments; “Everything's just grand here. How could you complain. Look at that for a breakfast, it's like a hotel.” and “I love it here, very much. They (the staff) are all good.”

Discussions with staff confirmed that they felt positive about the provision of care, staffing levels, training, morale and managerial support.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Meadowbank Care Home was undertaken on 24 August 2021 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. Review of two staff members' recruitment checklists received from the organisation's human resources department confirmed that staff were recruited in accordance with Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005.

The staff duty rota was maintained in good detail and accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty.

Any member of staff who has responsibility of being in charge of the home in the absence of the manager has a competency and capability assessment in place. Review of two staff members' assessments found these to be comprehensive in detail to account for the responsibilities of this role.

Staff said there was good team work and that they felt well supported in their role, were satisfied with the staffing levels and the level of communication between staff and management.

There were systems in place to ensure staff were trained and supported to do their job. A range of mandatory and additional training was completed by staff on a regular basis.

Staff said that there was enough staff on duty to meet the needs of the residents.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day. For example with dietary needs and social activities.

Staff told us that the residents' needs and wishes were very important to them. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. One resident said; "I can't complain about a thing. They are all very nice here."

5.2.2 Care Delivery and Record Keeping

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs

At times some residents may be required to use equipment that can be considered to be restrictive. For example, bed rails, alarm mats. It was established that safe systems were in place to manage this aspect of care.

Resident care records were maintained which accurately reflected the needs of the residents. Staff were knowledgeable of individual residents' needs, their daily routine wishes and preferences. An area of improvement was identified with residents' spiritual care needs, which needed to have contact details, assessment and details of interventions, as appropriate.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly. Staff were seen to engage with residents' consent with statements such as "Would you like to..." and "Are you okay with…." when delivering personal care.

Examination of records and discussion with staff confirmed that the risk of falling and falls were appropriately managed. There was evidence of appropriate onward referral, eg with their GP, as a result of the post falls review.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff.

There was a good provision of meal choices including those residents who needed specialist diets. It was observed that residents enjoyed their lunchtime meal and their dining experience. Staff had made an effort to ensure residents were comfortable, had a pleasant experience and had a meal that they enjoyed.

There was evidence that residents' weights were checked at least monthly to monitor weight loss or gain. Records were kept of what residents had to eat and drink daily.

Residents care records were held confidentially. Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs.

Residents' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each resident's care needs and what or who was important to them.

Daily records were kept of how each resident spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Each resident had an annual review of their care, arranged by their care manager or Trust representative.

5.2.3 Management of the Environment and Infection Prevention and Control (IPC)

The home was clean, tidy and fresh smelling throughout. Residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were suitably furnished and comfortable. Bathrooms and toilets were clean and hygienic.

Cleaning chemicals were maintained safely and securely.

Fire safety records were well maintained with up-to-date fire safety checks of the environment, fire safety drills and fire safety training for staff. The home's most recent fire safety risk assessment was dated 28 December 2021. There were no corresponding recorded statements of actions taken made in response to the recommendations made from this assessment. This has been identified as an area of improvement. .

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control measures and the use of PPE had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

5.2.4 Quality of Life for Residents

Residents were seen to be comfortable, content and at ease in their environment and interactions with staff. Two residents made the following comments; "It's a peaceful happy home" and "We all get on well here. It feels like a big family."

Review of the record of activities and general observations of care practices confirmed that residents' social care needs were facilitated on a person centred basis.

The genre of music and television played was in keeping with residents' age group and tastes.

5.2.5 Management and Governance Arrangements

Mrs Clare Laverty has been the Registered Manager of the home since 27 April 2020. She is supported in her role by Ms Tina Rodgers, Deputy Manager, who was present during feedback at the conclusion of the care inspection.

A review of the record of accidents and incidents found these to be appropriately recorded and reported to the relevant stakeholders. The manager carries out a monthly audit of all accidents and incidents to establish if there are any patterns of trends and need for corresponding actions.

The home is visited each month by the Responsible Individual. A report is then published of these visits for relevant parties to examine. A review of the last two monthly monitoring visit reports found these to be well maintained with corresponding action plans put in place to address any issues identified.

Complaints were seen to be taken serious and effectively managed. Records of complaint were recorded appropriately.

5.2.6 Medicines Management

The audits completed at the inspection indicated that the residents had received their medicines as prescribed.

Personal medication records were in place for each resident. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments. The residents' personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate.

It is important to have a clear record of which medicines have been administered to residents to ensure that they are receiving the correct prescribed treatment. A sample of these records was reviewed. The records were found to have been completed to the required standard.

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the resident's medicines are available for administration as prescribed. The records inspected showed that medicines were available for administration when residents required them.

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another. The management of medicines for one resident who had been admitted to this home was reviewed. Staff had been provided with a list of prescribed medicines from the GP practice. The resident's personal medication record had been accurately written.

Medicines must be stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.
The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each resident could be easily located.

Records were maintained of the disposal of medicines.

Residents will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the resident's distress and if the prescribed medicine is effective for the resident. The management of medicines prescribed on a "when required" basis for the management of distressed reactions

was reviewed for two residents. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were in place Records included the reason for and outcome of administration.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required. The records belonging to two residents who were prescribed medicines for the management of pain were reviewed. Care plans directing the use of the medicines were available.

Some residents may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the resident should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the resident. The management of thickening agents was reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out.

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. The audit system in place in this home helps staff to identify medicine related incidents.

7.0 Quality Improvement Plan/Areas for Improvement

Two areas for improvement have been identified were action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes' Minimum Standards (August 2011) (Version 1:1).

	Regulations	Standards
Total number of Areas for Improvement	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs. Clare Lafferty, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27(4)(a) **Stated:** First time **To be completed by:** 15 July 2022	The registered person shall submit a time bound action plan to the home's aligned estates inspector detailing how the recommendations from the fire safety risk assessment, dated 28 December 2021, will be addressed. Ref: 5.2.3
	Response by registered person detailing the actions taken: The fire risk assessment has been updated and all recommendations have been implemented and up to date policy and proceduresare up to date and action plan completed.The estates inspector has been e-mailed and informed of same.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)	
Area for improvement 1 **Ref:** Standard 5.2 **Stated:** First time **To be completed by:** 15 July 2022	The registered person shall ensure that the person centred spiritual care needs are assessed in detail, including contact details and interventions as appropriate. This needs to be done in consultation with the resident or their representative. Ref: 5.2.2
	Response by registered person detailing the actions taken: A spiritual careplan has been implemented into each residents individual file and letters sent to all family representatives requesting relevant information pertaining to any special requests or wishes for their family member.

Please ensure this document is completed in full and returned via Web Portal

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