Unannounced Care Inspection Report
27 and 28 April 2017

Massereene Manor

Type of Service: Nursing Home
Address: 6 Steeple Road, Antrim, BT41 1AF
Tel no: 028 9448 7779
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Massereene Manor took place on 27 and 28 April 2017 from 09.45 to 16.45 hours on day one and from 09.30 to 12.40 hours on day two.

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?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

Concerns were identified in the delivery of safe care, specifically in relation to timely NMC checks and storage of medicines. Compliance with the two recommendations made will achieve improvements within this domain.

Is care effective?

Review of patient care records evidenced that care plans were reviewed on a regular basis. We reviewed the management of pressure area care, management of wounds, nutrition and management of weight loss. Care records also reflected, where appropriate, that referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians.

Supplementary care charts such as repositioning, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records and patient information.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

There were no areas for improvement identified within this domain.

Is care compassionate?

We arrived in the home at 09.45 hours on day one of the inspection and were greeted by staff who were helpful and attentive. Patients were observed enjoying either their breakfast or a morning cup of tea/coffee in the dining room or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice depending of which they preferred and staff were observed assisting patient to drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. In particular the knowledge staff had gained in relation to dementia care was commended.

Discussion with staff and review of the activity programme evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

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 some patients confirmed that living in Massereene Manor was a positive experience.

There were no areas for improvement identified in this domain.

Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

Unannounced quality monitoring visits were completed on a monthly basis by an external person on behalf of the provider. Copies of the quality monitoring visits were available in the home. A recommendation was made regarding the anonymising of the content of the report to ensure patients, and/or other persons working or visiting the home, could not be recognised from reading the report.

Discussion with staff evidenced that there was a clear organisational structure within the home. In discussion, patients and representatives/relatives were aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

The term 'patient' is used to describe those living in Massereene Manor which provides both nursing and residential care.

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	0	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Olive Hall, 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 14 December 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. 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: Massereene Manor/Ms Naomi Carey	**Registered manager:** Mrs Olive Hall
Person in charge of the home at the time of inspection: Mrs Olive Hall	**Date manager registered:** 1 April 2005
Categories of care: NH-LD, LD (E), DE, MP and MP (E). RC-DE. A maximum of 10 residential beds in category RC-DE. A maximum of three patients in categories NH-LD & LD (E). The home is also approved to provide care on a day basis to 4 persons.	**Number of registered places:** 74

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 met with 11 patients individually and with others in small groups; six registered nurses, six care staff, two domestic staff and one relative. Questionnaires were also left in the home to obtain feedback from relatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives were left.

The following information was examined during the inspection:

- duty rota for all staff from 23 April to 6 May 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment and induction file
- seven patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- consultation with patients, relatives and staff
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 December 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. The actions detailed in the returned QIP were validated during this inspection as detailed in the next section.

4.2 Review of requirements and recommendations from the last care inspection dated 14 December 2017

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 14 (3) **Stated:** First time	The registered provider must ensure arrangements are put in place, and monitored, to provide a safe system for moving and handling patients.	**Met**
	Action taken as confirmed during the inspection: Observation of moving and handling practice evidenced that this requirement had been met.	

Requirement 2 **Ref:** Regulation 30 **Stated:** First time	The registered provider must ensure notification to RQIA and other relevant agencies is made in accordance with regulations and regional procedures and in a timely manner.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of accident/incident records, complaints record and notifications submitted to RQIA since the care inspection in December 2016 evidenced that this requirement had been met.	
Requirement 3 **Ref:** Regulation 15 **Stated:** First time	The registered provider must ensure that patient assessments, including risk assessments, are completed and kept under review.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of a number of patient records and audit records evidenced that this requirement had been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 4 **Stated:** Second time	The registered provider should ensure that the care planning process is improved to ensure care plans are individualised and support the care needs of the patient.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and nursing staff; and review of a number of patient records and audit records evidenced that this recommendation had been met.	
Recommendation 2 **Ref:** Standard 43 (4) **Stated:** First time	The registered provider should ensure that staff are aware of the need to ensure that all parts of the home, to which patients have access, are free from avoidable hazards to their safety.	**Met**
	Action taken as confirmed during the inspection: Observation of a number of areas to which patients may have access confirmed that this recommendation had been met.	

Recommendation 3 **Ref:** Standard 46 **Stated:** First time	The registered provider should ensure that robust audit systems are re-introduced to minimise the risk of infection.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager, observation of the environment and review of audit records confirmed that this recommendation had been met.	
Recommendation 4 **Ref:** Standard 35 **Stated:** First time	The registered provider should ensure that the development of care plans is monitored by senior staff to ensure it meets with DHSSPS care standards for nursing homes and professional standards. Records of this should be maintained and available for inspection.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and deputy manager and review of audit and patient records confirmed that this recommendation had been met.	
Recommendation 5 **Ref:** Standard 16 **Stated:** First time	The registered provider should ensure that the investigative process, outcome and action taken is discussed with the person who made a complaint and a record made of whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of 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. A review of the staffing rota from 23 April to 6 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Staff said that on occasions staffing levels were affected by short notice leave. However staff confirmed that this only happened occasionally. We also sought staff opinion on staffing via questionnaires; 10 were returned following the inspection. All respondents answered 'yes' to the question, "Are there sufficient staff to meet the needs of the patients?"

Patients spoken with during the inspection commented positively regarding the staff and the care delivered. Patients able to communicate indicated that they were satisfied that when they required assistance staff attended to them in timely manner. We also sought the patients' opinions on staffing via questionnaires; six were returned indicating that there was sufficient staff to need their needs. One respondent indicated that they felt staffing levels were "inadequate."

One relative spoken with commented that they had no concerns and felt assured that their loved one's needs were being met. The relative was complimentary regarding nursing and care staff and named one member of staff in particular. Details were provided to the registered manager during feedback. We sought other relatives' opinion on staffing via questionnaires; eight completed questionnaires were returned. All respondents indicated that staff had enough time to care for their relatives.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained; and that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that the registered manager had a process in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC. However, checks were not carried out in a timely manner to ensure nursing staff did not work unregistered. A recommendation was made.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2016/17. Records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Mandatory training compliance was monitored by the registered manager and was also reviewed by senior management as part of the monthly quality monitoring process. Additional training was also available to staff to ensure they were able to meet the assessed needs of patients.

Observation of the delivery of care evidenced that training had been embedded into practice. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager, confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedures into practice. A safeguarding champion was in the process of being identified and that training had been delivered.

Review of seven patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process and that these assessment informed the care planning process.

Review of accidents/incidents records from 1 January 2017 and notifications forwarded to RQIA confirmed that these were appropriately managed.

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

In the Holyhill Suite two black plastic boxes were observed in a bathroom, with a toilet, on top of a low cupboard. Observations confirmed that the boxes contained various external medicines and creams prescribed for patients within the Suite. The nurse in charge confirmed that the medicines were stored here for ease of access. Discussion took place regarding the secure storage of medicines and storage in relation to infection prevention and control measures where there is a toilet. A recommendation was made.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and personal protective equipment (PPE) such as gloves and aprons were available throughout the home. Some inappropriate storage of equipment and aids was observed in two bathrooms in Maplehill Suite, this was brought to the attention of the registered manager who addressed this with staff.

Areas for improvement

A recommendation was made that checks of the registration status of registered nurses with the NMC are carried out in a timely manner to ensure that nursing staff do not work unregistered.

A recommendation was made that external medicines are stored securely in accordance with medicine management standards and in line with best practice guidelines for infection prevention and control.

Number of requirements	0	**Number of recommendations**	2

4.4 Is care effective?

Review of seven patient care records evidenced that care plans were in place to direct the care required. Nursing staff spoken with were aware of professional requirements to review and update care plans as the needs of patient changed. Nursing staff were also demonstrated awareness to review and update care plans when the recommendations made by other healthcare professionals such as, the speech and language therapist (SALT) or the tissue viability nurse (TVN) were changed.

We reviewed the management of pressure area care, wound care, nutrition and weight loss. Care records contained details of the specific care requirements in each of the areas reviewed and a contemporaneous record was maintained to evidence the delivery of care. Care records also reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians.

Supplementary care charts such as repositioning, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Discussion took place regarding the registered nurses' daily evaluation/record of the effectiveness of fluid intake monitoring. For example, staff recorded a statement that fluid intake was poor but no specifics or details of the plan to improve the patient's intake. However, we were satisfied, from review of fluid intake charts that action was taken to address identified deficits. The registered manager agreed to address this with nursing staff.

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

The registered manager and review of records confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff spoken with confirmed that staff meetings were held and records were maintained of the staff who attended, the issues discussed and actions agreed.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their immediate line manager, the deputy manager and/or the registered manager.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

We arrived in the home at 09.45 hours on day one of the inspection and were greeted by staff who were helpful and attentive. Patients were enjoying either their breakfast of a morning cup of tea/coffee in the dining room or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice depending of which they preferred and staff were observed assisting patient to drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. In particular the knowledge staff had gained in relation to dementia care was commendable. For example, one patient who was asleep was about to be wakened by another patient; a staff member approached the second patient and engaged their attention in a discreet manner, enabling the first patient to remain undisturbed and the second patient to experience a positive interaction with the staff member.

Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Discussion with patients and staff; and review of the activity programme evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. The activity therapist was observed to undertake a singing and exercise activity in the Edenhill Suite during the morning. It was evident that the activity therapist knew the patients well and from observations of interactions and reactions between her and the patients; that the patients were familiar and comfortable with her.

Patients able to communicate their feelings indicated that they enjoyed living in Massereene Manor. 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.

As stated previously one relative spoken with was very complimentary regarding the care their loved one received and the care provided to them as a family.

Discussion with the registered manager and review of records confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home.

Ten relative questionnaires were issued; eight were returned within the timescale for inclusion in this report. Seven relatives were very satisfied and one was satisfied with the care provided across the four domains. There were no additional comments recorded.

Ten questionnaires were issued to staff; 10 were returned prior to the issue of this report. Eight staff members were very satisfied and two were satisfied with the care provided across the four domains. There were no additional comments recorded.

Eight questionnaires were issued to patients; six were returned prior to the issue of this report. Three patients responded that they were very satisfied and three that they were satisfied.

Two additional comments were recorded as follows:
"I would like to see the manager more often in the unit."
"Don't always see Olive."

Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

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?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.

Review of the home's complaints records evidenced that systems were in place to ensure 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.

Review of records evidenced that monthly audits were completed to ensure the quality of care and services was maintained. For example, audits were completed for accidents/incidents, complaints, infection prevention and control and care records. The records of audit evidenced that any identified areas for improvement had been addressed and checked for compliance. Audit outcomes informed the monthly quality monitoring process undertaken by an external person on behalf of the provider.

Review of records evidenced that quality monitoring visits were completed on a monthly basis. Recommendations were made within the report to address any areas for improvement. Copies of the quality monitoring visits were available in the home. The reports for February and March 2017 were reviewed and a recommendation made regarding the anonymising of the content to ensure patients, and/or other persons working or visiting the home, could not be recognised from reading the report. Details were discussed with the registered manager.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with staff evidenced that there was a clear organisational structure within the home. In discussion some patients and the relative spoken with were aware of the roles of the staff in the home and to whom they should speak to if they had a concern.

The registered manager confirmed that the organisation had been recently achieved leadership awards from the European Foundation for Quality Management (EFQM) and Investors In People (IiP) and that a number of care staff were being supported to undertake their nurse training through the Open University.

Areas for improvement

A recommendation was made regarding the anonymising of the content of the monthly quality monitoring reports, to ensure patients, and/or other persons working or visiting the home, could not be recognised from reading the report.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Olive Hall, 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

Recommendations	
Recommendation 1 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 31 May 2017	The registered provider should ensure that the checking of the registration status of registered nurses with the NMC is carried out in a timely manner to ensure that nursing staff do not work unregistered. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: NMC checks have been up to date with a system in place to ensure that they are completed in a timely fashion. There had been one occasion whereby the Registered Manager had checked on her own pin a number of days late knowing herself she had completed the process.
Recommendation 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** Immediate action required	The registered provider should ensure that external medicines are stored securely in accordance with medicine management standards and in line with best practice guidelines for infection prevention and control. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The box of external medicines was transferred to the external medications cupboard in the treatment room.
Recommendation 3 **Ref:** Standard 6 **Stated:** First time **To be completed by:** Immediate action required	The registered provider should ensure that the content of the monthly quality report undertaken on behalf of the providers is anonymised to ensure patients, and/or other persons working or visiting the home, could not be recognised from reading the report. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: This will be taken into consideration for future report writing.

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

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