Announced Post Registration Inspection Report
21 June 2016

Milesian Manor

Type of Service: Nursing Home
Address: 9 Ballyheifer Road, Magherafelt, BT45 5DX
Tel No: 028 7963 1842
Inspector: Lyn Buckley

1.0 Summary

A short notice (24 hours) announced inspection of Milesian Manor took place on 21 June 2016 from 09:20 to 15:45 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led under the new ownership. In March 2016 the home was purchased by Macklin Care Homes Ltd who own and manage other nursing homes in Northern Ireland.

Is care safe?

There was evidence of competent delivery of care with positive outcomes for patients.

Review of records evidenced that planned staffing levels were adhered to; and discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing levels. 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 demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities and specifically in relation to adult safeguarding.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

There were no areas for improvement identified.

Is care effective?

It was evident that care was effectively managed and delivered with positive outcomes for patients. For example, care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses assessed, planned, evaluated and reviewed care in accordance with Nursing and Midwifery Council (NMC) guidelines.

Staff stated that there was "effective teamwork". This was also evidenced through discussion and observation of interactions throughout the inspection process.

There were no areas for improvement identified.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plans.

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.

A recommendation was made in relation to the storage of patient information. Refer to section 4.5 for details.

Is the service well led?

There was clear evidence that system and process were in place and effectively managed to ensure the safe, effective, and compassionate care was delivered by a competent and caring team of staff. For example, staff were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function.

A review of notifications of incidents to RQIA since April 2016 confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

The change of ownership had been managed effectively to ensure patients and their relatives were well informed and reassured. Patients, relatives and staff commented positively in relation to the change and in relation to the registered manager.

There were no areas for improvement identified.

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.

For the purposes of this report, the term 'patients' will be used to describe those living in Milesian Manor which provides both nursing and residential care.

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Mrs Martha O'Kane, and the Macklin Group's regional 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 9 December 2015. Other than those actions detailed in the QIP there was no further actions required. 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 provider: Macklin Care Homes Ltd / Mr Brian Macklin	**Registered manager:** Mrs Martha Therese O'Kane
Person in charge of the home at the time of inspection: Mrs Martha Therese O'Kane – registered manager	**Date manager registered:** 01 April 2005
Categories of care: NH-I, RC-I, NH-PH, NH-PH(E)	**Number of registered places:** 34

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 the inspector spoke with six patients and others in small groups, three care staff, one registered nurse, three catering staff, one staff member from housekeeping and five relatives/visitors.

In addition to meeting with patients, staff and relatives the inspector also provided the registered manager with questionnaires to be distributed to eight patient, 10 relatives and 10 staff not on duty during the inspection. Eight patients, three staff and five relatives returned their questionnaires within the timeframe requested. Comments and responses can be viewed throughout the report.

The following information was examined during the inspection:

- three patient care records
- staff roster 12 - 26 June 2016
- staff training and planner/matrix for 2016
- complaints record
- incident and accident records
- record of quality monitoring visits carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit/governance
- staff appraisal and supervision planners 2015/16
- staff meeting minutes
- staff training records
- records pertaining to consultation with staff, patients and relatives.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 09 December 2015

The most recent inspection of the home was an unannounced care inspection. Issues arising from this inspection were followed up and validated by the care inspector during this inspection. Details can be viewed in the next section.

4.2 Review of requirements and recommendations from the last care inspection dated 09 December 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 35.3 **Stated:** First time **To be Completed by:** 06 February 2016	The registered manager should ensure that care records are audited, using a robust system that provides traceability of audit. **Action taken as confirmed during the inspection**: Review of audit records April and May 2016 and discussion with the registered manager confirmed that this recommendation had been met.	**Met**

Recommendation 2 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:** 06 February 2016	The registered manager should ensure that patient assessments are completed, as appropriate, in particular pain assessments and continence assessments.	**Met**
	Action taken as confirmed during the inspection: Review of three patient care records, audit records and discussion with the registered manager 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 12 to 26 June 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff confirmed that newly appointed staff were required to complete a structured orientation and induction programme at the commencement of their employment. Discussion with the registered manager confirmed that staff turnover was 'virtually nil' and that the only recruitment having taken place in the last two years was currently in progress between the registered manager and head office. Discussion also confirmed that the process for recruitment was in accordance with best practice guidance, The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Care Standards for Nursing Homes 2015, adult safeguarding legislation and employment legislation.

Review of the training planner/matrix for 2016 indicated that training was planned to ensure that mandatory training requirements were met. Staff confirmed that they were required to attend mandatory training and any other training to assist them in providing quality of care. Training records reviewed confirmed that the majority of staff had, so far this year, completed training in fire safety and evacuations, adult safeguarding and moving and handling training. The registered manager confirmed that the majority of staff had attended training provided by the new owners in relation to 'living our values' and that she had attended specific training for managers in April and June 2016. Support for the registered manager was provided by the regional manager and other registered managers within the organisation.

A planner was in place to manage staff supervision sessions and appraisals.

The registered manager and staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding. Staff described their role and responsibilities and said that they were able to 'make a difference' and believed they provided a high standard of care and other services.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with NMC and Northern Ireland Social Care Council (NISCC).

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since April 2016 confirmed that these were managed appropriately. Audits of falls and incidents were maintained and clearly evidenced analysis of the data to identify any emerging patterns or trends and action plans were in place as required. This information also informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounge/s, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts. Patients, relatives and staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of wounds indicated that registered nurses were adhering to regional guidelines in wound and pressure ulcer management.

Care records reviewed reflected the assessed needs of patients were kept under review and that patients received 'the right care at the right time'. Recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians were reflected in the care plan and evaluated regularly. Supplementary records such as repositioning charts and fluid intake charts were accurately maintained and evidenced that care was delivered as planned. Nursing and care staff were aware of how and when to escalate concerns about the health and wellbeing of patients. For example, the registered nurse was confident that care staff would report any changes in patients' skin or their general health. There was also evidence of regular communication with representatives within the care records and in the discussion with relatives.

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

Observations evidenced that call bells were answered promptly and patients requesting assistance were responded to in a calm, quiet and caring manner. All patients and relatives spoken with commented positively regarding the care they received and the staffs' caring and kind "nothing is any trouble" attitude. One relative describing the care their loved ones received commented, "Martha and her staff are extraordinary".

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the handover reports at the beginning of their shift. Staff also confirmed that regular staff meetings were conducted and minutes were available for review. Staff confirmed that they felt confident in their registered manager's ability to lead and direct them; and in the new management team to help improve the home. Staff said management were available and approachable. Staff comments regarding the new owners included "training a lot [since new owners took over] – great training", "looking forward to the future", " good teamwork, know our patients very well and we know how to support them and provide comfort".

Staff stated that there was "effective teamwork"; this was also evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were "proud" to be a part of their team and to "make a difference". Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their manager, and/or the new regional manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Communication with patient and their relatives was evident on a one to one basis as recorded in the care records and through observations of interactions. Patients confirmed that both the registered manager was available to them on a daily basis. One patient said, "I am very happy here, staff are great".

Discussion with relatives confirmed that they were kept informed of any changes in their loved ones health and wellbeing and stated that they felt assured that the care was effective, caring, loving and kind. Relatives confirmed that they could ask the registered manager and her staff anything and were confident that if they raised concerns these would be addressed. One relative commented, "It is very good here… you wouldn't know they were patients because [staff] treat them all and us like their own relatives".

Patient, relatives and staff confirmed that they had been informed about the new owners and many had attended the meeting when the previous owners introduced the new owners to the home. Comments made about the change process and the new owners were as follows:

- "Seamless" meaning the change of ownership process
- "Patients are their first interest"
- "investing in staff with training"
- "Didn't change a lot but added to it to improve".

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?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. It was observed, throughout the home that outside some bedrooms charts such as reposition and fluid intake charts were placed on handrails outside the bedroom doors. Discussion with staff confirmed that the purpose for this was to enable accurate recording of care delivery. During feedback this was discussed in relation to the requirements regarding patient information and confidentiality. A recommendation was made.

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 discussed previously in sections 4.3 and 4.4 patients and relatives were very complimentary regarding the management, staff and the care they received.
In addition to the provision of tea and coffee for patients' visitors, the inspector observed a number of very personal touches within patients' bedrooms which were small gestures on the part of staff but would have added greatly to the patient's comfort and reassurance.

Patients also commented positively in relation to the standard of food. Patients confirmed that they enjoyed going to the dining room but could also arrange to have their meal in the lounge or their bedroom.

Observation of the serving of the lunchtime meal evidenced that patients were offered choices and enabled to be as independent as possible. Nursing and care staff provided support to patients requiring assistance to eat and drink appropriately. Patients also confirmed that tea and coffee, accompanied by various snacks such as scones and cakes/buns, were offered between meals and on request. Relatives were also offered hospitality while visiting.

Patient confirmed that there were arrangements were in place to meet their religious and spiritual needs within the home.

Discussion with the registered manager confirmed that the views of patients, their representatives and staff on the running of the home were sought. Patients and relatives had met with the new owners and their views were sought by the responsible individual as part of the monthly quality monitoring visit undertaken on his behalf by the regional manager.

As part of the consultation process the inspector asked the registered manager to distribute questionnaires. Ten questionnaires were provided for staff and patient representative/relative and eight for patients. Eight patients, three staff and five relatives returned their questionnaires within the timeframe requested. The questionnaires asked if care was safe, effective and compassionate and if the service was well led.

Relatives responded that they were either very satisifed (4) or satisified (1) with care in relation to all four domains.

Patients' questionnaire responses were similar to relatives with four patients indicating that they were very satisified with their care and four indicating that care was satisfactory, in relation to all four domains.

Staff responded that they were very satisified with the care delived across all the domains.

Areas for improvement

A recommendation was made that all patient information is held in a confidential manner.

Number of requirements	0	Number of recommendations:	1

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern. Staff were able to identify the person in charge of the home when the registered manager was not on duty.

Staff, patients and relatives were all complimentary in relation to how the registered manager managed the home and supported them on a daily basis. One patient recorded in the questionnaire – Is the service well led? “excellent…. Martha manages the home very well and is a lovely lady”. A relative said…”it had to be Milesian Manor – great place”.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed. The home’s statement of purpose and patient guide was reviewed and found to be reflective of the homes registered categories of care, the services provided by the home and legislative requirements. Discussion with the registered manager and observations evidenced that the home was operating within its registered categories of care.

Policies and procedures were indexed, dated and approved by the registered person. Staff confirmed that they had access to the home’s policies and procedures and were expected to read and record that they had read various policies.

Discussion with the registered manager and review of the home’s complaints record evidenced 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. Patients and relatives spoken with confirmed that they were aware of the home’s complaints procedure. Patients/relatives confirmed that they were confident that staff and management would manage any concern raised by them appropriately.

Staff were knowledgeable of the complaints and adult safeguarding process commensurate with their role and function. A review of notifications of incidents to RQIA April 2016 confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents/accidents.

Records also evidenced that the results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

There was an effective system in place to ensure nursing staff were registered with the NMC; and that care staff were registered with the NISCC. Care staff not registered with NISCC were required and supported to register.

Review of reports and discussion with the registered and regional managers evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Areas for improvement

No 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 this QIP were discussed with the registered manager, Mrs Martha O'Kane and the regional manager, Mrs Christine Thompson, 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 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 may enhance service, quality and delivery.

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements 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 6 **Stated:** First time **To be completed by:** Immediate action required	The registered person should ensure that all patient information is held in a confidential manner. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: New folders have been put in place for each of the residents and the information is now in the patients rooms for turn charts and fluid and food charts.

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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