Unannounced Care Inspection Report
5 April 2017

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

An unannounced inspection of Milesian Manor took place on 5 April 2017 from 09:10 to 14:30 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?

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. One relative and staff evidenced that patients' needs were met by the number 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 obligation 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 infection prevention and control and the assessment and care planning process for patients from the day of admission to the home. Compliance with the requirement and recommendation made will achieve improvements within this domain.

Is care effective?

Review of three patient care records evidenced that care plans were reviewed on a regular basis however, they had not been updated/rewritten to reflect changes in the patients nursing needs and a recommendation was made.

We reviewed the management of pressure area for one patient. Care records contained details of the reposition programme and a contemporaneous record was maintained to evidence the delivery of care. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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.

Is care compassionate?

We arrived in the home at 09:30 and were immediately greeted by staff who were helpful and attentive. Patients were enjoying their breakfast in the dining room or in their bedrooms as was their personal preference; some patients remained in bed, again in keeping with their personal preference.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. 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 patients individually and with others in smaller groups, confirmed that living in Milesian Manor was a positive experience.

All of the patients spoke highly of the staff and the registered manager. It was evident that patients knew staff and the registered manager well.

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 a person independent of the home. Copies of the quality monitoring visits were available in the home.

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/s' is used to describe those living in Milesian 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	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Selvan Lobin, the nurse in charge of the home during the inspection, and with Mrs Martha O'Kane, Registered Manager, by telephone on 6 April 2017 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 medicines management inspection undertaken on 9 January 2017. 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: Macklin Care Homes Limited/ Mr Brian Macklin	**Registered manager:** Mrs Martha Therese O'Kane
Person in charge of the home at the time of inspection: Registered Nurse Selvon Lobin	**Date manager registered:** 1 April 2005
Categories of care: NH – I, PH and PH(E) RC – I	**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 we met with 12 patients individually and with others in small groups; two registered nurses, three care staff, two domestic staff, the home's administrator and one relative.

Questionnaires were also left in the home to facilitate feedback from relatives and staff not on duty and from patients. Ten, staff and relatives and eight patient questionnaires were left for completion.

The following information was examined during the inspection:

- duty rota for staff from 2 April to 15 April 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 file
- five patient care records
- client satisfaction survey
- resident/relative meetings
- record of staff meetings
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliment record
- record of audits
- RQIA registration certificate
- certificate of public liability
- monthly 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 9 January 2017

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 22 June 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 6 **Stated:** First time	The registered provider should ensure that all patient information is held in a confidential manner.	**Met**
	Action taken as confirmed during the inspection: Observations confirmed that this recommendation had been met.	

4.3 Is care safe?

The nurse in charge 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 2 to15 April 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.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; five were returned following the inspection. Four of the respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?" One staff member answered 'no' to this question and recorded "I often feel there isn't enough staff on the floor…"

Twelve patients spoken with during the inspection commented positively regarding the staff and the care delivered. Patients were satisfied that when they required assistance staff attended to them in timely manner. We also reviewed five returned patient questionnaires. Four patients responded that they were satisfied there was enough staff on duty to meet their needs and one responded that they were not.

One relative spoken with commented that "staff were excellent and nothing was any trouble to them." We sought other relatives' opinion on staffing via questionnaires; two completed questionnaires were returned. The 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 an effective process in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2016/17. Records were maintained in accordance with The Nursing Homes Care Standards – standard 39. 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. For example, palliative care and enteral feed management.

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 obligation to report concerns. Discussion with the registered manager, on 6 April 2017 by telephone, confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedures into practice. A safeguarding champion had been identified and that training had been delivered.

Review of three 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. However, for one patient risk assessments and care plans had not been completed in a timely manner from the date of their admission to the home. Details were provided during feedback to the nurse in charge and to the registered manager on 6 April 2017. A recommendation was made.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since December 2016 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. Patients spoken with were complimentary in respect of the home's environment. However, throughout the home it was observed that wooden skirting boards and wooden architraves had the wood exposed and a number of radiator covers in bathrooms were no longer sealed against water. A requirement was made in relation to infection prevention and control measures.

We spoke with two members of housekeeping staff who were knowledgeable regarding the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths. Sluice rooms and bathroom/toilets were observed to be clutter free and well organised. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

A recommendation was made that a detailed plan of care for each patient is generated from a comprehensive, holistic assessment commenced on the day of admission and completed within five days of admission to the home.

A requirement was made in accordance with infection prevention and control measures; that wooden skirting boards, wooden architraves and radiators covers are sealed to ensure they can be effectively cleaned.

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

4.4 Is care effective?

Review of three patient care records evidenced that care plans were in place to direct the care required for two patients; a recommendation was made; refer to section 4.3 for details. Care plans were reviewed on a regular basis, however, they had not been updated/rewritten to reflect changes in the patients nursing needs. For example, one patient was no longer fully mobile and the recommendations made by the speech and language therapist (SALT) had not been updated for a second patient. A recommendation was made.

We reviewed the management of pressure area for one patient. Care records contained details of the reposition programme 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. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

The nursing staff 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 a review of records confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting was held on 27 February 2017 with nursing staff.

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 patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

A recommendation was made that care plans are reflective of the assessed needs of patients and of recommendations made by healthcare professionals.

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

4.5 Is care compassionate?

We arrived in the home at 09:10 and were greeted by staff who were helpful and attentive. Patients were enjoying their breakfast 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.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

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

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. 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 patients individually and with others in smaller groups, confirmed that living in Milesian Manor was a positive experience.

All of the patients spoke highly of the staff and the registered manager. It was evident that patients knew staff and the registered manager well. Patients, one relative and staff confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

We reviewed the compliment records. Comments recorded included the following:

- "Sincere thanks for looking after our … so well over the past few years…"
- "To all the amazing staff at Milesian Manor. We appreciate so much how patient and gentle you were with … Your care and genuine kindness gave us great comport."
- "Thank you all so much for everything you do for … and for us as a family. It means the world to us."

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; two were returned within the timescale for inclusion in this report. Both relatives were very satisfied with the care provided across the four domains.

The following comments were provided:

- "…cannot speak however, we…are advocates and all wishes in terms of respect dignity and expectations in terms of quality of care is being met. We are extremely happy."

Ten questionnaires were issued to staff; five were returned prior to the issue of this report. The staff members were very satisfied or satisfied with the care provided across the four domains. One staff member raised a concern regarding staffing levels as detailed in section 4.3. However, the inspection findings evidenced that patients' needs were met in a timely manner by the number and skill mix of staff on duty.

Eight questionnaires were issued to patients; five were returned prior to the issue of this report. Patients were very satisfied or satisfied with the care provided across the dour domains.

Any comments from patients, 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 infection prevention and control, complaints 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 the regional manager 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.

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

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

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, 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.

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 the QIP were discussed with Mrs Selvan Lobin, the nurse in charge of the home during the inspection, and with Mrs Martha O'Kane, Registered Manager, by telephone on 6 April 2017 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

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 15 May 2017.	The registered provider must ensure that wooden skirting boards, wooden architraves and radiators covers are sealed to ensure they can be effectively cleaned in line with infection prevention and control guidance. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: Maintenance man employeed and paint work carried out.
Recommendations	
Recommendation 1 **Ref:** Standard 4.1 **Stated:** First time **To be completed by:** 15 May 2017.	The registered provider should ensure that a detailed plan of care for each patient is generated from a comprehensive, holistic assessment commenced on the day of admission and completed within five days of admission to the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Memo completed and put up for staff about time limit for risk assessments and care plans to be completed. Since inspection new admissions care files have all been completed within the 5days.
Recommendation 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 15 May 2017.	The registered provider should ensure that care plans are reflective of the assessed needs of patients and of recommendations made by healthcare professionals. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Care plans have been rewritten to reflect patients needs identified by all health care professionals. Monthly audit of same now being carried out.

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