Unannounced Care Inspection Report
7 June 2016

Moneymore

Address: Cookstown Road, Moneymore, BT45 7QF
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Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Moneymore took place on 7 June 2016 from 09.30 to 14.30 hours. The inspection sought to assess progress with any 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.

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

Is care safe?

There were systems in place for the recruitment and selection of staff. New staff completed an induction programme and there were systems in place to monitor staff performance or to ensure that staff received support and guidance. The planned daily staffing levels were subject to regular review to ensure the assessed needs of the patients were met. Training had been provided in all mandatory areas and this was kept up to date.

The staff were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. A range of risk assessments were completed on a regular basis and were reflected in the care planning process. Patients' risks of falls were managed appropriately. The home was clean, infection prevention and control measures were adhered and fire exits and corridors were maintained clear from clutter and obstruction.

Is care effective?

There was evidence that the care planning process included input from patients and/or their representatives and there was evidence of regular communication with patient representatives regarding any changes in the patients' condition. Patients were repositioned in line with their care plans; and patients' fluid intake had been monitored, as required. Communication was well maintained and all those consulted with stated that they had confidence in raising any concerns.

However, weaknesses were identified in the completion of care records. Two previous recommendations in relation to the completion of patient care records were not met and have been stated for the second time. A requirement has also been made during this inspection in regards to the completion of validated pain assessments.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely and patients were afforded choice, privacy, dignity and respect. Staff responded to patients' needs in a timely manner. Menus were displayed clearly throughout the building and the atmosphere was quiet and tranquil where patients were encouraged to eat their food. Patients were encouraged to socialise within the home and there was a range of activities for patients to choose from. There was a system in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Patients and relatives commented positively regarding the care of the patients in the home and a number of the comments are included in the report.

Is the service well led?

There was a clear organisational structure within the home. Observation of patients evidenced that the home was operating within its registered categories of care. The policies and procedures for the home were systematically reviewed on a three yearly basis. There was a system in place to manage any complaints, in accordance with regulation and best practice. Urgent communications, safety alerts and notices were reviewed and actioned, where appropriate. Systems were in place to monitor and report on the quality of nursing and other services provided. Monitoring visits were completed in accordance with the regulations and care standards. Given that a requirement has been made during this inspection; and that two recommendations have been stated for the second time in relation to the completion of care records, this has the potential to impact on the well led domain.

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

1.1 Inspection outcome

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

The total number of recommendations above includes two that have been stated for the second time.

Details of the QIP within this report were discussed with the 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 medicines management inspection.

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 10 May 2016. Other than those actions detailed in the previous QIP there were no further actions required.

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. There were no areas that required to be followed up in this inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Fionnuala Kidd
Person in charge of the home at the time of inspection: Fionnuala Kidd	**Date manager registered:** 17 July 2013
Categories of care: RC-I, RC-PH(E), RC-MP(E), NH-I, NH-PH	**Number of registered places:** 41

3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

Prior to inspection we analysed the following information:

- notifiable events submitted 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 plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. The inspector also met with five patients, one domestic staff, three care staff, one registered nurse and five patient's representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to adult safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 10 May 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP is due to be returned and will be reviewed by the pharmacy inspector. There were no issues required to be followed up during this inspection and any action taken by the registered person/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 25 January 2016

Last care inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall make suitable arrangements for the safe administration of medicines. Registered nurses must be aware of the plan of care for each patient and ensure that a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, is made in accordance with NMC standards for medicines management.	**Met**
	Action taken as confirmed during the inspection: All medicines were observed to be administered as prescribed.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 12, criteria 6 and 13 **Stated:** First time	Patients should be offered a choice of pureed meals and be made aware that alternative pureed options are available upon request.	**Met**
	Action taken as confirmed during the inspection: Consultation with patients and staff confirmed that patients, who required a modified diet, were offered an alternative pureed option, if requested.	

Recommendation 2 **Ref**: Standard 12, criterion 16 **Stated:** First time	The registered person should ensure that all staff, including kitchen staff, are made aware of the equipment required for each patient to enable them to eat and drink as independently as possible.	**Met**
	Action taken as confirmed during the inspection: Observation on the day of the inspection confirmed that there were sufficient specialist cups available for patients. All staff were aware of the patients' individual needs.	
Recommendation 3 **Ref**: Standard 4, criteria 8 and 9 **Stated:** First time	Records of wound care delivery should be maintained contemporaneously and in accordance with best practice guidelines in wound management.	**Not Met**
	Action taken as confirmed during the inspection: A review of patients care records evidenced that wound assessments had not been completed for every wound at the time of care delivery. **This recommendation was not met and has been stated for the second time.**	
Recommendation 4 **Ref**: Standard 4, Criterion 4 **Stated:** First time	A referral should be made to the occupational therapist in regards to the seating arrangements for one named patient. Confirmation that this referral has been made should be sent with the return of the QIP.	**Met**
	Action taken as confirmed during the inspection: A referral had been made to the occupational therapist in regards to the seating arrangements for one identified patient.	

Recommendation 5 **Ref**: Standard 4, Criterion 1 **Stated:** First time	A detailed plan of care should be generated from a comprehensive, holistic assessment and drawn up with each patient. The assessment should be commenced on the day of admission and completed within five days of admission to the home.	**Not Met**
	Action taken as confirmed during the inspection: A review of the care records evidenced that risk assessments and care plans had not been developed within the five day period, following admission to the home. **This recommendation was not met and has been stated for the second time.**	

4.3 Is care safe?

There were systems in place for the recruitment and selection of staff. A review of two personnel files evidenced that these were reviewed by the registered manager and checked for possible issues. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. Where nurses and carers were employed, their PIN numbers were checked on a regular basis, with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that their registrations were valid. The review of recruitment records evidenced that enhanced criminal records checks were completed with AccessNI and a record was maintained which included the reference number and date received.

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota commencing 30 May 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. This ensured that they had the basic knowledge needed to begin work. Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly

monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals. Individual supervisions were also conducted with staff in response to a learning need being identified. For example, where a patient developed pressure damage, supervision was undertaken with staff, to promote learning and prevent recurrence.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. There were no recent records pertaining to safeguarding incidents. Discussion with the registered manager confirmed that there was a process in place to manage potential safeguarding incidents, in accordance with the regional safeguarding protocols and the home's policies and procedures.

A range of risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails and restraint, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate; assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident, care management and patients' representatives were notified appropriately. RQIA had been notified appropriately, in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout.

Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction. Fire evacuation plans had been completed for each patient taking into account their mobility and assistance level. These plans were reviewed monthly to ensure that they were up to date. These plans are to assist in the event of the building needing to be evacuated in an emergency.

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?

A review of four patient care records evidenced that registered nurses generally assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. As discussed in section 4.2, assessments and care plans were not consistently completed within the recommended five day period following admission. A recommendation has also been stated

for the second time in this regard. The registered manager provided assurances that a system to audit the care records of patients newly admitted to the home would be implemented, to ensure that this is addressed.

The review of care records evidenced that where patients required a modified diet, a choke risk assessment had been completed and this information was included in the patient's care plan. However, patients who were prescribed transdermal opioid patches did not have a validated risk assessment completed. This was discussed with the registered manager and a requirement has been made in this regard.

The 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 consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records regarding any changes in the patients' condition.

A review of supplementary care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective. Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. 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 line manager and/or the registered manager.

Discussion with the registered manager and review of records evidenced that patients and/or relatives' meetings were held on a regular basis and records were maintained. The registered manager also obtains feedback from three patients' representatives on a weekly basis, to ascertain their views on the home environment and the care of their relative. Relatives had also been asked to comment regarding the safety of the patients in the home. Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

Pain assessments must be completed for all patients requiring regular or occasional analgesia, as appropriate. This information should be reflected in the patients' care plans.
A requirement has been made in this regard.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients consulted with stated that they knew how to use their call bells and stated that staff usually responded to their needs in a timely manner.

Menus were displayed clearly throughout the building and were correct on the day of inspection. We observed the lunch time meal in both dining rooms. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with tablecloths and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. We also observed that menus were displayed in pictorial format to assist in making choices and to provide an awareness of the meal to be served.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. A range of activities were displayed near the front entrance, in order to assist patients to choose which to participate in. On the day of the inspection, the activities coordinator made pancakes with the patients and all those present stated that they enjoyed this very much. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

A review of patient care records confirmed information about the patient's background. However, the 'connecting with community' section had not been consistently completed. Life histories had also not been consistently undertaken. This was discussed with the registered manager who advised that the completion of the life histories was ongoing and that this would be completed on admission in the future.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included: 'nothing is too much trouble, the attitude and the homely environment made the transition to the home easier'.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

"'The care is good. Personal care is very important and we treat all the patients as if they were our own parents."
"The care is of a high standard, we meet the patients' needs in every way we can."
"I have no concerns."
"All the patients are treated like our own family."

Patients

"The staff are good. There is not much to do but I am happy I can stay in my bedroom."
"I couldn't complain. They are good to me here."
"It's good enough here."
"I like it here."
"It's a home away from home."

Two patients provided written comment in relation to the staffing levels, stating that they felt there sometimes wasn't enough staff on. Given that there was no impact on patient care observed on the day of the inspection, these comments were communicated to the registered manager to address.

Patients' representatives

"Excellent. Even the most minor thing is dealt with. The staff greet us by name."
"The attention we received, when my mother was poorly was unreal."
"Communication is very good, we are very happy."
"This is the best home, we have ever been in, you couldn't get better."
"They are very good."'
"We are delighted, the nursing care is exceptional. Everything we ask for, we get immediately."
"The staff are so friendly, they never pass my father's bedroom without speaking in to him."

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

All written comments received from patients' representatives were very positive regarding the management of the home. One such comment described the registered manager as being 'an exemplary manager who manages to combine great professionalism with a maternal attitude while not being in any way condescending'.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

The manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis. Staff confirmed that they had access to the home's policies and procedures.

Discussion with the registered manager confirmed that no complaints had been received. Consultation with patients, staff and relatives also confirmed that any minor things are dealt with immediately. All those consulted with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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. These included medication and equipment alerts and alerts regarding staff who had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- wound management
- medicines management
- care records
- infection prevention and control
- complaints
- health and safety (hoists/slings)
- bedrails
- patients' weights

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. For example, an audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. There was evidence that identified deficits had been followed up on. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. A review of notifications of incidents to

RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records evidenced that Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. The monthly monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. Discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas for improvement

Given that a requirement has been made during this inspection; and that two recommendations have been stated for the second time in relation to the completion of care records, this has the potential to impact on the well led domain.

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

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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 person/s 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed 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 person/manager 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 person/manager 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**: Regulation15 (2)(a)(b) **Stated:** First time	The registered persons must ensure that pain assessments are completed for all patients requiring regular or occasional analgesia, as appropriate. This information should be reflected in the patients' care plans. **Ref: Section 4.4**
To be completed by: 7 August 2016	**Response by registered person detailing the actions taken:** All residents on pain relief have been reviewed and have an assessment in place reflective of their needs and care plans updated . This will be reviewed on a monthly basis in the medication audit process.
Recommendations	
Recommendation 1 **Ref**: Standard 4, criteria 8 and 9 **Stated:** Second time	Records of wound care delivery should be maintained contemporaneously and in accordance with best practice guidelines in wound management. **Ref: Section 4.2**
To be completed by: 7 August 2016	**Response by registered person detailing the actions taken:** As per FSHC policy and QOL system a wound analysis will be completed monthly and reviewed. This will be checked by the manager monthly
Recommendation 2 **Ref**: Standard 4, Criterion 1 **Stated:** Second time	A detailed plan of care should be generated from a comprehensive, holistic assessment and drawn up with each patient. The assessment should be commenced on the day of admission and completed within five days of admission to the home. **Ref: Section 4.2**
To be completed by: 7 August 2016	**Response by registered person detailing the actions taken:** All nurse are aware of the need to commence the admission assessment upon admission and complete within five days.All nurses have their primary residents to whom they complete monthly evaluations. This will be monitored by the Registered anager .

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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