Inspection Report

14 June 2024

Moneymore

Type of service: Nursing Home
Address: Cookstown Road, Moneymore, Magherafelt
Londonderry, BT45 7QF
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Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Ann's Care Homes **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Mrs Wendy McMaster **Date registered:** 22 July 2022
Person in charge at the time of inspection: Mrs Wendy McMaster, Manager	**Number of registered places:** 41 A maximum of 22 patients in category NH-I to be accommodated within the Cairndaisy unit. A maximum of 19 patients in category NH-DE to be accommodated within the Springhill unit.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** Cairndaisy unit: 19 Springhill unit: 6
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 41 patients. The home is divided in two units; Springhill unit for patients living with dementia and Carndaisy unit for general nursing care. The accommodation is on one level and the patients have access to communal lounges, dining rooms and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 14 June 2024 from 1.40 pm until 5.40 pm. The inspection was carried out by a care inspector.

The purpose of the inspection was to assess progress with all areas for improvement identified in the home 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.

Patients told us that they felt well looked after. Patients who were less able to communicate their views were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report.

Areas for improvement were identified during the inspection as detailed throughout this report and within the Quality Improvement Plan (QIP) in section 6.0.

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

3.0 How we inspect

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

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

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

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

The findings of the inspection were provided to the management team at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "The staff are brilliant", "one hundred and ten percent good care", "This is a very good place" and "They (staff) have us all spoilt". There were no questionnaires received from patients or relatives.

Staff said that the management team were very approachable, teamwork was great and that they felt well supported in their role. Comments included: "I really enjoy working here", "Good induction", "We are all one big family here" and "Staffing levels are good". There was no feedback from the staff online survey.

Two relatives commented positively during the inspection regarding the staff and delivery of care. Comments included: "The staff are very friendly and welcoming", "A hundred percent good care here", "Very happy with the care provided" and "No concerns".

5.0 The inspection

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

Areas for improvement from the last inspection on 6 December 2023		
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that the daily fluid intake of patients is meaningfully and regularly reviewed by nursing staff.	**Partially met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with the management team evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics including fire safety and adult safeguarding.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC). A discussion was held with the manager regarding one care assistant's registration status. Following the inspection, the manager provided written confirmation that relevant action had been taken to address this.

Review of a sample of staff recruitment files evidenced that relevant pre-employment information had been obtained prior to commencing work in the home. A record of induction had been completed and retained within staff files.

Staff said they felt supported in their roles and that there was good team work with effective communication between staff and management. Staff also said that, whilst they were kept busy, the number of staff on duty was generally satisfactory to meet the needs of the patients.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the manager was not on duty.

Review of a sample of registered nurses' competency and capability assessments for taking charge of the home in the absence of the manager found these to have been completed.

A matrix system was in place for staff supervision and appraisals to record staff names and the date that the supervision/appraisal had taken place.

5.2.2 Care Delivery and Record Keeping

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patients' needs, their daily routine, wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly.

Patients who were less able to mobilise require special attention to their skin care. Review of a sample of patients care records evidenced that they were mostly well maintained, however some entries exceeded the recommended frequency of repositioning. On review of other supplementary care charts, it was evident that the patients position had been changed but not recorded within the repositioning chart. This was discussed with the management team and following the inspection, written confirmation was received that relevant action had been taken to address this.

Review of care records specific to wound care evidenced that the recommended dressings recorded within the patient's care plan were not reflective of the dressings applied within the wound assessment charts. Details were discussed with the management team and an area for improvement was identified.

Falls in the home were monitored monthly to enable the manager to identify if any patterns were emerging. Review of one patient's accident report evidenced that where neurological observations were required following an unwitnessed fall, there were inconsistencies with the recording of observations in accordance with best practice guidance and the homes policy. Details were discussed with the management team and an area for improvement was identified.

Review of the Deprivation of Liberty Safeguards (DoLS) register for patients evidenced that it had not been appropriately maintained to ensure that it remained reflective of the current patients' requirements. Following the inspection, written confirmation was received that relevant action had been taken to address this.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. A pictorial menu was displayed within the dining room with a choice of two meals.

Patients commented positively about the food provided within the home with comments such as: "The food is lovely", "Very good food here" and "We get plenty of choices."

Staff described how they were made aware of patients' individual nutritional and support needs based on recommendations made by the Speech and Language Therapist (SALT). On review of electronic care records, one patient's 'profile page' stated that they were 'independent' with eating and drinking. However, on review of the patient's care plan it stated they required one to one assistance. This was updated during the inspection and the management team agreed to review all other records. Following the inspection, written confirmation was received that relevant action had been taken to address this.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily.

A number of entries within patients' daily progress notes were not reflective of the total volume of fluid intake recorded within supplementary charts. This was discussed in detail with the management team and area for improvement has been stated for a second time.

Review of a sample of care records evidenced that care plans and risk assessments were reviewed regularly. There were some discrepancies identified within care records which were mostly updated prior to the completion of the inspection. Following the inspection, written confirmation was received that all other records had been updated accordingly.

Daily progress records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was warm and comfortable and patient's bedrooms were found to be personalised with items of memorabilia and special interests.

Whilst most areas of the home were clean, staining was evident to a number of over sink light pull cords and to silicon around the base of toilets. It was further identified that insert caps to hot and cold water taps were missing on a number of taps; corrosion was evident to a number of wash hand basin plug holes and two holes were identified to the wall of a bedroom. Details were discussed with the management team and following the inspection, written confirmation was received that all remedial issues identified had been addressed.

A discussion was held with the management team regarding the alarm to an exit door within the Cairndaisy unit, leading to an enclosed garden which had been isolated resulting in the alarm not being able to sound in the event that the door is opened. It was further identified that the code to relevant keypads was not displayed within the Cairndaisy unit and a set of double doors leading from the dining room were not secure to prevent patients from entering into the Springhill unit garden. This was discussed with the management team and following the inspection, written confirmation was received that relevant action had been taken to resolve these issues with ongoing monitoring to ensure it remains effective.

There was a good supply of personal protective equipment (PPE) and hand sanitising gel throughout the home. A system for regular auditing of hand hygiene and infection prevention and control (IPC) was in place.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested.

During the inspection the activity person provided chair exercises for patients, a game of bingo, board games and interactive catch the ball games. Other patients were engaged in their own activities such as; watching TV, resting or chatting to staff. Patients were seen to be content and settled in their surroundings and in their interactions with staff.

An activity schedule was displayed within the home offering a variety of activities such as; bingo, music, arts and crafts. One patient said: “This is a very good place. A very well run home”.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Staff said that the manager was very approachable and accessible.

Review of accidents/incidents records confirmed that relevant persons were notified and a record maintained. One notification was required to be submitted retrospectively. This was submitted by the manager following the inspection.

A number of audits were completed on a monthly basis by the management team to ensure the safe and effective delivery of care. For example, care records, environment, IPC and hand hygiene. Where deficits were identified the audit process included an action plan, the person responsible for completing the action, a time frame for completion and a follow up to ensure the necessary improvements had been made.

The home was visited each month by a representative of the responsible person to consult with patients, their relatives and staff and to examine all areas of the running of the home. Written reports were completed following these visits and were available within the home.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	0	3*

* The total number of areas for improvement includes one standard that has been stated for a second time.

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

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 21 June 2024	The registered person shall ensure that the daily fluid intake of patients is meaningfully and regularly reviewed by nursing staff. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: The meaningful and regular review of daily fluid intake has been further discussed with staff under supervision . It was identified that staff were not making effective use of the electronic systems in place to ensure that fluids were correctly recorded and reviewed. Re-training has been provided in the system and Home Manager will continue to review.
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 14 June 2024	The registered person shall ensure that patients who require wound care have a care plan in place detailing the type of dressings to be used and the frequency of renewal which is reflective within wound assessment charts. Ref: 5.2.2
	Response by registered person detailing the actions taken: A review of all wound documetation has been undertaken. The dressing regime for the identifed resident has been amended to ensure all records are consistent with the care plan. Home Manager complete a monthly wound audit to ensure compliance is maintained
Area for improvement 3 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 14 June 2024	The registered person shall ensure that where neurological observations are required following a fall, the recording of the patient's observations is in accordance with best practice guidance and the homes policy. Ref: 5.2.2
	Response by registered person detailing the actions taken: A review of al the recent falls has taken place. Staff have received supervision in the new falls protocol to ensure full understanding. Visual prompts have been placed at both nurses stations. Home manger will complete an audit following all falls to ensure complaince is maintained.

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