Inspection Report

17 June 2021

Moneymore

Type of service: Nursing (NH)
Address: Cookstown Road, Moneymore, Magherafelt, Londonderry, BT45 7QF
Telephone number: 028 8674 8118

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual** Mrs Natasha Southall	**Registered Manager:** Mrs Joy McKay - not registered
Person in charge at the time of inspection: Mrs Joy McKay	**Number of registered places:** 41 A maximum of one patient in category NH-PH.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 26
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 accommodation is on one level and patients have access to communal lounges, dining rooms and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 17 June 2021, from 9.50am to 5.30pm by a care inspector.

The inspection assessed 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.

Areas requiring improvement were identified in relation to repositioning frequencies and record keeping.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.
We found that there was safe, effective and compassionate care delivered in the home and the home was well led by the manager.

The findings of this report will provide the manager 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 RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires and 'Tell Us' cards 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 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.

The findings of the inspection were discussed with Joy McKay Manager at the conclusion of the inspection.

4.0 What people told us about the service

We spoke with 11 patients, 10 staff and four visitors/ relatives. No questionnaires were returned and we received no feedback from the staff online survey. Patients spoke highly on the care that they received and on their interactions with staff. Patients confirmed that staff treated them with respect and that they would have no issues in raising any concerns with staff. Staff were complimentary in regard to the home's new manager and spoke of how much they enjoyed working with the patients. A relative commented on how well their family member looked and they had no concerns in regard to the care they received, a visitor told us "I couldn't say a bad word; all the girls (staff) are very good".

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 10 September 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (1) (a) **Stated:** Third and final time	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. Specific reference to recording charts and daily records: • Action taken should be documented within daily records when set fluid targets have not been maintained • Where a patient has been repositioned the frequency should reflect the current care plan and state the intervention on each repositioning.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of care records evidenced this area for improvement has been met.	
Area for Improvement 2 **Ref:** Regulation 27(4)(c) **Stated:** First time	The registered person shall ensure that all fire exits and corridors are kept clear and unobstructed at all times.	**Met**
	Action taken as confirmed during the inspection: Fire exits and corridors were observed clear and unobstructed.	

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		Validation of compliance
Area for Improvement 1 **Ref:** Standard 14.26 **Stated:** Third and final time	The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of patient inventory records evidenced this area for improvement has been met.	
Area for improvement 2 **Ref**: Standard 4.8 & 4.9 **Stated:** First time	The registered person shall ensure the following with regard to patients care records: • the daily care records clearly evidence the care delivered to patients by all care staff • the time of entry should be clearly recorded on the daily progress notes • patient care plans and risk assessments should be meaningfully reviewed.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of care records evidenced this area for improvement has been met.	
Area for improvement 3 **Ref:** Standard 28 **Stated:** First time	The registered person shall make the necessary arrangements to ensure that disposal of medicines records are fully maintained; and clearly indicate that all controlled drugs in Schedules 3 and 4 (Part 1) have been denatured prior to disposal, by two trained staff.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed and this is carried forward to the next inspection.	
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time	The registered person shall review the management of topical medicines to ensure that medicine records are fully and accurately completed.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed and this is carried forward to the next inspection.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect patients.

There was a system in place to monitor staff compliance with mandatory training and to indicate what training was due.

Appropriate checks had been made to ensure that the professional registration of staff with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC) was in place.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty. It was noted that there were enough staff in the home to respond to the needs of the patients in a timely way. Call bells were answered promptly by staff who were observed to respond to requests for assistance in a caring and compassionate manner.

Staff said that teamwork was good, the manager was approachable and that they felt well supported in their role.

Patients told us “I get great care and attention” and “The girls (staff) are all good, they’d do anything for you.”

There were safe systems in place to ensure that staff were recruited and trained appropriately; and that patient needs were met by the number and skill of the staff on duty.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. In addition, patient care records were maintained which accurately reflected the needs of the patients. 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’ needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients’ needs; and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the patients’ needs.

Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails, alarm mats. It was established that safe systems were in place to manage this aspect of care.

Patients who are less able to mobilise require special attention to their skin care.
Whilst patients were assisted by staff to change their position regularly and the care records accurately reflected this. Within the care records reviewed a number of patients were prescribed different repositioning frequencies for day and night-time; this appeared to cause some inaccuracies in the documentation. The specific examples were discussed with the manager who agreed to review and provide clarity on the appropriate timings for the day and night time repositioning frequencies; an area for improvement was identified.

Examination of records and discussion with the manager confirmed that the risk of falling and falls were well managed. Review of records confirmed that staff took appropriate action in the event of a fall, for example, they completed neurological observations and sought medical assistance if required. The appropriate care records were reviewed and updated post fall. Staff also completed a post fall review to determine if anything more could have been done to prevent the fall.

Patients who required care for wounds or pressure ulcers had this clearly recorded in their care records. There was evidence that nursing staff had consulted with specialist practitioners in the management of wounds or pressure ulcers, for example, the Podiatrist and the Tissue Viability Specialist Nurse (TVN) and were following any recommendations made by these professionals.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was seen to be a pleasant opportunity for patients to socialise and the atmosphere was calm and relaxed. Staff had made an effort to ensure patients were comfortably seated and enjoyed their meal. It was observed only one of the dining rooms was in use, this was discussed with the manager who advised some patients preferred to have their meal in their bedroom or in the lounge area.

There was a choice of meals offered to patients, the food was attractively presented and smelled appetising with generous portions. There was a variety of drinks available. The patients commented positively on the quality of the food.

There was a system in place to ensure that all staff were aware of individual patient's nutritional needs and any modified dietary recommendations made by the Speech and Language Therapist (SALT).

Nutritional assessments had been conducted on a monthly basis by staff using the Malnutrition Universal Screening Tool (MUST), and there was evidence that patients' weight was checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily. Discussion with staff confirmed how concerns were escalated and if required patients were monitored if they had a reduced food or fluid intake.

There were systems were in place to ensure that patients' needs were individually assessed and their care needs met. Care documentation was up to date and evidenced regular review. An area for improvement was identified in regard to patient repositioning frequencies.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. Surface damage was evident to a number of items of furniture and paintwork. This was discussed with the manager who advised plans are in place to redecorate the home in the very near future; this will be followed up on a future inspection. Patients' bedrooms were personalised with items important to the patient. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

There was evidence throughout the home of 'homely' touches. Patients' artwork, flowers, newspapers, magazines and jugs of juice or water were available in lounges and bedrooms and patients were offered suitable drinks and snacks between their main meals.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks. There was evidence the home conducted frequent fire drills however, the documentation observed was not in keeping with record keeping guidelines. An area for improvement was identified.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Authority (PHA).

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

Visiting arrangements were managed in line with DoH and IPC guidance.

There were systems in place to ensure that the risk of infection and the internal environment of the home were well maintained in order that patients were comfortable and safe. One area for improvement was identified in relation to fire drill records.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. Patients confirmed they could remain in their bedroom or go to the communal lounges when they wished.

There was a range of activities provided for patients by activity staff. Patients had been consulted and helped plan their activity programme. The range of activities included social, cultural, religious, spiritual and creative events. The activity staff member shared her plans for celebrating Father's Day with the patients at the weekend.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted patients to make phone or video calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

There were systems in place to support patients to have meaning and purpose to their day within Moneymore Care Home.

5.2.5 Management and Governance Arrangements

There has been a change in the management of the home since the last inspection. Mrs Joy McKay has been appointed as the new home manager; an application for registration has been submitted to RQIA and RQIA were appropriately informed of this change.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. There was evidence of auditing across various aspects of care and services provided by the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment. Staff said that the manager was approachable and accessible.

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

Review of the home's record of complaints confirmed that these were well managed and used as a learning opportunity to improve practices and/or the quality of services provided by the home.

Patients said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

Staff commented positively about the manager and described her as supportive and approachable.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home.

The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

There were robust systems in place to monitor the quality of care and services provided and to drive improvement in the home.

6.0 Conclusion

Staff were observed engaging compassionately with patients and in a manner which promoted their privacy and dignity. The home was observed to be clean and tidy.

The lived experience of patients was promoted by activity staff that provided a schedule of activities so that patients had meaning and purpose to their day.

Based on the inspection findings and discussions held we are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager.

Two new areas for improvement were identified in regard to patient repositioning frequencies and record keeping.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (April 2015)**

	Regulations	Standards
Total number of Areas for Improvement	0	4*

* The total number of areas for improvement includes two areas under the standards which were not reviewed as part of this inspection and are carried forward for review to a future inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Joy McKay, Manager, 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 (April 2015)	
Area for improvement 1 **Ref:** Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall make the necessary arrangements to ensure that disposal of medicines records are fully maintained; and clearly indicate that all controlled drugs in Schedules 3 and 4 (Part 1) have been denatured prior to disposal, by two trained staff. Ref: 5.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review the management of topical medicines to ensure that medicine records are fully and accurately completed. Ref: 5.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 3 **Ref:** Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review the repositioning frequency of patients so staff are clear as to what constitutes day and night frequency differences. Ref: 5.2.2
	Response by registered person detailing the actions taken: The repositioning frequency of the residents in the Home is under review, taking into account assessed individual need and any personal sleeping preferences requested by the resident. This will help ensure that the timings between day and night duty are appropriate.
Area for improvement 4 **Ref:** Standard 37 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that records and documentation is completed in accordance with legislative requirements, minimum standards and best practice. This specifically relates to fire drill records. Ref: 5.2.3
	Response by registered person detailing the actions taken: The specific staff member has been advised that the use of correction fluid is not permitted on any documents.

Please ensure this document is completed in full and returned via Web Portal*

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care