Unannounced Care Inspection Report
8 August 2019

The Court Care Home

Type of Service: Nursing Home
Address: 1a Queens Avenue, Ballymoney, BT53 6DF
Tel No: 0282766 6866
Inspectors: James Laverty and Briege Ferris

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 45 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons (No 11) Limited **Responsible Individual(s):** Dr Maureen Claire Royston	**Registered Manager and date registered:** Claire Wilkinson 15 March 2017
Person in charge at the time of inspection: Claire Wilkinson	**Number of registered places:** 45 A maximum of three persons in category NH-PH. A maximum of 14 patients in category NH-DE to be accommodated in the dementia unit.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 36

4.0 Inspection summary

An unannounced inspection took place on 7 August 2019 from 12.30 to 14.00 and 8 August 2019 from 10.40 to 14.45 hours. The inspection was undertaken by the care and finance inspectors.

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 Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to the internal environment, staff interaction with patients, nutritional care for patients, the use of restrictive practices, quality assurance audits and monthly monitoring reports.

An area for improvement was identified for a second time in regard to ensuring that patients' property records are reconciled and signed and dated by two people at least quarterly.

Patients said that they were well cared for and expressed confidence in the ability and willingness of staff to meet their care needs. Feedback from patients is referenced further throughout the report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	*1

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

Findings of the inspection and details of the Quality Improvement Plan (QIP) were discussed with Claire Wilkinson, Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 4 April 2019

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 4 April 2019. No areas for improvement were identified. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received, for example serious adverse incidents.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined and/or discussed during the inspection:

- staff training records for the period 2019/20
- accident and incident records
- two patients' care records including relevant supplementary wound care/nutritional care records
- a selection of governance audits
- complaints records
- adult safeguarding records
- notifiable incidents to RQIA
- RQIA registration certificate
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a sample of patients' property records

Areas for improvement identified at the last finance inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspection(s)

There were no areas for improvement identified as a result of the last care or medicines management inspections.

Areas for improvement from the last finance inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 14.26 **Stated:** First 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.	**Not met**

	Action taken as confirmed during the inspection: A sample of four patients' property records were reviewed to identify if patients' records had been updated as required. This review identified that the records had not been updated at least quarterly. The registered manager confirmed that the last time they had been updated was January 2019 and that the failure to update the records was an oversight.	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Upon arrival to the home we were greeted by the home administrator and manager. The foyer entrance was neatly and attractively presented and had several display boards containing a range of information for patients and visitors – these are referenced further in section 6.5.

Staffing levels within the home were discussed and reviewed with the manager who confirmed that staffing levels were planned and kept under review to ensure that the needs of patients were met. No patients or staff expressed any concerns in regard to staffing levels.

We were told by staff that they received regular mandatory training to ensure they knew how to provide the right care. All staff stated that they felt that their mandatory training provided them with the skills and knowledge to effectively care for patients within the home. Staff described the support they received from the manager in enthusiastic terms; one staff member told us "I feel well supported."

The way in which staff are supported in their roles was considered. A review of supervision and appraisal records for staff highlighted that a robust system was in place and regularly monitored by the manager.

A review of governance records provided assurance that all notifiable incidents had been reported to the Regulation and Quality Improvement Authority (RQIA) as required. It was further noted that there were effective arrangements for monitoring and reviewing the registration status of nursing staff with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC). The manager advised that the home now uses an electronic 'live' system ('Home view') to monitor the professional registration of staff twice monthly.

Discussion with the manager evidenced that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. Appropriate governance arrangements were in place to ensure that all staff attend adult safeguarding training and have sufficient awareness of the home's adult safeguarding policy to help ensure that it is embedded into practice. The manager also confirmed that an 'adult safeguarding champion' (ASC) was

identified for the home. Staff who were spoken with expressed a good understanding of how to recognise and respond to potential safeguarding incidents.

An inspection of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home consists of a ground floor nursing unit for those patients living with dementia (named 'Fairtree Gardens') and a first floor nursing unit for those patients requiring frail elderly nursing care (named 'Evergreen Court'). However, it was noted that there was no signage for patients or visitors which clearly displayed these unit names. The manager agreed to action this appropriately. Access and egress to/from the Fairtree Gardens is via a doorway which is secured using an electronic keypad. The unit was attractively decorated throughout and included communal rooms such as the 'Quiet Lounge' and 'Sensory Room'. Evergreen court was similarly neat and tidy for patients and decorated in a homely fashion. This unit included a small 'Library' room which could be used by patients if desired. It was noted that some minor de-cluttering was required in two identified areas and the manager agreed to action this immediately.

Fire exits and escape routes were observed to be free from clutter throughout the inspection while staff adhered to good fire safety practices.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the internal environment and staff supervision/appraisal.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total numb of areas for improvement	0	0

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

Staff told the inspector that there was effective communication at the commencement of each shift which allowed them to discuss and review the ongoing needs of patients.

Staff who were spoken with stated that that if they had any concerns, they could raise these with their line manager and/or the manager. One staff member stated that they had received a "good" induction at the commencement of their arrival to the home.

A review of patients' care records evidenced that nursing staff regularly engaged with members of the multi-professional team; this included regular contact with professionals such as GPs, tissue viability nurses (TVN), dieticians and speech and language therapists (SALT).

Regular contact with patients' families is also a vital aspect of care delivery. Care records which were viewed demonstrated that staff regularly communicated with patients' families or representatives as they used/reviewed a range of risk assessments to help inform the care being provided.

The provision of wound care was considered. Review of the care records and feedback from staff provided assurance that wound care to one identified patient had been provided consistently by staff and in keeping with their relevant care plan. It was noted however that some supplementary wound care records were not always completed fully and/or maintained in a chronological manner so as to avoid potential confusion. This was discussed with the manager who agreed to address this with nursing staff by means of targeted supervision sessions.

The management of patients' nutritional needs was reviewed. The care records for one patient who required a modified diet evidenced detailed and person centred care plans. Appropriate nutritional assessments were up to date and the patient's dietary needs had been accurately communicated to kitchen staff in a timely manner.

At times, some patients may require the use of equipment which restricts their movement, or alerts staff when patients try to mobilise unaided. The care records for one patient who required the use of an alarmed pressure mat were reviewed. Care records evidenced that the use of this equipment had been discussed with the patient's family and multiprofessional team. It was also evidenced that the use if this equipment had been regularly reviewed by staff to ensure that it remained necessary and proportionate.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to collaboration with the multiprofessional team and the use of restrictive practices.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Throughout the inspection, staff interactions with patients were observed to be compassionate, timely and caring. Discreet observation of staff highlighted a high level of patient and effective engagement to some patients who were displaying distressed reactions. This is commended.

Staff demonstrated a good knowledge of patients' wishes, and preferences as identified within the patients' care plans. Staff were also aware of the requirements regarding patient information and confidentiality.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Discussions with staff provided evidence that they considered the manager to be supportive and approachable and they felt confident that they could raise concerns if they arose.

There was evidence of ongoing commitment to person centred formal and informal activities for patients. Staff who were spoken with demonstrated a good awareness of the need to meet patients' needs in a holistic way which values their personal preferences, likes and dislikes.

An array of information for patients and visitors was available within the main foyer. This included items such as:

- photographic display boards from events organised by the home
- birthday celebrations
- the weekly Activity Planner for patients
- dates of relatives' meetings

Feedback received from several patients during the inspection included the following comments:

- "It's tremendous here."
- "The staff are lovely."

Feedback received from several patients' relatives during the inspection included the following comments:

- "I really like it …"
- "Oh, I've no complaints."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff interaction with patients and the provision of activities.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. All staff spoken with were able to describe their roles and responsibilities and confirmed that there were good working relationships within the home. Staff also stated that management was responsive to any suggestions or concerns raised.

The registration certificate was up to date and displayed appropriately. Discussion with the manager evidenced that the home was operating within its registered categories of care.

Patients spoken with confirmed that they were aware of the home's complaints procedure and that they were confident the home's management would address any concerns raised by them appropriately. It was also confirmed with the manager that any expression of dissatisfaction should be recorded appropriately as a complaint.

Discussion with the manager and a review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

A review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

Staff recruitment information was available for inspection and records for one staff member evidenced that all relevant checks including enhanced AccessNI checks were sought, received and reviewed prior to them commencing work. It was agreed with the manager that the date on which the home receive written references for new staff would be clearly recorded.

Discussion with the manager confirmed that staff meetings were held on a regular basis and that minutes were maintained. Staff confirmed that such meetings were held and that the minutes were made available.

A review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to the falls, infection prevention and control, and wound care. All audits which were sampled had been completed in an effective and robust manner and the manager confirmed that their findings helped to inform ongoing quality improvement within the home.

Management of service users' monies

A sample of patients' property records were reviewed to identify if patients' records had been reconciled at least quarterly with the reconciliation signed and dated by two people. This review identified that the records had not been updated as required. The registered manager confirmed that the last time they had been updated was January 2019 and that the failure to update the records as required was an oversight. This area for improvement is listed in the quality improvement plan for the second time and requires urgent review by the registered person.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to quality assurance audits and monthly monitoring reports.

Areas for improvement

No new areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Claire Wilkinson, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 14.26 **Stated:** Second time **To be completed by:** 31 August 2019 at least quarterly thereafter	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. Ref: 6.6
	Response by registered person detailing the actions taken: Matrix was developed on day of inspection 7th August 2019 and inventory of property commenced for all residents. Matrix included date of completion and signature of both staff (one being a senior staff member); the inspector requested for the initial checks to be addressed by end of August, this was addressed. It was agreed that all blue booklets detailing belongings must be dated and signed by two staff annually and when any new items are received, and that matrix would cover the quarterly checks. Quarterly belonging checks diarised for both units and inputted onto Home Manager outlook calendar to ensure compliance, for new Manager. Diarised for OCT/JAN/APRIL/JULY. Supervision completed with care staff to ensure understanding and compliance.

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

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