Unannounced Care Inspection Report
4 December 2018

Hamilton Court

Type of Service: Nursing Home (NH)
Address: 45 Hamiltonsbawn Road, Armagh, BT60 1HW
Tel No: 028 37528523
Inspector: Sharon McKnight

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.

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 39 persons and residential care to one named patient.

3.0 Service details

Organisation/Registered Provider: EBBAY Limited Responsible Individual(s): Patrick Anthony McAvoy	Registered Manager: Daniel Dougan
Person in charge at the time of inspection: Daniel Dougan	**Date manager registered:** 8 June 2018
Categories of care: Nursing Home (NH) DE – Dementia.	**Number of registered places:** 40 The home is also approved to provide care on a day basis to 2 persons. There shall be a maximum of 1 named resident receiving residential care in category RC-DE

4.0 Inspection summary

An unannounced inspection took place on 4 December 2018 from 10.00 to 14:00.

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.

The term 'patient' is used to describe those living in Hamilton Court which provides nursing care and residential care for one named patient.

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 staffing, risk management and the home's environment. There were examples of good practice found in relation to the assessment of patient need and care planning and the communication of patient need between staff. Good practice was evident in relation to the culture and ethos of the home, the provision of activities and mealtimes. There were examples of good practice found throughout the inspection in relation to governance arrangements and maintaining good working relationships.

There were no areas requiring improvement identified.

Patients said they were happy living in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

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**	**0**

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Daniel Dougan, registered 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 27 June 2018.

The most recent inspection of the home was an unannounced care inspection undertaken on 27 June 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with all of the patients in small groups, three patients' relatives and five staff. Questionnaires were also left in the home to obtain feedback from patients' relatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line.

The inspector provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

A poster informing visitors to the home that an inspection was being conducted was displayed on the front door of the home.

The following records were examined during the inspection:

- duty rota for nursing and care staff from 3 – 9 December 2018
- incident and accident records
- three patient care records
- complaints record
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 27 June 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and was validated during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 27 June 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 35.6 **Stated:** First time	The registered person shall review how short term changes to prescribed regimes are communicated to staff to ensure they are implemented.	**Met**
	Action taken as confirmed during the inspection: The registered manager explained that short, focused meetings are now held with the registered nurses approx. 2 -3 times weekly. At these meetings they review aspects of patient care including wound management, weight loss and accident management. A review of the records of these meetings	

	evidenced that any changes to prescribed regimes are discussed. This area for improvement has been met.	

6.3 Inspection findings

6.4 Is care safe?

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

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from week commencing 3 December 2018 evidenced that the planned staffing levels were adhered to. Staff confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients.

We spoke with three patient's relative; no issues were raised with regard to staffing. Questionnaires were provided for relatives; none were received within the timescale specified. Any comments from patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

We reviewed accidents/incidents records completed in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example bed rails. There was also evidence of consultation with relevant persons. Care plans were in place for the management of bedrails and alarm mats.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Fire exits and corridors were observed to be clear of clutter and obstruction. The home was found to be warm, well decorated, fresh smelling and clean throughout. The home was tastefully decorated for Christmas.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, risk management and the home's environment.

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 effective?

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

We reviewed three patients' care records with regard to the admission process, management of wound care and the day to day maintenance of care records.

A review of one care record evidenced that a comprehensive, holistic assessment of patients' nursing needs and a range of risk assessments were commenced at the time of admission to the home. The holistic assessment contained good detail of the patient's individual needs. Initial plans of care were generated within 24 hours of admission.

A review of care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient. Care records contained details of the specific care requirements and a daily record was maintained to evidence the delivery of care. Interventions prescribed were individualised and care records were reviewed regularly.

We reviewed the management of pressure ulcer care for one patient. Details of the care required were recorded in the patient's care plan. Records evidenced that the prescribed interventions and the frequency of review were adhered to.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), SALT and dieticians. Supplementary care charts such as food and fluid intake records evidenced that contemporaneous records were maintained. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), the speech and language therapist (SALT) or the dietician changed.

A review of accidents/incidents records evidenced that patients were appropriately monitored following falls and that medical advice was sought as required.

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 the registered manager or the nurse in charge. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and that this handover provided information regarding each patient's condition and any changes noted.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping and the communication of patient needs between staff.

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 care compassionate?

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

We arrived in the home at 10:00 and were greeted by staff who were helpful and attentive. Patients were relaxing in one of the lounges or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Discussion with staff and review of the activity programme displayed in the home evidenced that arrangements were in place to meet patients' social, religious and spiritual needs. A number of the gentlemen were attending the gentlemen's club which is held each morning. The morning paper is available and a range of activities, including wood work, take place and the gentleman are encouraged to participate; the level of which depends on their cognitive ability. The activity co-ordinator explained that this daily group focuses on activities and past times that the gentleman would have been interested in prior to their admission to the home. It was good to note that the materials and tools provided for the woodwork were age appropriate; this was commended by the inspector. There were seven patients attending the group on the morning of the inspection. Patients spoken with stated that they enjoyed the newspapers and the tea and scones served. Patients who could not verbalise their feelings were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

We discussed the wider activity programme and the activity co-ordinator explained that activities are planned on a weekly basis and the programme is displayed in the home for patients and their relatives. Activities are delivered on both a group and individual basis. Group activities included armchair exercises, social games, reminiscence, crafts and seasonal activities. One to one activities are also delivered to patients who are unable to participate in the group activities.

Following discussion with the registered manager, staff and the activity co-ordinator, and a review of the activity plan we conclude that meaningful activities were provided regularly. Relatives spoken with were well informed about the planned activities and spoke positively of the co-ordinator and the range of activities provided.

We observed the serving of the lunchtime meal in the main dining room. The majority of patients had their meal in the dining room; a few had trays delivered to them as required. The dining room tables were nicely set with condiments available on a number of tables. Staff were observed offering condiments to those patients who required support to use them appropriately ensuring that all patients had access to condiments; this was commended by the inspector. There was a choice of two main dishes on the menu; staff confirmed that alternatives meals were also provided in response to their requests. The meals served appeared appetising and patients were complementary regarding the meal. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Staff were observed assisting patients with their meal in a timely manner. The serving of the meal was well organised and there was a calm atmosphere throughout the meal.

We spoke with the relative of three patients who commented positively regarding the caring attitude of staff, the delivery of care, the provision of activities and the quality of the meals.

As previously discussed questionnaires were also provided for relatives; no completed questionnaires were received prior to the issue of this report.

Any comments from relatives and staff in returned questionnaires received after this report is issued will be shared with the registered manager for their information and action as required.

We spoke with five members of staff. Staff stated they were happy working in the home and were of the opinion that care was delivered to a high standard. Staff were asked to complete an on line survey, we had no responses within the timescale specified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, the provision of activities and mealtimes.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 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.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with the registered manager, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff and relatives evidenced that the registered manager's working patterns provided opportunities to meet with them, if required. Staff and relatives reported that the registered manager was very approachable and they were confident that any concerns or issues brought to the attention of the registered manager would be appropriately addressed.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the operations manager on behalf of the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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