Unannounced Care Inspection Report
27 June 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 servicefrom 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 patientsand residential care for one identified 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 27 June 2018 from 10.00 to 17:00.

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 both nursing and residential care.

The inspection assessed progress with any areas for improvement identified during andsince 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, staff recruitment, training and development, adult safeguarding, the management of restrictive practice, risk management, infection prevention and control and the home’s environment. There were examples of good practice found throughout the inspection in relationto record keeping, the management of nutrition and falls and timely referrals to healthcare professionals.Good practice was observed in relation tothe culture and ethos of the home and individualised care for patients. There were robust systems in place in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

An area for improvement was identified under the standards in relation to how short term changes to prescribed regimes are communicated to staff to ensure they are implemented.

Patientssaid they happy living in the home. Patients 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 homewith the necessary information to assist them to fulfil their responsibilities, enhance practice and patients'experience.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	**0**	**1**

Details of the Quality Improvement Plan (QIP) were discussed with Daniel Dougan, registered manager and Sharon Loane, operations manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcementaction did not result from the findings of this inspection.

4.2Action/enforcementtaken following the most recent inspection dated 17 July 2017.

The most recent inspection of the home was an announced variation to registration care inspection undertaken on 17 July 2017. No areas for improvement were identified as a result of this inspection. Due to the focus of this inspection the areas for improvement from the last care inspection on 31 May 2017 were not reviewed and were carried forward to the next care inspection.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 inspectionwemet with all of thepatients in small groups, 5 staffand onepatients'relative.Questionnaires were also left in the home to obtain feedback from patients' relatives. A poster was provided which directed staff to an online survey.The inspector provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients, relatives and families, 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 at the main door of the home.

The following records were examined during the inspection:

- duty rota for staff from 18 June to 1 July 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- four patient care records
- three patient care charts including food and fluid intake charts, reposition charts and management of lap straps
- a sample of governance audits
- complaints record
- compliments received
- 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 theinspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 17 July 2018.

The most recent inspection of the home was an announced variation to registration care inspection. This focused solely on the variation to registration application. The areas for improvement from the last care inspection on 31 May 2017 were not reviewed and were carried forward to the next care inspection.

6.2 Review of areas for improvement from the last care inspection dated 31 May 2017.

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 4 **Stated:** First time	The registered provider should ensure that care plans are kept updated to reflect patients' needs to ensure the delivery of safe and effective care.	**Met**
	Action taken as confirmed during the inspection: Care records evidenced that they were regularly reviewed and updated to reflect the needs of the patients. This area for improvement has been met.	
Area for improvement 2 **Ref**: Standard 21 **Stated:** First time	The registered provider should ensure that the system for recording and monitoring patients' bowel care is robust to ensure safe effective care.	**Met**
	Action taken as confirmed during the inspection: The registered manager explained the recording and storage of bowel care records was reviewed following the previous inspection to ensure they were accessible to the registered nurses. Care records reviewed evidenced that systems in place to record and monitor bowel care were robust. This area for improvement has been met.	
Area for improvement 2 **Ref**: Standard 23 **Stated:** First time	The registered provider should ensure that records for repositioning are maintained in accordance with best practice guidelines.	**Met**
	Action taken as confirmed during the inspection: Repositioning charts evidenced that patients were assisted to reposition regularly. An assessment of the patients' skin condition was recorded throughout the day. 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 for weeks commencing 18 and 25 June 2018 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff. Staff were employed to deliver activities.

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 the relative of one patient during the inspection; they were complimentary regarding staff. No completed questionnaires from relatives were received during or following the inspection.

Review of two staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. In one file there was evidence to support that gaps in employment had been explored and a comment recorded "explained." Following discussion it was agreed that some detail of the information discussed would be recorded in the future. Records evidenced that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work. A review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC. The record of the checks of care staff registration did not include the date that staff were due to pay the annual fee; failure to pay this fee would render the registration invalid. The administrator explained that they received anemail from the NISCC to alert them when a staff member's registration was due for renewal. As an additional safeguard the record was updated to include the expiry date prior to the conclusion of the inspection.

We discussed the provision of mandatory training with the registered manager and staff and reviewed staff training records. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training was delivered through face to face interactive sessions. Training records included the date the training was attended/completed, the names and signatures of those who attended and provided the registered manager with oversight of compliance. Records evidenced good compliance with mandatory training. The registered manager confirmed that systems were in place to ensure staff received annual appraisal and regular supervision.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

Review of four patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

We reviewed accidents/incidents records for the period April - June 2018 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 confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. From a review of records, observation of practices and discussion with the registered manager and staff there was evidence of proactive management of falls.

Discussion with the registered manager and a review of records evidenced that there were robust systems in place to manage restrictive practice. Records evidenced that appropriate risk assessments had been completed prior to the use of equipment, for example; bed rails, lap straps and alarm mats. Staff were knowledgeable regarding the use of lapstraps, the frequency with which they should be released and the records to be maintained. Observation of staff practice and a review of care records evidenced that lap strap were released frequently and supervision and assisted walks provided during this time. The registered manager completed a monthly audit to monitor the type of restrictive practice in use. Restrictive practice was well managed within the home and staffs' understanding was commended.

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

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control measures were adhered to. We observed that personal protective equipment, for example gloves and aprons, were available throughout the home. The outer covers on a number of bedrail covers, crash mats and specialised chairs were worn; this issue had been identified by the registered manager and operations manager prior to the inspection. A date had been arranged to complete an audit of equipment after which an action plan would be drawn up to repair or replace equipment as required. Progress with this will be reviewed at the next care inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, the management of restrictive practice, risk management, infection prevention and control 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.

Review of four patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of nutrition, patients' weight, management of falls and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

We discussed the monitoring of patients' weights and were informed that all patients were weighed a minimum of monthly. We reviewed the management of nutrition for one patient. The patient had been referred to the dietician and was reviewed regularly. A nutritional risk assessment was completed monthly; a care plan for nutritional management was in place. Food and fluid intake charts were maintained daily with fluid intake reconciled on a 24 hour basis.

We reviewed the management of falls for two patients. Falls risk assessments and care plans were completed and reviewed regularly. Care records for falls management were in place and were reviewed for each patient following a fall in accordance with good practice. Clinical observations were completed appropriately for suspected head injuries.

We reviewed the management of wound care for two patients. Care plans contained a description of the wound, location and the prescribed dressing regime. A review of care records evidenced that dressings were changed regularly and an assessment of the wound recorded at each dressing change. In one care file we noted that the frequency with which the dressings were to be renewed was increased for a short period by the Tissue Viability Nurse (TVN); staff had continued to redress the wound according to the original frequency. This was discussed with the registered manager and it was agreed that they would review how short term changes to prescribed regimes are communicated to staff to ensure they are implemented. This was identified as an area for improvement under the standards.

Where dressings were prescribed but the skin was intact the skin condition was evaluated throughout the day and records maintained to ensure early detection of any further damage; this is good practice. The settings on pressure relieving mattresses where checked and recorded daily.

Supplementary care charts, for example; food and fluid intake records and repositioning charts were completed daily. Records evidenced that patients were assisted to change their position for pressure relief in accordance with their care plans. Staff demonstrated an awareness of the importance of contemporaneous record keeping.

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.

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.

Areas of good practice

There were examples of good practice found throughout the inspection in relationto record keeping, the management of nutrition and falls and timely referrals to healthcare professionals.

Areas for improvement

An area for improvement was identifiedin relation to how short term changes to prescribed dressing regimes are communicated to staff to ensure they are implemented.

	Regulations	Standards
Total number of areas for improvement	**0**	**1**

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. The reception area of the home was bright and welcoming. Patients were relaxing in one of the lounges or quiet areas throughout the home 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. There was a calm atmosphere throughout the home and staff interactions with patients were observed to be caring and timely. We observed that patients were afforded choice, privacy and dignity during interactions and care interventions with staff.

Discussion with staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. We observed that a number of patients were engaged in doll therapy. In the foyer of the home information on doll therapy was displayed for visitors and relatives. The information explained the background to doll therapy and provided assurances that it was an evidences based initiative for people with dementia. Therapy dolls were provided for those patients who engaged with the therapy.

Patients said that they were generally happy living in the home. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were knowledgeable of patients non-verbal cues and what they were trying to communicate.

We observed the serving of the lunchtime meal. Patients were assisted to the dining room or had trays delivered to them as required. Staff were present in the dining room throughout the meal and were observed assisting patients with their meal as required. Gentle encouragement and regular reminders were provided by staff to encourage patients to finish their meal. The daily menu was displayed in pictorial and word format. Patients able to communicate indicated that they enjoyed their meal. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks and confirmed that choices were available at each meal.

The environment had been adapted to promote positive outcomes for the patients.Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example appropriate signage, photographs, the provision of clocks and prompts for the date. A number of black and white photographs of old scenes from Armagh and the local area were framed and displayed throughout the home. The photo frames included brief descriptions of where the photo was taken, name of the street, type of shop etc. The registered manager explained that this information provided prompts to reminisce with the patient and engage them in discussions.

A compliments book was available in the foyer of the home. Cards and letters of compliment and thanks were also displayed in the home. Some of the comments recorded included:

"What an improvement I have seen in …. over the month." (May 2018)

"First visit to the home–loved the caring atmosphere, made very welcome by staff, very happy that … is being well cared for." (June 2018)

"Thank you for the great care of our mother … and the friendship shown to her from each and everyone of you."

We spoke with the relative of one patient. They commented positively regarding the care their loved one was receiving and was confident that if they had any concerns they would be addressed by the registered manager and/or directors of the home.

Relative questionnaires were also provided. As previously discussed none were returned.

Staff were asked to complete an on line survey;we received no responses within the timescale specified.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relationtothe culture and ethos of the home and individualised care for patients.

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 reception area of the home. Discussion with registered manager and staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been a 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 patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required.It was obvious from the interactions observed between the registered manager and the patients that they were familiar with each other and that the registered manager knew the patients individually.Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The registered manager was knowledgeable regarding section 75 of The Northern Ireland Act1998. They explained that they are currently trying to source training for staff. The service did not collect any equality data on service users and the registered manager was advised of the role of the Equality Commission for Northern Ireland and that guidance on best practice in relation to collecting the data was available from them.

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 a number of audits were completed to assure the quality of care and services. Examples of audits completed monthly were accidents/incidents, the use of restrictive practice and care records. An action plan was developed for any areas of improvement and identified who was responsible for completing the improvements and by when. The registered manager re-audited the care records to ensure the required improvements had been made. We observed a copy of the most recent action plan was available in the nurses' office.

Discussion with theregistered manager and review of records evidenced that quality monitoring visits were completed on a monthly basisin accordance with Regulation 29 of The

Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated to address any areas for improvement and the progress on compliance with the areas for improvement commented on in the next report.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement 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

Areas for improvement identified during this inspection are detailed in the QIP. Details of theQIP were discussed withDaniel Dougan, registered manager and Sharon Loane, operations 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 standardsthis 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 improvementidentified 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 providershould confirm that these actions have been completed and return the completed QIPvia Web Portalfor assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance withthe Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
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. Ref: section 6.5
To be completed by: 25 July 2018	**Response by registered person detailing the actions taken:** Since the inspection, daily flash meetings are now convened between 11.00 - 11.30 am. These meetings provide an opportunity for management & registered nurses to be updated in regards to any changes in patients condition, care and treatment to include wound management.

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

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