Unannounced Care Inspection Report
31 May 2017

Hamilton Court

Type of service: Nursing Home
Address: 45 Hamiltonsbawn Road, Armagh, BT60 1HW
Tel no: 028 3752 8523
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Hamilton Court took place on 31 May 2017 from 10.30 to 16.50 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We reviewed the staffing arrangements; recruitment practices; staff registration status with their professional bodies; staff training and development and the environment. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Is care effective?

There was evidence of positive outcomes for patients. Staff understood their role, function and responsibilities. All staff consulted clearly demonstrated their ability to communicate effectively with patients, with their colleagues and with other healthcare professionals. The majority of care records reviewed were maintained to a satisfactory standard however, areas for improvement have been identified in relation to some aspects of care planning, the recording of repositioning and bowel management records and monitoring of same.

Is care compassionate?

The interpersonal contact between staff and patients was observed to be compassionate and caring. Patients were afforded choice, privacy, dignity and respect. Patients, representatives and members of staff spoken with confirmed that patients were listened to, valued and communicated with in an appropriate manner. 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. Activities offered are meaningful to the patients and are recognised by all staff as an integral part of the care process.

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Relationships between staff and management were positive and staff views were considered in the running of the home. Systems were in place to monitor, audit and review the quality of nursing and other services provided withn the nursing home.

The term 'patients' is used to describe those living in Hamilton Court which provides both nursing and residential care.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mary McKee, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 11 May 2017. No requirements or recommendations were made at this inspection. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.
There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: EBBAY Limited Patrick McAvoy	**Registered manager:** Mary McKee
Person in charge of the home at the time of inspection: Mary McKee	**Date manager registered:** 5 July 2016
Categories of care: NH-DE, RC-DE A maximum of 4 residents in RC-DE category. The home is also approved to provide care on a day basis to 2 persons.	**Number of registered places:** 35

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report
- pre-inspection assessment audit

During the inspection we met with nine patients individually and with others in small groups; two registered nurses, four care staff, ancillary staff and one relative. Questionnaires for patients, staff and relatives were left in the home for completion and return to RQIA.

The following information was examined during the inspection:

- duty rota for all staff from 22 May to 4 June 2017
- 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
- three patient care records
- supplementary care charts for example; food and fluid intake charts and reposition charts
- consultation with patients, relatives and staff
- staff supervision and appraisal planners
- a selection of governance audits
- complaints record
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 May 2017

The most recent inspection of the home was an unannounced medicines management inspection. No QIP resulted from this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 22 September 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 4 **Criteria** (1) (7) **Stated:** Second time	It is recommended that continence and bowel assessments and care plans are fully completed to include all aspects of continence management for example, specific continence products required**,** normal bowel pattern and type, stoma products required.	**Met**
	Action taken as confirmed during the inspection: A review of three patients care records evidenced that continence and bowel risks assessments were completed. Risk assessment outcomes were reflected within care plans. The care plans included information as outlined above. This recommendation was met.	

Recommendation 2 **Ref:** Standard 22.9 **Stated:** Second time	It is recommended that a post falls review is carried out within 24 hours of a patient sustaining a fall to determine the reason for falling and any preventative action to be taken. This is in addition to existing mechanisms to record incidents within the home. The risk assessments and care plans are amended accordingly.	**Met**
	Action taken as confirmed during the inspection: A review of accident and incident records evidenced that in the majority falls risk assessments had been reviewed and updated accordingly. Care plans were also reviewed and evaluated.	
Recommendation 3 **Ref:** Standard 39 Criteria 1 **Stated:** First time	The registered provider should ensure that all newly appointed staff are complete a structured orientation and induction and records are retained.	**Met**
	Action taken as confirmed during the inspection: A review of induction records for two staff members evidenced that inductions had been completed and/or underway. Records were signed by the employee and the person assisting with the induction process.	
Recommendation 4 **Ref:** Standard 4 Criteria 1 **Stated:** First time	The registered provider should ensure that the assessment process is commenced on the day of admission based on the pre-admission assessment and referral information received from the commissioning Trust. The assessment and care planning process should be completed within five days of admission to the home	**Met**
	Action taken as confirmed during the inspection: A review of one patient care record evidenced that risk assessments and care plans had commenced at the time of admission and the process was completed within five days of admission to the home.	

4.3 Is care safe?

The registered nurse 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 22 May to 4 June 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed the hours worked by catering; housekeeping and activities 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 staffing levels met the assessed needs of the patients. We also sought opinions from staff, patients and relatives on staffing via questionnaires; three staff and one relative returned their questionnaires within the timeframe specified. Responses indicated that they were either 'very satisfied' or 'satisfied'. No concerns were raised.

Patients and one relative spoken with during the inspection commented positively regarding the staff and the care delivered. Patients who had the ability to verbalise their views indicated that they were satisfied that when they required assistance staff attended to them in a timely manner. Comments made by one relative spoken with were complimentary regarding nursing and care staff.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained; and that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff spoken with confirmed that the induction programme was appropriate to their role and responsibilities. A recommendation made at a previous inspection pertaining to records for induction was met.

A review of records confirmed that the registered manager had a system and process in place to monitor the registration status of registered nurses with the NMC and care staff registration with NISCC. There was evidence that actions had been taken in instances were care staff had not registered or renewed their registration.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2016/2017. Records were maintained in accordance with Standard 39 of the Nursing Homes Care Standards. Mandatory training compliance was monitored by the registered manager. Additional training was also provided for staff to ensure they were able to meet the assessed needs of patients. Additional training sessions were scheduled for June 2017 to ensure that all staff had achieved their mandatory training requirements.

Observation of the delivery of care evidenced that training had been embedded into practice. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Discussion with the registered manager, confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedures into practice. The home had identified an adult safeguarding champion who would attend training to ensure that they had the necessary knowledge to fulfil their role and responsibilities in regards to same.

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process and that these assessments informed the care planning process.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

A review of the home's environment was undertaken and included observations of a number of bedrooms, bathrooms, lounges, the dining room and storage areas. The home was found to be warm, well decorated and fresh smelling throughout. A variation was received by RQIA, January 2017, to increase the occupancy of the home. At the time of the inspection, works were being carried out accordingly. The responsible individual advised that the works were due to be completed in the near future. Upon completion, RQIA will undertake a pre-registration inspection to approve the registration of the additional bedrooms and other changes made to the environment of the home.

Fire exits and corridors were observed to be clear of clutter and obstruction. Risk assessments had been updated to reflect the building works underway in the home. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Care records accurately reflected the assessed needs of patients were kept under review and in the majority reflected recommendations prescribed by other healthcare professionals such as Tissue Viability Nurse Specialist (TVN), Speech and Language Therapist (SALT) or Dieticians. However, one patient's care plan for the management of food and fluids did not include recommendations made during a review carried out by the Speech and Language Therapist (SALT). Discussion with staff confirmed that the patient was receiving the appropriate care and treatment. The registered manager took immediate actions and the care plan was updated accordingly. A recommendation has been made to ensure that care plans are kept updated to reflect patients' needs to ensure the delivery of safe, effective care.

We reviewed the management of wound and pressure area care for one identified patient. A care plan was available and reflected the regime of care and primary treatment required. Wound assessments records were maintained to a satisfactory standard and evidenced that the care delivered was consistent with the care plan in place. The schedule for repositioning was not included in the plan of care and a review of repositioning records identified that these were not completed in accordance with best practice guidelines. For example; the terminology used in regards to comments on the condition of the patient's skin did not always reflect this; for example some comments included: 'pad changed.' The use of this terminology was discussed with staff who recognised that this was not appropriate recording. A recommendation has been made.

Supplementary care charts such as food and fluid intake records and bowel management records were reviewed. Food and fluid intake records in the majority were maintained in accordance with best practice guidance, care standards and legislative requirements.

However, a shortfall was identified in records pertaining to bowel management for one wing of the home. Records were not completed accurately and some gaps were noted. However, a review of daily progress notes evidenced that on some occasions entries had been made indicating that the patient had a bowel movement although this was not consistent. There was limited evidence to demonstrate that registered nurses were monitoring this area of practice. This was discussed with the registered manager who gave assurances that immediate actions would be taken to address this issue both with nursing and care staff. A recommendation has also been made to develop a system to ensure effective monitoring of this area of care and that appropriate actions are taken as deemed necessary.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Discussion with the registered manager and staff confirmed that staff meetings were held and records were maintained of the staff who attended, the issues discussed and actions agreed. A notice for meetings to be held in June 2017 across various staff teams was displayed.

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 their line manager and /or the registered manager. It was evident from staff interactions that there were good relationships among all grades of staff

Areas for improvement

Areas for improvement have been identified in relation to care planning, the recording of repositioning and bowel management records and monitoring of same.

Number of requirements	0	**Number of recommendations**	3

4.5 Is care compassionate?

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

Patients able to communicate their feelings indicated that they enjoyed living in Hamilton Court. 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. The standard of personal care afforded to patients was completed to a satisfactory standard; some male patients could have been shaven to a higher standard however records evidenced the rationale for same. Some female patients observed had their clothing accessorised with scarfs and jewellery and had been to the hairdresser within the home and expressed they enjoyed getting their hair attended to.

Discussion with patients and staff; a review of the activity programme and observations of activities held evidenced that these were varied and appropriate to the needs of the patients living in the home. A dedicated member of staff is employed to co-ordinate and delivers activities. It was very evident from discussion and observation that they understood how to deliver meaningful, appropriate and enjoyable activities and events for patients and demonstrate this understanding in their interactions with them. This is commended.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Annual survey questionnaires had been issued March 2017; however the report had not yet been compiled due to operational reasons. A review of some of the questionnaires returned indicated that responses were very positive regarding the care, staff, management and the environment.

One written comment included:
"Excellent staff who genuinely care, they are the backbone of the home."

As stated previously, questionnaires were issued to patients, their relatives and staff. Three staff and one relative returned their questionnaires within the timescale specified for inclusion in the report.

The three staff members responded that they were either 'very satisfied'/'satisfied' with the care provided across all four domains and that the service was well led.

The relative who responded was very satisfied with the care provided and the management of the home. There were no additional comments recorded.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered.

Discussion with the registered manager and 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. Compliments cards were displayed in the home and included positive written comments about the standard of care, the compassionate and caring attitude of staff and management and kindness and support offered to family relatives.

Review of records evidenced that monthly quality audits were completed to ensure the quality of care and services was maintained. For example, audits were completed for accidents/incidents, infection prevention and control and care records. The records of audit evidenced that any identified areas for improvement had been addressed and checked for compliance. There was evidence that actions which had been taken by management in relation to one identified area of practice resulted in positive outcomes for care delivered in this regard.

Discussion with the registered manager and reviews of records evidenced that Regulation 29 monitoring monthly visits were completed in accordance with the regulations and/or standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, and staff and Trust representatives.
A review of notifications of incidents/accidents submitted to RQIA since the last inspection confirmed that these were managed appropriately.

Discussion with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. As previously discussed, responses received in returned questionnaires indicated that the home was 'well-led'.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to RQIA's office for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 31 July 2017	The registered provider should ensure that care plans are kept updated to reflect patients' needs to ensure the delivery of safe and effective care. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** All Care files are currently being audited by Care Home Manager and Clinical lead with achievable timescales for action plans. Guidance will be afforded to ensure care plans are person specific.
Recommendation 2 **Ref:** Standard 21 **Stated:** First time **To be completed by:** 31 July 2017	The registered provider should ensure that the system for recording and monitoring patients' bowel care is robust to ensure safe effective care. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** All Registered Nurses are monitoring Residents bowel care daily to ensure care and comfort are achieved. Details of bowel activity are recorded in care plan evaluations.
Recommendation 3 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 31 July 2017	The registered provider should ensure that records for repositioning are maintained in accordance with best practice guidelines. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** All Registered Nurses check and countersign repositioning charts daily to ensure best practice. Guidance given to Care Assistants re appropriate content to record.

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