Unannounced Care Inspection Report
13 June 2017

Copperfields

Type of service: Nursing Home
Address: 1 – 3 Moore Street, Aughnacloy, BT69 6AX
Tel no: 028 8555 7922
Inspector: Sharon Loane

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 and residential care for up to 32 persons.

3.0 Service details

Organisation/Registered Provider: Edwards Enterprises N.I. Ltd **Responsible Individual(s):** Mr William Henry Hume Edwards	**Registered Manager:** Cherith McKeown
Person in charge at the time of inspection: Cherith McKeown	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. LD – Learning disability. LD (E) – Learning disability – over 65 years. Residential Care (RC) I – Old age not falling within any other category.	**Number of registered places:** 32 comprising: 8 – NH-DE 2 – NH-LD/LD(E) 1 – Day care

4.0 Inspection summary

An unannounced inspection took place on 13 June 2017 from 10.30 to 14.30 hours.

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 'patients' is used to describe those living in the home which provides both nursing and residential care.

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.

There were good examples of practice found throughout the inspection in relation to staff recruitment; induction, training, adult safeguarding, risk management processes; the completion of risk assessments and care plans; wound management; repositioning and fluid intake monitoring and communication between patients, staff and other key stakeholders. There was also evidence of good governance and management systems.

No areas of improvement were identified at this inspection.

Patients said that they were satisfied with the care and services provided and described living in the home, in positive terms.

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 Cherith Mc Keown, 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

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 19 December 2016. No further actions were required to be taken following 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
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.
- pre inspection assessment audit

During the inspection the inspector met with nine patients individually, three care staff, three registered nurses and one patient's representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- staffing arrangements in the home
- two staff recruitment and induction files
- staff induction, supervision and appraisal records
- 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
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- annual quality report
- sample of quality monitoring audits
- records of staff, patient and relatives meetings

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.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 19 December 2016

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 2 June 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 39 **Stated:** First time	A system should be developed to monitor the registration status of care staff with the Northern Ireland Social Care Council (NISCC).	**Met**
	Action taken as confirmed during the inspection: A record was available and maintained appropriately to monitor the registration status of care staff with the Northern Ireland Social Care Council (NISCC). All care staff on the duty rota were either registered or registration was pending.	
Area for improvement 2 **Ref:** Standard 35 Criteria 16 **Stated:** First time	The registered person should implement a more systematic approach to monitor and report on the quality of nursing and other services provided.	**Met**
	Action taken as confirmed during the inspection: A suite of quality audits were in place to monitor the quality of nursing care and other services provided in the home. There was evidence that these were completed regularly and any shortfalls identified were included in an action plan. These included; care planning; falls, accidents and incident; infection control and environmental.	

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 rotas for week commencing 12 June 2017 evidenced that the planned staffing levels were adhered to. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. The registered manager advised that currently the home had no staff vacancies and no agency staff is used.

Discussion with the registered manager and a review of two personnel files evidenced that 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.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Two completed induction records were reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction process, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The registered manager also signed induction records to ensure that all areas of the induction process had been satisfactorily completed. Induction records were completed for staff that held more than one position in the home. A record was also maintained of all information provided to staff at the commencement of their employment, this included; a job description, sample policies among others. This is good practice.

Discussion with staff and a review of training records confirmed that training had been provided in all mandatory areas and records were kept up to date. Training was provided via 'face to face' by both internal and external providers. The records reviewed confirmed that the majority of staff had completed their mandatory training. A discussion with staff confirmed that failure to complete training resulted in actions being taken.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified and the relevant training had been planned for the near future.

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.

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.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last inspection confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patient's bedrooms were personalised with photographs, pictures and personal items. Since the last inspection, a number of improvements had been made to the home both internally and externally which have enhanced the home. Patients/representatives/staff spoken with were complimentary in respect of the home's environment and the improvements made.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas of good practice

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

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 were a number of examples of good practice found throughout the inspection in this domain. For example; risk assessments and care plans were commenced on the day of admission and completed within five days of admission to the home. Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. 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.

Supplementary care charts such as repositioning/food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislation.

A review of wound care records evidenced that wound care was managed in line with best practice. A review of the records of one patient evidenced that the dressing had been changed according to the care plan. Records were maintained to demonstrate care delivery and the effectiveness of same.

There was also good practice identified in relation to the management of diabetes. A review of one patient's records evidenced that a care plan was in place to direct care in this regard and included the signs and symptoms of hypoglycaemia and hyperglycaemia. There was evidence that the care plan had been updated to reflect any alterations made to the prescribed insulin regime. Blood sugar monitoring records evidenced that these were appropriately and being monitored in accordance with the care plan.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Discussions held at the handover provided the necessary information regarding any changes in patient's condition.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained. The most recent staff meeting was held on 1 May 2017. Staff stated that there was effective teamwork; each staff member knew there role, function and responsibilities.

All those consulted with confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager. A patients meeting had been held on 2 February 2017 and records were available.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, audits and reviews, communication between residents, staff and other key stakeholders.

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.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. 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 demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Patients able to communicate their feelings indicated that they enjoyed living in Copperfields Nursing home and that staff were caring and attentive.

Comments included:
"Excellent home, excellent staff."
"Care is very good, staff are friendly and would feel happy about approaching management we see Mrs Mc Keown every day."

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.

Review of letters and cards received by the home indicated the thoughts and feelings of relatives as follows:
"We would like to express our sincere thanks to you all for your kindness and warmth."
"Nowhere like it, staff is constant."

One relative spoken with at the time of the inspection commended the management and staff for the care and compassion shown to them and their relative. The relative advised that the registered manager spent time with their loved one talking and listening to them on a daily basis and did special things which meant "they were not lost in their illness but kept alive." This is commended.

As previously discussed questionnaires were issued to patients, relatives and staff. Five staff, six patients and five relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

The responses received from patients were either "very satisfied " or "satisfied" that the care provided was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Similarly the responses received from relatives were positive. The well-led domain included the question "Do you know the Manager" and one of the respondents included a written comment as follows; "see her all the time".

All responses received from staff indicated that they were “very satisfied” across all four domains. No additional comments were made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of 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 registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager and review of records and observations evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. As previously discussed staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

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 evidenced that the registered manager’s working patterns supported effective engagement with patients, their representatives and the multi-professional team.

Discussion with the registered manager and review of the home’s complaints record evidenced that no complaints were received since the last inspection. The registered manager was knowledgeable in regards to Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Patients and representatives spoken with confirmed that they were aware of the home’s complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager/person was. This was evidenced throughout the inspection.

Discussion with the registered manager and 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 falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been embedded into practice.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately.

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

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

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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