Unannounced Care Inspection Report
2 July 2018

Meadows

Type of Service: Nursing Home (NH)
Address: 15 Newline Road, Richhill, Armagh, BT61 9QR
Tel No: 02838870005
Inspector: Kieran Murray

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 46 persons.

3.0 Service details

Organisation/Registered Provider: Armagh Care Services **Responsible Individual:** Daniel McHugh	**Registered Manager:** Daniel McHugh
Person in charge at the time of inspection: Daniel McHugh	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of registered places:** 46 The 15 persons accommodated in the bungalows at Ross Court must be assessed as nursing patients who are assessed as low to medium dependency on the Rhys Heron dependency scale. Category RC-LD for 3 named individuals only.

4.0 Inspection summary

An unannounced inspection took place on 2 July 2018 from 09.30 to 17.00 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 ‘patient’ is used to describe those living in the Meadows 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.

Evidence of good practice was found in relation to staff recruitment, induction and training, supervision and appraisal, care reviews, record keeping, good communication between patients, staff and other stakeholders, management of complaints, incidents/accidents and maintaining good working relationships.

No areas requiring improvement were identified during the inspection.

Patients said they felt safe in the home and 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 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 McHugh, 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 7 December 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 7 December 2017. There were no further actions required to be taken following the most recent 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 previous care inspection report

During the inspection we met with 15 patients and five staff. No trust professionals were visiting during the time of inspection. Following the inspection the inspector made contact with one service users' representative. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was provided which directed staff to an online survey and staff not on duty during the inspection.

The inspector requested that the registered manager place a 'Have we missed you?' card in a prominent position in the home to allow service users, relatives and families who were not available on the day of the inspection to give feedback to RQIA regarding the quality of service provision. No responses were received prior to the issue of the report.

The following records were examined during the inspection:

- duty rota for all staff from 2 July 2018 to 15 July 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- four staff training records
- incident and accident records
- two staff recruitment and induction files
- four patient care records
- one patient care charts including food and fluid intake charts
- a sample of governance audits
- patient register
- complaints record
- compliments received
- 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.

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 7 December 2017

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 30 November 2017

There were no areas for improvement identified as a result of the last care inspection.

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 week commencing 2 to15 July 2018 evidenced that the planned staffing levels were adhered to. In the absence of the registered manager the deputy manager or a registered nurse was designated as the person in charge of the home. The registered manager advised that should shortfalls in staffing levels arise then these would be covered by the home's staff. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Discussion with staff evidenced that there were no concerns regarding staffing levels. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of patients and to support the nursing and care staff.

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Meadows. We also sought the opinion of patients on staffing via questionnaires. No questionnaires were returned prior to issue of report.

One relative spoken with did not raise any concerns regarding staff or staffing levels. We also sought relatives' opinion on staffing via questionnaires. Two questionnaires were returned and both relatives indicated that they were very satisfied that staff had 'enough time to care'.

Staff spoken with were satisfied that there were sufficient staff to meet their needs. We also sought staff opinion on staffing via questionnaires; three responses were received in time for inclusion in the report. All three members of staff were very satisfied with the staffing.

Staff commented:

"The rota is fair."
"The manager is very accommodating."

A nurse was identified to take charge of the home when the registered manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. The assessments had been signed by management to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home. The inspector evidenced that these assessments were reviewed annually.

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. Staff were mentored by an experienced member of staff during their induction. Recruitment records for two staff were reviewed and found to be well maintained and in keeping with The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 21, schedule 2. Records confirmed that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work.

The inspector noted that rotas highlighted new staff who were still undergoing induction and were supernumerary.

Discussion with the registered manager and review of written 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). There were systems and processes in place to ensure that alerts issued by Chief Nursing Officer (CNO) were managed appropriately and shared with key staff.

As stated previously, 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.

One staff member commented on a questionnaire:

'All the residents in the Meadows are happy, busy and content.'

We discussed the provision of mandatory training with staff and reviewed staff training records for four staff. 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 records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients. There was evidence that staff have attended additional training e.g. Palliative Care and Breaking Bad News, Incontinence, OCD/Mental Health and Anaphylaxis training, in order to meet the needs of patients.

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 and staff 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. On the day of the inspection the inspector noted that the home had made one safeguarding referrals to the trust since the last inspection 30 November 2017. The referral was made appropriately and management plans were made in conjunction with the HSC Trust as evidenced by the inspector.

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.

On the day of the inspection it was noted that there were a number of restrictive practices in place. It was noted that they were of the least restrictive nature and considered necessary in conjunction with the patient, HSC Trust, service user representatives and the staff; they were reviewed yearly.

We reviewed accidents/incidents records from the previous inspection 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.

Discussion with the registered manager and 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. Following this review an action plan was devised to address any identified deficits. This information was also reviewed as part of the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

From a review of records, observation of practices and discussion with the nurse in charge/registered manager and staff there was evidence of proactive management of falls.

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. Patients, representatives and staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Observation of practices/care delivery, discussion with staff and review of records evidenced that infection prevention and control measures/best practice guidance were consistently adhered to.

The inspector evidenced staff carrying out good handwashing techniques between patients.

The manager had an awareness of the importance of monitoring the incidents of HCAI's and/or when antibiotics were prescribed.

The registered manager provided the inspector with a register of all staff employed in the home.

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, infection prevention and control, risk management, restrictive practice 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.

A 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. The home continued to have a number of patients admitted for regular respite. Generally the assessments and risk assessments were reviewed on admission and updated to reflect any change.

We reviewed the management of nutrition. 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.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), speech and language therapist (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 speech and language therapist (SALT) or the dietician changed.

The inspector examined the management of enteral feeding for one patient. The dietetic reports which detailed the prescribed nutritional regime were readily available in the patient's care records. Fluid balance charts were maintained. A review of the dietician's report and the completed fluid balance intake charts evidenced that the prescribed regime was adhered to. Care plans were in place for the management of enteral feeding. The inspector spoke to the patient's family who were up to date with the patient's current enteral feeding regime.

The inspector was informed that care and support plans are reviewed on a monthly basis or sooner if required. These records evidenced that the home carries out reviews with patients if changes to their needs are identified. The inspector examined annual reviews in place and the records were satisfactory. The home maintains daily progress notes for each patient.

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.

Examination of documentation and discussion with staff indicated that the home promotes good working relationships with a range of appropriate professionals when relevant.

It was evident that the home maintains a range of methods to communicate with and record the comments of patients, including through routinely speaking with patients on a daily basis and being available for discussion. In the course of the inspection it was noted that patients freely approached staff as they wished and appeared to enjoy good relationships with staff.

Discussion with the registered manager and a review of records confirmed that staff meetings were held on a regular basis and 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.

Discussion with the registered manager and review of records evidenced that patient meetings were held on a monthly basis. Records reviewed evidenced the list of patients who attended, the discussions held and actions agreed. Outcomes of agreed actions were recorded in a consistent and meaningful manner.

A review of records evidenced that relative meetings were held annually. The inspector noted the time and date of the meeting i.e. 8 May 2018 on the noticeboard. The registered manager advised the inspector that a copy of the minutes was sent to all relatives.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

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.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patient's admission was held in a patient register. This register provided an accurate overview of the number of patients residing in the home on the day of the inspection.

The inspector evidenced and viewed the annual report 2017/2018 and found it to be satisfactory.

One staff commented via the on-line survey:

'There are lots of activity opportunities and day care for them to choose from.'

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, annual report, reviews and 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.

We arrived in the home at 09.30 hours and were greeted by staff who were helpful and attentive. Patients were enjoying their breakfast or a morning cup of tea/coffee in the dining room, 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. Patients had access to fresh water and/or juice and staff were observed assisting patients to enjoy their chosen activity and to eat and drink as required. A group of 22 patients, supported by staff, had already been for their daily walk around the local forest park.

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. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Patients who wished to meet the inspector were provided with privacy as appropriate.

The inspector noted that patients are encouraged to develop their independence inside and outside of the homes. On the day of inspection the inspector observed 18 patients preparing to go on a boat trip supported by staff.

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.

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 observed assisting patients with their meal appropriately and a registered nurse was overseeing the mealtime. Patients able to communicate indicated that they enjoyed their meal. The inspector noted the menu choice on the noticeboard and patients were asked which choice they wanted for their 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.

Cards and letters of compliment and thanks were displayed in the home.

The inspector reviewed the home's patient questionnaires (February 2018) and found them to be satisfactory. It was noted 26 had been completed and returned.

The inspector reviewed the home's relative's questionnaires (April 2018) and found them to be very positive. Some of the comments recorded:

'Staff are always very professional and take time to hear my voice.'
'Satisfied with yearly reviews and summary relating to them, 10 out of 10.'

There were systems in place to obtain the views of patients and their representatives on the running of the home.

Consultation with three patients individually, and with others in smaller groups, confirmed that living in Meadows was a positive experience.

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.

Ten relative questionnaires were provided; two were returned within the timescale. Both indicated that they were very satisfied with the care provided across the four domains. Additional comments were recorded as follows:

Representative's comments:

'Everything about the Meadows is carried out so well that it gives me such a real sense of assurance that XXXX is so well cared for. Thank you.'

Staff were asked to complete an on line survey, we had three responses within the timescale specified. Staff members were very satisfied with the care provided across the four domains. An additional comment was recorded as follows:

'Staff are treated well and the manager is very compassionate when required.'

Any comments from patients, 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.

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 certificate of registration issued by RQIA was appropriately displayed in the foyer of the home.

Discussion with staff, and observations confirmed that the home was operating within the categories of care registered. The inspector reviewed the home's Statement of Purpose (2017) and Patient Guide (2017) and found them to be satisfactory.

Since the last inspection there has been no change in management arrangements. Discussion with staff, patients and their representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

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 equality data collected was managed in line with best practice.

Discussion with the 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. The inspector noted that the home had not received any complaints since the last inspection on 30 November 2017.

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. For example, audits were completed regarding accidents/incidents and care records.

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

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

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Staff comments received via on-line responses:

'The manager is very approachable.'
'Pay rates and conditions are excellent.'

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.

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