The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
03 October 2016

Meadows

Type of Service: Nursing Home
Address: 15 Newline Road, Richill, Armagh, BT61 9QR
Tel No: 028 3887 0005
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Meadows took place on 03 October 2016 from 10.30 to 14.30 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?

There was evidence of positive outcomes for patients who were being assisted and responded to in a timely manner. The home was found to be warm, fresh smelling throughout. Staff clearly demonstrated the knowledge, skills and experience necessary to fulfil their roles and responsibilities. There was evidence of a structured orientation and induction for newly appointed staff and there were systems in place to monitor staff performance or to ensure that staff received support and guidance. The majority of staff had completed training in all mandatory areas. Staffing levels were subject to regular review to ensure that the assessed needs of the patients were met.

Is care effective?

A review of care records evidenced that patients' needs were assessed on admission and were reviewed as required. The assessments were used to inform the care planning process. Care plans were very person-centred and demonstrated an excellent understanding of the patients' needs. This is to be commended. The care planning process included input from patients and/or their representatives, as appropriate. Staff stated that there was excellent teamwork in the home; each staff member knew their roles and responsibilities. Staff meetings were held on a regular basis and records were maintained. Patients expressed their confidence in raising concerns with the home's staff/management.

Is care compassionate?

Staff interactions with patients were observed to be particularly compassionate, caring and timely and examples are given within the report. Patients were afforded choice, privacy, dignity and respect. Patients appeared content and relaxed in their environment. There was good provision of activities and management and staff ensured that patients were frequently able to attend external activities in regards to their personal interests. Discussion with staff and patients evidenced that staff cared for the patients in a kind, caring and thoughtful manner.

Is the service well led?

There was a clear organisational structure within the home and evidence that the home was operating within the categories of care for which the home was registered. All comments received in regards to the responsiveness of the registered manger were very positive. The registered manager was very visible in the home at the time of inspection and demonstrated a great knowledge of the patients' needs holistically. Patients were observed interacting with the registered manager and approaching him to advise of their plans for the day and/or make special requests. Monthly monitoring visits, in respect of Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 were completed as required.

The term ‘patients’ is used to describe those living in the Meadows 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	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Daniel McHugh, 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 care inspection undertaken on 10 November 2015. 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: Armagh Care Services/Mr Daniel McHugh & Mrs Pamela Halliday	**Registered manager:** Mr Daniel McHugh
Person in charge of the home at the time of inspection: Mr Daniel McHugh	**Date manager registered:** 01 April 2005
Categories of care: RC-LD, RC-LD(E), NH-LD, NH-LD(E) The 15 persons accommodated in the bungalows at ROAA Court must be assessed as nursing patients who are assessed as low to medium dependency on the RHYS Heron dependency scale. There shall be a maximum of 3 residents accommodated in the residential unit	**Number of registered places:** 46

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication since the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with 12 patients individually and greeted the majority of others in smaller groups, three registered nurses, two care staff, the maintenance operative and a group of ancillary staff. No patient representatives were visiting during the time of inspection.

The following information was examined during the inspection:

- three patient care records
- staff duty rota from 26 September to the 9 October 2016
- staff training records
- staff recruitment records including staff induction
- complaints
- incident and accident records
- sample of quality audits
- records of meetings; staff, patient and patient representatives
- reports of monthly monitoring visits 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 10 November 2015

The most recent inspection of the home was an unannounced care inspection.

There were no issues required to be followed up during this inspection as no QIP resulted from this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 10 November 2015

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

The registered manager confirmed the number of patients accommodated on the day of inspection and the planned daily staffing levels for the home. They advised 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 26 September and 3 October 2016 evidenced that the planned staffing levels were adhered to. The registered manager's hours of work were identified in the rota and the person in charge of the home was also identified. Staff spoken with were very satisfied that there were sufficient staff to meet the needs of the patients. Patients commented positively regarding the staff and care delivered.

Discussion with the registered manager and a registered nurse and a review of records evidenced that the arrangements for monitoring the registration of nursing and care staff were appropriately managed. A review of records confirmed that all registered nurses were on the current live NMC register. The majority of care staff were registered with the Northern Ireland Social Care Council (NISCC) or registration was pending for care staff recently recruited.

A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 2, schedule 2. The records maintained of Access NI checks was reviewed and evidenced that the registered manager had checked the certificate prior to the candidate commencing employment.

A discussion with staff confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction record was reviewed. The programme of induction included a written record of the areas completed and the signature of the staff member and the person mentoring the new employee. The registered manager also signed the induction record to confirm that the induction process had been satisfactorily completed.

A discussion with staff confirmed that training was delivered via “face to face”. A system was in place to monitor staff attendance and compliance with training. These systems included a matrix of all staff employed and the training that they had completed in regards to mandatory training requirements and also additional topics relevant to their category of care and needs of the patients living in the Meadows. A review of the matrix evidenced that good compliance was achieved for mandatory training for the year to date. There was also notices displayed for upcoming training and the names of staff required to attend were listed.

Staff spoken with advised that they received supervision every three months or more frequent if required and also an annual appraisal. These records were not reviewed as part of the inspection.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Contact details of the adult safeguarding teams for the local healthcare trust were available for staff to reference. A review of information evidenced that this area of practice was managed in accordance with the regional safeguarding protocols and the home’s policies and procedures. RQIA were notified appropriately.

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. Although some shortfalls were identified and are discussed further in section 4.4.

Discussion with the registered manager and a review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random sample of accidents and incidents recorded since the previous care inspection evidenced that these had been appropriately notified to RQIA in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager also completed a monthly analysis of falls to identify any trends or patterns.

A general inspection of the home’s environment was undertaken to examine a random sample of patients’ bedrooms, bathrooms, lounges, dining rooms and storage areas. The majority of patients’ bedrooms were personalised with photographs, pictures and items of personal interest. The home was found to be warm, fresh smelling and clean throughout. A programme of refurbishment was in progress and a number of improvements had been made since the last care inspection to meet the needs of the patients and enhance their comfort. These included but not limited to; improvements to the structure of the conservatory area to enable its use throughout all the seasons, replacement flooring in corridors, bedrooms and bathroom areas and redecoration throughout the homes environment. During the time of inspection, work was being undertaken in this regard. The home is commended for the improvements made and patients expressed their satisfaction with the improvements.

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 for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

A review of three patient care records evidenced that initial plans of care were based on the pre-admission assessment and referral information received by the commissioning Trust. A range of validated assessments were completed as part of the admission process and reviewed as required. Whilst these were in place some shortfalls were identified as follows.

A review of one care record evidenced that although some assessments and care plans had been commenced on the day of admission there were some identified, that had not been completed for up to and including 10 days after admission to the home. A recommendation has been made.

A second care review identified that a care plan had not been updated or developed in regards to changes in the patient's mobility and in addition the manual handling assessment had also not been reviewed. A falls risk assessment had also not been reviewed following an incident in which the patient had sustained injury. This was discussed with the registered manager and registered staff who acknowledged the shortfalls identified. A recommendation has been made.

Some care plans reviewed had not been formally re-written since 2013 as there had been no change in the patients' needs and the care plan in place was still appropriate. There was no evidence to indicate that the registered nurse had reviewed the care plan to ensure that the interventions included remained appropriate. Following discussion, staff agreed that going forward an entry would be recorded to validate that the care plan had been reviewed and continued to be adequate to meet the patients assessed needs.

Whilst there were shortfalls identified in some areas care plans in relation to behaviours which challenge were detailed and included identified triggers and appropriate responses the staff should take in order to alleviate the patients' distress. Care plans were very person-centred and evidenced a good understanding of the patients' needs. The level of person-centred detail within the care plans is to be commended.

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.

There was also evidence within care records reviewed that registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and Language Therapist (SALT) and the dietician.

Discussion with staff and a review of the duty rota evidenced that registered nurses were required to attend a handover meeting at the beginning of each shift. Information was then shared with care staff accordingly. Staff advised that this arrangement ensured effective communication.

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 and communication across all staff teams. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager and that all concerns were dealt with in an efficient and effective manner.

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 bi-annually. A letter of invite was issued to all relatives pre-meeting which included an agenda. Records of the meeting were maintained and any suggestions and outcomes recorded. Following the meeting a letter was again issued to all relatives to advise of the discussion and agreed actions. This is good practice.

Areas for improvement

Two recommendations have been made in regards to the standard for individualised care and support as per the DHSSP'S Care Standards for Nursing Homes, 2015.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

Throughout the inspection, observations and interactions between management, staff and patients evidenced that the culture of the home was based on quality relation-ship-centred care that nurtures the wellbeing of the patients, enabling them to feel valued and promotes and supports their engagement and participation in the running of the home and decisions about their daily lives. The opportunities that are made available and the routines of daily living are flexible and varied to suit patients' preferences and capabilities.

Patients are able to maintain contact with their families and friends and the social community. Staff supports patients to maintain friendships and socialise within the home. Discussion with staff and patients also confirmed that patients are afforded numerous opportunities to attend external activities.

Staff members were available to drive the home's minibus. This meant that patients could be brought out daily. A number of patients accompanied by staff go the local forest park for a daily morning walk. Patients expressed their enjoyment of same and staff advised that this activity was also of therapeutic value for the patients and themselves. Discussions and a review of pictures evidenced that patients had experienced holidays to Scotland, Manchester and Portrush to mention a few. The home had also its own boat and there were a number of pictures displayed of boat trips at Oxford Island. It was very evident from discussion and patients expressions that they enjoyed and benefited from such activities. The registered nurse in charge also advised that the home host an annual pantomime in which the patients are all involved. Plans were in place to commence practices for this year's pantomime "Scrooge". The management and staff are to be commended for enabling and providing opportunities for patients to live a full life in a supportive and homely environment.

Patients' bedrooms were observed to personalised, with pictures of family members and friends.

There were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

As part of the inspection process, questionnaires were provided by RQIA to the registered nurse in charge for distribution to include; five patient and ten staff and patient representatives. At time of issuing this report, five patients, five staff and three relatives returned their questionnaires within the specified timeframe. All comments on the returned questionnaires were positive.

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 staff evidenced that there was a clear organisational structure within the home. 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.

The complaints procedure was displayed in the home and a review of the record of complaints evidenced that there had been no complaints recorded in a significant period of time. A discussion with staff indicated that they were knowledgeable in what constituted a complaint. A review of records and information did not evidence any concerns raised. The record available for recording complaints was in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

An annual quality report was last completed on July 2016. The registered manager had submitted a copy of the report to RQIA at the time of completion. A copy of the annual report was also available for patients and their relatives and relevant others.

As discussed previously a review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with staff 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, 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 improvements 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 records evidenced that Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. The monthly monitoring reports reviewed provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. In addition, the monthly visits undertaken focussed on a particular theme for example; the theme for August was “Atmosphere and staff communication”. An action plan was generated to address any areas for improvement.

As discussed in the preceding sections, it was evident that the registered manager maintained a highly visible profile in the home and had implemented and managed systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff and patients to participate in the life of the home. The registered manager was available to patients and their relatives and provided staff with a positive role model for their practice and attitude.

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 with Daniel McHugh, registered manager, 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 nursing.team@rqia.org.uk 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

Statutory requirements: No requirements resulted at this inspection	
Recommendations	
Recommendation 1 **Ref**: Standard 4 Criteria 1 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that assessments and care plans are commenced on the day of admission and completed within five days of admission to the home. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: All care plans are commenced on the date of admission and for all future admissions will be completed within 5 days of admission to the home.
Recommendation 2 **Ref**: Standard 4 Criteria 7 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that assessments and care plans are kept under review and updated to reflect the current needs of patients. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Care Plan in question has been updated and devloped with regards to changes to the patients mobility. Manual Handling Assessment and Falls Risk Assessment have both been reviewed and are no w current.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care