Unannounced Care Inspection Report
12 September 2019

Meadows

Type of Service: Nursing Home (NH)
Address: 15 Newline Road, Richhill, Armagh BT61 9QR
Tel No: 028 3887 0005
Inspector: Julie Palmer

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.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 46 patients.

3.0 Service details

Organisation/Registered Provider: Armagh Care Services **Responsible Individual:** Daniel McHugh	**Registered Manager and date registered:** Daniel McHugh 1 April 2005
Person in charge at the time of inspection: Daniel McHugh	**Number of registered places:** 46
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 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 12 September 2019 from 09.50 hours to 17.30 hours. This inspection was undertaken by the care inspector.

The term ‘patient’ is used to describe those living in the Meadows which provides both nursing and residential care.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staffing, adult safeguarding, training, record keeping, risk assessment and care planning, communication between patients and staff, the culture and ethos in the home, listening to patients, governance and management arrangements.

Areas requiring improvement were identified in relation to appropriate storage of linens and continence products and completion of neurological observations in the event of a fall.

Patients described living in the home as being a good experience. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

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	2

Details of the Quality Improvement Plan (QIP) 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.

4.2 Action/enforcement taken following the most recent inspection dated 21 January 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 21 January 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from 2 to 15 September 2019
- 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 patients' care records including food and fluid intake charts and repositioning charts
- a sample of governance audits/records
- complaints and compliments records
- staff supervision and appraisal schedule
- registered nurse competency and capability assessment records
- a sample of monthly monitoring reports from January 2019
- RQIA registration certificate

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as either met, partially met, or not 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 previous inspections

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that the monthly quality monitoring reports consistently include completion of an action plan for identified repairs/improvements, date for completion of same and the named person responsible.	Met
	Action taken as confirmed during the inspection: Review of the monthly quality monitoring reports evidenced that an action plan was included and this detailed identified repairs/improvements, date for completion of same and the named person responsible.	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

We discussed the planned daily staffing levels for the home with the registered manager who confirmed that these were subject to at least monthly review to ensure the assessed needs of patients were met. The duty rotas reviewed reflected that the planned daily staffing levels were adhered to. Staff spoken with were very satisfied with staffing levels and working relationships in the home, they commented:

- ‘‘Staffing levels are excellent here.”
- “Our shift works well together.”
- “Great teamwork.”
- “Brilliant relationships, Danny is very good.”
- “I enjoy working here.”
- “You’re always busy, there’s always something to be done.”

We also sought staff opinion on staffing via the online survey; no responses were received.

Patients spoken with indicated they were satisfied with staffing levels. We also spoke with one visitor on the day of the inspection who told us they were satisfied with staffing levels.

We also sought the opinion of patients and patients’ visitors on staffing levels via questionnaires. Six responses were received, with all respondents indicating they were very satisfied with staffing levels.

We reviewed two staff recruitment and induction files and these evidenced that staff had been vetted prior to commencing employment to ensure they were suitable to work with patients in the home.

All staff spoken with stated they had completed, or were in the process of completing, a period of induction and review of records confirmed this. A staff appraisal and supervision schedule was in place and a record of supervisions and appraisals was maintained.

We reviewed the system in place to monitor the registration status of registered nurses with the NMC and care staff with NISCC and this clearly identified the registration status of all staff.

Staff spoken with demonstrated their knowledge of how to deal with a safeguarding issue; they were also aware of their duty to report concerns.

Review of care records evidenced that a range of validated risk assessments was completed and informed the care planning process for patients. Where practices were in use that could potentially restrict a patient’s choice and control, for example, bedrails or alarm mats, the appropriate risk assessments and care plans had been completed.

We looked at the home's environment and reviewed a selection of bedrooms, bathrooms, shower rooms, storage rooms, sluices, dining rooms and lounges. The home was found to be warm, well decorated, clean and fresh smelling throughout. Patient's bedrooms were personalised with items that were meaningful to them. We identified areas in the bungalows that required repainting but discussion with the registered manager evidenced that a redecoration plan was in place and work had commenced to carry out any necessary repairs and redecoration in the bungalows that week.

We also observed that identified shower chairs and a shower plinth showed signs of rust and lap belts needed to be replaced on the chairs. We brought this to the attention of the registered manager who informed us that as these items of specialised equipment had been provided by the local trust they were checked and serviced by an external company. The registered manager confirmed that a date had been arranged for servicing of the identified equipment and showed us evidence to confirm the arrangement.

The linen store on the first floor was untidy; items were also inappropriately stored on the floor in the room. We also observed that continence products were inappropriately stored in a first floor sluice room cupboard and in an identified bathroom cupboard. Items such as linens and continence products should be appropriately stored in order to minimise the risk and spread of infection; an area for improvement was made.

Staff were observed to wear personal protective equipment (PPE), for example aprons and gloves, when required and PPE was readily available throughout the home.

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

The registered manager confirmed that staff compliance with mandatory training was monitored and they were prompted when training was due. Staff spoken with were satisfied they had sufficient access to training.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, supervision and appraisal, adult safeguarding, the redecoration plan in place and training.

Areas for improvement

An area for improvement was identified in relation to ensuring appropriate and tidy storage of linens and continence products.

	Regulations	Standards
Total numb of areas for improvement	0	1

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

We observed the daily routine and the care given to patients in the home and were satisfied that patients received the right care at the right time. Patients who were unable to express their views appeared to be comfortable and content in their surroundings and in their dealings with staff. Patients who were able to voice their opinions indicated that they were satisfied their care needs were met.

Staff confirmed they received a handover when they came on duty and they felt this enabled effective communication prior to the commencement of their shift. Staff spoken with were knowledgeable about the patients' care needs and confirmed these were regularly reviewed to determine the effectiveness of care delivered and if the patients' needs had changed.

We reviewed the care records for three patients and evidenced that a range of validated risk assessments had been completed to inform care planning for the individual patients.

Patients weights were monitored on at least a monthly basis and their nutritional needs had been identified. There was evidence of referrals having been made to relevant health care professionals, such as the dietician or speech and language therapist (SALT), where necessary. Patients care plans included recommendations from the dietician and/or SALT if required and were regularly reviewed. Food and fluid intake charts were maintained where necessary and the records reviewed were up to date.

A monthly falls analysis was completed to determine if there were any trends or patterns emerging and an action plan was devised if necessary. Staff were knowledgeable regarding the actions to take to help prevent falls and how to manage a patient who had a fall; the relevant risk assessments and care plans were updated in the event of a fall. However, neurological observations had not been completed for the full 24 hour period following a fall in two of the records reviewed. Staff had noted in one record that the patient had been uncooperative but the other record did not indicate a rationale for non-completion for the full 24 hour period; an area for improvement was made.

Discussions with staff identified that none of the patients had a wound. Risk assessments and care plans were in place to direct care for the prevention of pressure ulceration.

We reviewed the care record for a patient who required administration of nutrition and fluids via the enteral route. A record was maintained of nutrition and fluid administered on a daily basis, however, we observed that the total fluid intake over the 24 hour period was not calculated. We discussed this with staff who stated that, as there was usually no deviation from the recommended regime, it was not necessary to calculate the total intake as it never changed. We pointed out that if, for any reason, there was deviation from the regime, for example, if the patient was unwell, it might not be readily apparent if the recommended daily nutrition and fluid intake was not achieved. Staff agreed that, going forward, it would be best practice to calculate the total daily fluid intake for this patient.

We observed the serving of lunch in the dining room. The menu was on display and a selection of condiments and drinks was available. The food smelled appetising and was well presented. Staff demonstrated their knowledge of how to thicken fluids if necessary and which patients required a modified diet. It was obvious that staff knew the patients well and were aware of their likes and dislikes. A registered nurse was overseeing the meal and the atmosphere was calm, unhurried and relaxed. Patients, who were able, were involved in tasks such as setting and clearing the tables. Patients told us they enjoyed the food provided in the home, comments included:

- "I'm full up, lunch was lovely."
- "The food is good."

A member of staff also told us that "patients love the food, it's really good".

Staff were seen to effectively communicate with patients and demonstrated their knowledge of how to manage barriers to communication. Staff provided patients with reassurance and took time to listen to them.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, risk assessment and care planning, referral to the multi-disciplinary team, the meal time experience and communication between patients and staff.

Areas for improvement

An area for improvement was identified in relation to completion of neurological observations in the event of a fall.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 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 09.50 hours and were met by staff who were friendly and welcoming. We observed daily life in the home throughout the day and noted that staff displayed a consistently caring and comforting approach to the patients in their care.

During the inspection we spoke with 11 patients both individually and in small groups. Patients who were unable to communicate their views appeared to be content and settled. Those patients who were able to voice their opinions spoke very positively about life in the Meadows, they told us:

- "I love it here."
- "I help out about the place."
- "Geraldine is very kind to me."
- "If I have something to say staff listen."
- "They look after me and take me wherever I want to go."
- "I'm happy, it's my home."

A visitor we spoke with told us that “it’s great here, no problems”.

Observation of care delivery evidenced that staff treated patients with dignity and respect. We observed that staff knocked on bedroom and bathroom doors before entering and ensured doors were closed when delivering care to preserve patients’ privacy.

A range of different activities were offered and staff were keen to ensure that these were meaningful and appropriate to meet the needs and interests of the patients. Patients were offered the opportunity to go out for a walk with staff each morning and this was generally a very popular activity with around 20 patients taking part daily.

Other activities provided included gardening, arts and crafts, computer classes, a drama group and regular shopping trips. The registered manager told us that the home encouraged local community involvement; patients were encouraged and enabled to attend events in the community such as the Gateway Club, church services and the day centre. The home held regular open days at which family, friends and visitors were welcomed.

Patients spoke enthusiastically about helping in the garden, shopping trips and the yearly Christmas play. They told us they were involved in decision making about daily life in the home and felt staff took their views into account.

The annual quality report for the home was reviewed prior to the inspection and this included the views of patients, their relatives and staff.

Staff and patients’ meetings were held regularly and a record of these was maintained.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, providing dignity and privacy, listening to and valuing patients and their relatives 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

6.6 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 displayed in the entrance hall of the home. Discussions with staff and observations confirmed that the home was operating within the categories of care registered.

There had been no change in management arrangements since the last inspection. 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, patients and visitors confirmed that the registered manager was accessible and approachable. Everyone was on first name terms with the registered manager and a patient's visitor told us that "Danny is great".

Systems were in place to monitor and evaluate the quality of nursing care and other services provided in the home and to ensure action was taken as a result of any deficits identified to drive quality improvement. Audits were completed to review areas such as accidents/incidents, IPC measures, falls and patients' weights.

Review of the complaints record evidenced that systems were in place to ensure complaints were appropriately managed.

There was a system in place to ensure notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Staff were knowledgeable regarding their own roles and responsibilities and were familiar with the home's whistleblowing policy.

Review of the monthly monitoring reports evidenced that an action plan was included and this detailed identified repairs/improvements, date for completion of same and the named person responsible; this area for improvement had been met.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of 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 if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 46 **Stated:** First time **To be completed by:** 19 September 2019	The registered person shall ensure that the identified linen room is maintained in a tidy and ordered condition and that items are not inappropriately stored on the floor; continence products should also be stored appropriately in the home. Ref: 6.3
	Response by registered person detailing the actions taken: The items in question were not inapropriately stored in the store - they had fallen off the shelf. Some continence products had been in a cupbard in the Sluice room - this is no longer in practice and are now stored approriately.
Area for improvement 2 **Ref**: Standard 22 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that in the event of a fall, where a head injury is confirmed or suspected, neurological observations are completed for the full 24 hour period of time following the fall. Ref: 6.4
	Response by registered person detailing the actions taken: It is general practice that neurolgicial observations are completed for the full 24 hour period. In both these incidents some observations had been taken but not all. This was due to the unco-operative nature of both clients. This was recorded in one patients notes but not for the other. In any further similar event where there is difficulty in obtaining observations, a full explantion will be given in the daily nursing notes and on the accident form.

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

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