Unannounced Care Inspection Report
30 November 2017

Meadows

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

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:** Mr Daniel McHugh	**Registered Manager:** Mr Daniel McHugh
Person in charge at the time of inspection: Mr Daniel McHugh	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years. Residential Care (RC) LD – Learning disability.	**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 30 November 2017 from 09:40 to 16:00.

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 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 the provision, deployment and management of staff, the environment and fire safety. Care records were well maintained and evidenced that care was delivered in accordance with assessed need. There was evidence to support that patients and relatives had opportunities to be involved in decision making in the home.

There were examples of good practice found in relation to the provision of meaningful activities, the culture and ethos of the home, listening to and valuing patients and their representatives and taking account of the views of patients.

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.

No areas for improvement were identified during this inspection.

Patients said they were happy living in the home.

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 5 December 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 5 December 2016. 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

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 returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with all of the patients and five staff. Questionnaires were also left in the home to obtain feedback from patients and their relatives/representatives Opportunities for staff not on duty to provide feedback were also provided.

The following records were examined during the inspection:

- duty rota for all staff for week commencing 27 November 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction file
- four patient care records
- one patient food and fluid intake charts
- a selection 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

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 the most recent inspection dated 5 December 2016.

The most recent inspection of the home was an unannounced medicines management inspection.

The completed QIP was returned and approved by the pharmacist inspector.

This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 3 October 2016

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 4 Criteria 1 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of four patients' care records evidenced that this area for improvement has been met.	
Area for improvement 2 **Ref:** Standard 4 Criteria 7 **Stated:** First time	The registered provider should ensure that assessments and care plans are kept under review and updated to reflect the current needs of patients.	**Met**
	Action taken as confirmed during the inspection: A review of four patients' care records evidenced that this area for improvement has been met.	

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 minimum staffing levels for the home and explained that, each week, additional staff were rostered to ensure there were sufficient staff to enable patients to attend appointments, activities and outings. A review of the staffing rota for week commencing 27 November 2017 evidenced that staffing levels varied daily in response to patients' needs and requests. Observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

We observed one interaction where a patient wanted to visit their family at home later in the week; there were already a number of additional staff rostered to assist with Christmas activities and commitments of other patients. The registered manager explained this to the patient, and following further discussion, an alternative date and time were agreed. This collaborative working with the patient was commended.

Patients were complimentary regarding staff and how they were assisted. We sought patient opinion via questionnaires; five patients completed a questionnaire. All of the patients were very satisfied with the staffing arrangements.

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

One commented:

“There is always plenty of staff on duty so we can have lots of activities with the residents and spend time with them too.”

We also sought relatives’ opinion on staffing via questionnaires; one was returned in time for inclusion in this report. The relative responded that they were satisfied with staffing.

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. These assessments were reviewed annually.

A review of two staff recruitment records evidenced that they were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records confirmed that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager who confirmed that the current system ensured that staff were alerted prior to their registration renewal date.

The registered manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. A review of two completed induction programmes evidenced that these were commenced and completed within a meaningful timeframe.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. All training was delivered face to face. Discussion with the registered manager and a review of training records evidenced that there were robust system in place to ensure staff attended mandatory training. A review of records for fire training and adult safeguarding evidenced good compliance. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns.

A review of four 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.

A review of a sample of records pertaining to accidents and incidents in November 2017 confirmed that these were appropriately managed. The accident/incident record included information with regard to behaviours which had the potential to impact on the occurrence and management of the incident. For example completed forms included the details of any behaviours displayed prior to the event and what, if any, diversional approaches helped. A body map was also included in the accident report; this is good practice. A trend analysis audit of accidents and incidents was completed monthly by the registered manager to identify any patterns with the type, place and outcome of incidents.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, fresh smelling and clean throughout. The majority of patients' bedrooms were individual and personalised to reflect the patients' likes and interests. The level of attention to detail was commended. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the provision, deployment and management of staff, the environment and fire safety.

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 patients care records evidenced that a comprehensive assessment and a range of validated risk assessments were completed for each patient; these assessments informed the care planning process. The home have a number of patients who are admitted for regular respite. The records evidenced that there were systems in place to confirm if the patient's needs had changed since the previous discharge. Generally the assessments and risk assessments were reviewed on admission and updated to reflect any change.

Care plans were in place to direct the care required. Each patient had a range of care plans to meet their physical, psychological and social needs. There was good detail of the patients social interests and how they liked to spend their day. Care plans were reviewed regularly to ensure they continued to meet the assessed needs of the patient and were updated to reflect changes to the patients' condition. There was good detail of the patient's condition since the previous review and this is good practice.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as GP's, speech and language therapist (SALT) and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

We 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 intake charts were maintained. A review of the dietician's report and the completed fluid intake charts evidenced that the prescribed regime was adhered to. Care plans were in place for the management of enteral feeding. It was good to note that the patient's family continued to be involved in the patient's care and that this involvement was supported by the registered nurses in the home and the wider multidisciplinary team.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Observations of staff interactions evidenced that communication was good within the home and that there was effective team work. Staff confirmed that they were provided with the relevant information in response to patients' daily needs and changing needs. Staff also confirmed that they enjoyed working in the home and with colleagues and if they had any concerns, they could raise these with the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

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 patients 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.

Discussion with the registered manager confirmed that staff meetings were held a minimum of quarterly and that the minutes were maintained of the staff who attended, matters discussed and agreed actions. The most recent meeting was held on 9 November 2017.

Records evidenced that patient meetings were held monthly and that minutes were available. The registered manager explained that the meetings are chaired by a registered nurse and that they try to ensure it is a different nurse each month. A record of which patients attended and the issues discussed was maintained. Records evidenced that the meetings were effective in providing the patients with an opportunity to be involved in decision making in the home. For example during the meeting in August a number of patients discussed going on a train journey; this activity was arranged and on 13 October 2017 the patients travelled on a train, some of them for the first time ever. Discussion with the patients evidenced that they were well informed of the day to day events and activities in the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, delivery of care, management of enteral feeding and opportunities for patients and relatives to involved in decision making in the home

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 09:40 hours. There was a busy atmosphere and staff were assisting patients in their preparation for the days activities. A group of 24 patients, supported by staff, had already been for their daily walk around the local forest park. Staff explained that this activity was beneficial for the patients' physical and psychological needs. One member of staff was rostered 07:45 to 10:00 hours five mornings a week to facilitate this activity. The patients spoken with looked forward to this morning activity and the opportunity to spend some time outdoors. We observed that the patients had sturdy outdoor shoes and warm, waterproof coats. Staff explained that ensuring the patients had suitable outdoor clothing meant that the walk could generally take place, even in poor weather.

All patients spoken with were happy living in the home. Patients were well informed of the activities planned for the day and of their opportunity to be involved. 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 were knowledgeable of patients non-verbal cues and what they were trying to communicate; the positive non-verbal responses by patients confirmed staffs understanding was correct.

During the morning a number of patients attended an arts and craft class which was taking place in a local venue across the road from the home. Staff accompanied the patients to this class. A number of patients remained in the home throughout the morning and were free to spend time in their bedrooms or seated in the lounge/dining area in keeping with their personal preference and safety needs. Staff interaction with patients was observed to be compassionate, caring and timely. Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

We observed the serving of lunch in the dining room. There was a choice of meals and drinks available and all patients, including those on a modified diet, could avail of the choices. Those patients who required assistance with their meals were attended to in a timely manner. As patients returned from their morning activities they joined their fellow patients in the dining room. Patients were heard to ask staff "what's the choice?" demonstrating that having a choice at mealtimes was common practice. There was a lively atmosphere in the room and a great sense of community throughout the meal.

Patients were also busy rehearsing for the home's Christmas pantomime which takes place in a local church hall each year. All of the patients play a role in the pantomime and relatives, friends and supporters of the home are all invited to attend. It was obvious from the excited and proud manner in which patients spoke about the rehearsals and their individual roles just how much their enjoyed this event and the feeling of self-worth it provided them. The commitment and dedication of staff and volunteers to ensure that all of the patients were actively involved and that the pantomime was a success was commended by the inspector.

As previously discussed patients were involved in decision making about their care. Patients view and opinions were sought during the patients monthly meetings. On a daily basis patients were consulted regarding meal choices and were offered a choice of meals, snacks and drinks throughout the day. Staff encouraged those patients who could express their preference to do so and demonstrated a detailed knowledge of patients' likes and dislikes for those patients who were unable to express their opinion.

The registered manager explained that questionnaires were given to patients annually to gain their views on the running of the home. These were last completed in February 2017; 26 patients participated. The responses were generally positive and any suggestions for improvement were responded to and the action taken recorded.

The registered manager explained that previously relatives meetings were held twice yearly but due to poor attendance they are now held annually. The most recent was held on 8 May 2017. A newsletter with events and information regarding the home is sent to relatives twice yearly.

Discussion with the registered manager confirmed that there were also systems in place to obtain the views of patients' representatives/relatives on the quality of the service provided. Relatives were provided with the opportunity to complete a satisfaction survey annually. The most recent was completed in March 2017 with a return rate of 50% . We reviewed a sample of the returned questionnaires which evidenced a high number of very satisfied and satisfied responses.

These are examples of some of the comments provided:

"Always feel welcome."
"Pleased that the home offers so many activities."
"The staff could not be better."

Any suggestions for improvement were responded to on an individual basis.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. The following are examples of comments received on thank you cards:

"…was always treated with love and showed dignity and respect. Words cannot express our sincere gratitude especially when she became ill during her last stay."
"… led a fulfilled and contented life with thanks to all the support and friendship received from you all."

As previously discussed we sought patient opinion via questionnaires; five patients completed a questionnaire. All of the patients were very satisfied with the staffing arrangements.

The following comments were provided:

"They are all very nice"
"I like the meadows"
"Everything is dead on."
"My room is lovely."

Two staff provided a response to questionnaires via an online survey. Both staff were very satisfied with all aspects of care.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the provision of meaningful activities, the culture and ethos of the home, 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 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. The Statement of Purpose and Patient Guide were available in the home.

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 patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required. It was obvious from the interactions observed between the registered manager and the patients that they were familiar with each other and that the registered manager knew the patients individually. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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.

A review of records evidenced that monthly audits were completed. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement

A review of notifications of incidents submitted to RQIA in November 2017 confirmed that these were managed appropriately.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the regional manager on behalf of the responsible person. An action plan was included within the report to address any areas for improvement. The action plan was reviewed at the next visit. A copy of the quality monitoring report was displayed in the home.

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.

The Regulation and Quality Improvement Authority

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