The Regulation and Quality Improvement Authority

Inspection Report

10 and 12 August 2021

Melmount Manor Care Centre

Type of Service: Nursing Home
Address: 1 Orchard Road,
Strabane, BT82 9QR
Tel no: 02871383990

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Larchwood Care Homes (NI) Ltd **Responsible Individual:** Mr Christopher Walsh	**Registered Manager:** Mrs Hayley Phillips - Pending Registration
Person in charge at the time of inspection: Mrs Hayley Phillips	**Number of registered places:** 69 A maximum of 38 patients in category NH-DE and a maximum of 31 patients in categories NH-I and NH-PH
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 64 Mourne (NH-I and NH-PH) - 15 Foyle (NH-I and NH-PH) – 12 Dennett (NH-DE) - 37
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 69 patients. The home is divided in three units on the ground floor. The Dennett unit provides care for people with dementia; the Mourne and Foyle units provide general nursing care. Patients have access to communal lounges, dining rooms and a garden. There is also a registered Residential Care Home under the same roof.	

2.0 Inspection summary

An unannounced inspection took place on 12 August 2021, from 9.20 am to 5.10 pm by a care inspector and on the 10 August 2021 from 09.25 am to 2.20 pm by a pharmacist inspector.

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

It was positive to note that most of the areas for improvement from the previous care inspection had been met and there were no new areas for improvement. Two areas for improvement have been stated for a second time in relation to management oversight of newly admitted patients care records and the recording of personal care.

Review of medicines management found that patients were being administered their medicines as prescribed. There were robust arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management.

RQIA were assured that the delivery of care and service provided in Melmount Manor was safe, effective and compassionate and there were appropriate management arrangements within the home.

Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report.

The findings of this report will provide the management team with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

4.0 What people told us about the service

The inspector spoke with 14 patients, 14 staff and one relative during the inspection. Patients told us that they felt well cared for, enjoyed the food and that staff were helpful and friendly. One questionnaire was returned from a relative who was very complimentary of the care provided within the home. Comments received included: "cannot praise and thank the staff enough for care, compassion and love shown on a daily basis to our mum."

Staff said that the manager was very approachable, teamwork was great and that they felt well supported in their role. One staff member said: "the new manager is great, you can go to her about anything and feel supported and listened to." There was no feedback from the staff online survey.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 11 February 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 14 (2) (a) (b) and (c) **Stated:** First time	The registered persons must ensure that all areas of the home to which patients have access are free from hazards to their safety. With specific reference to ensuring that: • chemicals are securely stored in keeping with control of substances hazardous to health (COSHH) legislation • thickening agents are stored securely • staff belongings are stored securely • the identified store room is decluttered and kept locked • all grades of staff are aware of their responsibility to report and action any	**Met**

	actual or potential hazards.	
	Action taken as confirmed during the inspection: Observation of the environment and discussion with staff evidenced that this area for improvement has been met.	
Area for improvement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that the nursing home is conducted so as to make proper provision for the health and welfare of patients. Specific reference to ensuring that patients' skin is monitored and any deficits are reported to the nurse in charge.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with staff evidenced that this area for improvement has been met.	
Area for improvement 3 **Ref:** Regulation 25 **Stated:** First time	The registered person shall ensure that care staff, document the full name of patients within repositioning charts and that any changes or alterations to the entry time for repositioning are made in such a way that the original entry can still be read.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of repositioning charts evidenced that they were mostly well maintained. The manager agreed to continue to monitor these records closely and to address any concerns with relevant staff. This area for improvement has been met.	
Area for improvement 4 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that patients are repositioned in accordance to the recommended frequency within their care plan.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of repositioning charts and care plans evidenced that they were mostly well maintained. This area for improvement has been met.	

<table>
<tr><td>Area for improvement 5

Ref: Regulation 13 (1) (a) (b)

Stated: First time</td><td>The registered person shall ensure that where a wound has been assessed as requiring specific treatment, the care plan is adhered to and evidenced as such within the evaluation records.</td><td rowspan="2">Met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:
Review of a sample of care records and discussion with the manager evidenced that this area for improvement has been met.</td></tr>
<tr><td>Area for improvement 6

Ref: Regulation 10 (1)

Stated: First time</td><td>The registered person shall ensure that the following measures are implemented for any patient being admitted to the home:

• risk assessments are completed within 24 hours of admission
• care plans are commenced on the day of admission and completed within five days
• assessments from the commissioning Trust are obtained and kept within the patients care records</td><td rowspan="2">Partially met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:
Review of a sample of care records evidenced that this area for improvement has not been fully met and has been stated for a second time.
This is discussed further in section 5.2.2.</td></tr>
<tr><td colspan="2">Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)</td><td>Validation of compliance</td></tr>
<tr><td>Area for improvement 1

Ref: Standard 39

Stated: First time</td><td>The registered person shall ensure that mandatory and other training requirements, for all staff working in the home, are met.</td><td rowspan="2">Met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:
Review of staff mandatory training records and discussion with the manager evidenced that this area for improvement has been met.</td></tr>
<tr><td>Area for improvement 2

Ref: Standard 4

Stated: Second time</td><td>The registered person shall ensure that care plans reflect the changing needs of patients and any recommendations made by other health care professionals.</td><td>Met</td></tr>
</table>

	Action taken as confirmed during the inspection: Review of a sample of care records evidenced that this area for improvement has been met.	
Area for improvement 3 **Ref**: Standard 41 **Stated:** First time	The registered person shall ensure the staff duty rota includes: • the full names of staff • the hours worked by staff and their job role.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of staff duty rotas evidenced that this area for improvement has been met.	
Area for improvement 4 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that appropriate snack options are made available during daily tea/drink rounds for those patients who require a modified and/or specialised diet.	**Met**
	Action taken as confirmed during the inspection: Observation of the tea/drinks round and discussion with staff/patients evidenced that this area for improvement has been met.	
Area for improvement 5 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that contemporaneous records are maintained to reflect the delivery of personal care.	**Partially Met**
	Action taken as confirmed during the inspection: Review of a sample of care records evidenced that this area for improvement has not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	
Area for improvement 6 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to: • care records • wound care.	**Met**

	Action taken as confirmed during the inspection: Review of a sample of wound and care record audits evidenced that this area for improvement has been met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. Review of a sample of employee recruitment records evidenced that robust systems were in place to ensure that patients are protected.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC).

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics including moving and handling, fire safety and adult safeguarding. Staff confirmed that they were provided with relevant training to enable them to carry out their roles and responsibilities effectively. The manager advised that additional training had been scheduled with ongoing monitoring to ensure full compliance.

Staff said teamwork was good and that the manager was approachable. Staff also said that, whilst they were kept busy, the number of staff on duty was satisfactory to meet the needs of the patients.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the manager was not on duty.

Patients said that they felt well looked after and that staff were attentive. One patient commented “I feel very safe here” and a further patient referred to the staff as “very friendly”.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients’ needs, their daily routine wishes and preferences.

It was observed that staff respected patients’ privacy by their actions such as knocking on doors before entering, discussing patients’ care in a confidential manner, and by offering personal care to patients discreetly. This is good practice.

Patients who were less able to mobilise require special attention to their skin care. Care records relating to repositioning were mostly well maintained. We discussed the importance of ensuring that the full names of patients are recorded within the charts. The manager agreed to monitor this going forward and to address with relevant staff where necessary.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was seen to be a pleasant opportunity for patients to socialise and the atmosphere was calm and relaxed.

Staff had made an effort to ensure patients were comfortably seated and enjoyed their meal. There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, staff recognised that patients may need a range of support with meals and were seen to helpfully encourage and assist patients as required.

There was a choice of meals offered, the food was attractively presented and smelled appetising. Staff knew which patients preferred a smaller portion and demonstrated their knowledge of individual patient's likes and dislikes. There was a variety of drinks available. Patients told us they very much enjoyed the food provided in the home.

Patients who choose to have their lunch in their bedroom had trays delivered to them and the food was covered on transport. A menu was displayed within each dining room.

Staff told us how they were made aware of patients' nutritional needs to ensure that recommendations made by the Speech and Language Therapist (SALT) were adhered to. Discussion with staff evidenced that they were providing the correct diet as recommended by SALT.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily.

On review of two recently admitted patients care records there were a number of risk assessments and care plans that had not been completed within the required timeframe. These were discussed in detail with the manager who agreed to monitor all new admission care records going forward. This area for improvement has been stated for a second time.

Review of four patient care records evidenced that they were mostly well maintained and any identified care plans and/or records that were inaccurate were updated prior to the completion of the inspection.

A sample of four patient care records relating to the recording of personal care was reviewed. Whilst two patients care records were well maintained, there were gaps identified in the delivery of personal care for two patients which did not indicate whether the patient had been offered certain aspects of personal care or whether they had refused. This was discussed in detail with the manager and an area for improvement has been stated for a second time.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. The home was warm, clean and comfortable. There was evidence that a number of areas had recently been painted or had flooring replaced. The manager confirmed that refurbishment works were ongoing including the replacement of identified furniture with surface damage to ensure the home is well maintained.

A system was in place to ensure any maintenance issues were reported and addressed in a timely way.

Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were suitably furnished. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices. The garden and outdoor spaces were well maintained with areas for patients to sit and rest.

The Manager told us that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Agency (PHA).

All visitors to the home had a temperature check and a health declaration completed when they arrived at the home. They were also required to wear personal protective equipment (PPE) such as aprons, masks and/or gloves. Visiting and care partner arrangements were managed in line with the Department of Health and infection prevention and control (IPC) guidance.

Whilst good IPC practices were observed overall, one care assistant was observed sitting on a patient's bed and wearing a wrist watch which would inhibit effective hand hygiene. The associated IPC risks were discussed with the manager who agreed to communicate with the relevant carer and to monitor during daily walk around.

The manager said that cleaning schedules included frequent touch point cleaning and this was carried out by both domestic and care staff on a regular basis. There was a good supply of PPE and hand sanitising gel in the home. The manager also said that any issues observed regarding IPC measures or the use of PPE were immediately addressed.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. Patients confirmed that they could go out for a walk when they wanted, remain in their bedroom or go to a communal room when they requested.

Patients were observed enjoying activities which had been arranged by the activity coordinator. Patients' needs were met through a range of individual and group activities, such as reflective thoughts, arts and crafts, music, games, exercise and walks. Patients commented positively on the activities provided.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted patients to make phone or video calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Medicine Management

The audits completed at the inspection indicated that the patients had received their medicines as prescribed

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example at medication reviews or hospital appointments. The patients' personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate.

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment. A sample of these records was reviewed. The records were found to have been completed to the required standard.

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. The records inspected showed that medicines were available for administration when patients required them.

Medicines must be stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.
The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. In one unit, the lock of the medicine refrigerator was broken; this was rectified during the inspection. Records were maintained of the disposal of medicines.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in controlled drug record books. Robust arrangements were in place for the management of controlled drugs. The controlled drugs record books had been maintained to the required standard.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and its effect. Directions for use of medicines prescribed on a "when required" basis were clearly recorded on the patients' personal medication records and care plans. Reasons for administration were recorded.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals to manage weight loss. A speech and language assessment report and care plan was in place for patients who were prescribed thickening agents for addition to fluids and food.

Records of prescribing and administration which included the recommended consistency level were maintained.

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. During a recent audit management had determined that the date of opening was not recorded on some medicine containers and were currently addressing this matter through the action plan.

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. The audit system in place in this home helps staff to identify medicine related incidents.

5.2.6 Management and Governance Arrangements

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment. Staff said that the manager was approachable and accessible.

There has been a change to management arrangements for the home since the last inspection. The manager said they felt well supported by the responsible individual and the organisation in their new role.

There were systems in place and a designated person identified to oversee the appropriate safeguarding procedures and the safeguarding policy. All staff were required to complete adult safeguarding training on an annual basis; the manager provided further training dates to ensure full compliance with this training. There was evidence that incidents were reported to the local Trust appropriately.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Where deficits were identified the audit process included an action plan with the person responsible for completing the action, a time frame for completion and a follow up to ensure the necessary improvements have been made. The manager further agreed to monitor the care records for new admissions going forward.

The home was visited each month by a representative of the responsible individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed and available for review by patients, their representatives, the Trust and RQIA.

6.0 Conclusion

Patients were seen to be content and settled in the home and in their interactions with staff. Staff treated patients with respect and kindness. There were safe systems in place to ensure that patient's needs were met by the number and skill of the staff on duty. Care was provided in a caring and compassionate manner.

It was positive to note that most of the areas for improvement from the previous care inspection had been met and there were no new areas for improvement. Two areas for improvement have been stated for a second time in relation to management oversight of newly admitted patients care records and the recording of personal care.

Based on the inspection findings and discussions held it was evident that Melmount Manor was providing safe and effective care in a compassionate manner; and that the management team had made the necessary improvements to ensure the service is well led.

7.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1*	1*

Areas for improvement and details of the Quality Improvement Plan were discussed with Hayley Philips, Manager and Christopher Walsh, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 10 (1) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that the following measures are implemented for any patient being admitted to the home: • risk assessments are completed within 24 hours of admission • care plans are commenced on the day of admission and completed within five days Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Staff supervision completed in regard this regulation with all staff

	nurses within the home ongoing rigiours audits of new recent admissions to the home have shown the documentation has been completed within the time frame required. Auditing of care files continue to be monitroed and reviewd on a monthly basis also reviewed as part of reg29 visits
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that contemporaneous records are maintained to reflect the delivery of personal care. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Daily review of supplementry charts by staff nurses on floor is undertaken supervision with care staff relating to the completion of supplementry records. A sample of records also reviewed on managers daily walk round each morning

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

The Regulation and Quality Improvement Authority

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