

Unannounced Care Inspection Report 5 March 2018



Melmount Manor Care Centre

Type of Service: Nursing Home (NH)
Address: 1 Orchard Road, Strabane, BT82 9QR
Tel no: 028 7138 3990
Inspector: Sharon Loane

www.rgia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 81 persons.

3.0 Service details

Organisation/Registered Provider: Larchwood Care Homes (NI) Ltd Responsible Individual(s): Christopher Walsh	Registered manager: Annie Frobisher
Person in charge at the time of inspection: Annie Frobisher	Date manager registered: 28 December 2012
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. Residential Care (RC) DE – Dementia.	Number of registered places: 81 comprising: 38 NH-DE 31 NH-I & NH-PH 12 RC-DE

4.0 Inspection summary

An unannounced inspection took place on 5 March 2018 from 10.00 to 16.30. This inspection focused specifically on the nursing units.

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 Care Standards for Nursing Homes 2015.

The term 'patients' is used to describe those living in Melmount Manor 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 staffing, adult safeguarding, and good communication between patients, staff and visitors. The culture and ethos of the home promoted privacy and dignity. Good practice was also identified in relation to the governance and management arrangements.

Areas requiring improvement were identified under the standards in relation to the completion of risk assessments and care plans at the time of admission; specific issues relating to infection prevention and control and the management of urgent safety and staff alerts.

Patients were positive in their feedback of the care and services provided in the home. Patient comments can be reviewed in section 6.6. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Annie Frobisher, 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 12 June 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 12 June 2017. There were no areas for improvement identified and no further actions required to be taken.

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
- pre-inspection assessment audit

During the inspection we met with five patients, eight staff, and five patients' relatives. One visiting professional was also consulted. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives.

A lay assessor, Marian Thompson was present during the inspection from 10.00 to 13.00 and their comments are included within this report.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- duty rota for all staff from 5 to 11 March 2018
- 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
- three patient care records
- two patient care charts including food and fluid intake charts and reposition charts
- staff supervision records
- a selection of governance audits
- complaints record
- compliments received
- 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 12 June 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 10 May 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Requirement 1 Ref: Regulation 20 (1) (a) Stated: First time	<p>The registered persons must ensure that the provision and deployment of staffing in the home is reviewed to ensure that there is adequate staff on duty to meet the needs of the patients.</p> <p>Records of the necessary action taken to address staff shortages should also be maintained.</p>	Met

	<p>Action taken as confirmed during the inspection: A discussion with staff, a review of information and observations made at the time of this inspection evidenced that this area for improvement was met. Staff spoken with were satisfied that the current staffing arrangements were sufficient and appropriate to meet the needs of the patients.</p> <p>Please refer to section 6.4 for further information.</p>	
<p>Requirement 2 Ref: Regulation 13 (1) (b) Stated: First time</p>	<p>The registered persons must ensure that there is proper provision for the nursing and where appropriate, treatment and supervision of patients.</p> <p>The registered manager must ensure that staff are aware of identified risks and introduce monitoring arrangements to ensure that risks are appropriately and safely managed. This requirement relates specifically to the management of food and fluids.</p> <p>Action taken as confirmed during the inspection: A review of care records, discussion with staff and observation of care delivery evidenced that this area for improvement had been met.</p> <p>Please refer to section 6.4 for further information.</p>	Met
<p>Requirement 3 Ref: Regulation 14 (2) (c) Stated: First time</p>	<p>The registered persons must ensure that care records are developed, reviewed and updated to ensure that unnecessary risks to health and safety of patients are identified and so far as possible eliminated and to direct care delivery.</p> <p>Action taken as confirmed during the inspection: A review of care records for patients assessed as having swallowing difficulties evidenced that the care plan reflected the recommendations as per the Speech and Language Therapist. There was evidence that systems were in place to review patients as deemed appropriate this included a re-assessment of the patient's needs by the Speech and Language Therapist.</p>	Met

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Recommendation 1 Ref: Standard 39 Stated: First time	The registered persons should ensure that training in relation to Dysphagia is provided for staff commensurate with their role and responsibilities.	Met
	Action taken as confirmed during the inspection: A discussion with the registered manager and staff, and a review of training records confirmed that 19 staff had completed Dysphagia training on the 13 February 2018. Arrangements were in place for additional training. The training provided was facilitated by a registered dietician. Discussion with staff and observations of practice in this regard evidenced that the learning had been embedded into practice.	

6.3 Inspection findings

6.4 Is care safe?

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

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the period from the 5 to 11 March 2018 evidenced that the planned staffing levels were adhered to. Since the last care inspection, staffing arrangements had been reviewed and staff consulted acknowledged that the outcomes of the review had had a positive impact on the delivery of safe, effective and compassionate care. Staff also stated that that the staffing arrangements in place for night duty (with particular reference to the Dennett unit) had also improved and were more stable. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff confirmed that this process and the training provided to them enabled them to fulfil their roles and responsibilities.

At the last inspection an area for improvement was identified in relation to the provision of training in regards to Dysphagia. As previously discussed in section 6.2 this area for improvement had been met. Observation of the delivery of care evidenced that training had been embedded into practice.

The arrangements in place to confirm and monitor the registration status of nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager and the administrator. A review of the records of NMC and NISCC registration evidenced that all of the staff on the duty rota for the week of the inspection were included in these checks.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Review of two patients 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 third care record reviewed identified some shortfalls which have been referred to in section 6.5.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last inspection confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm and the overall standard of cleanliness and compliance with infection prevention and control was satisfactory. However, the standard of cleanliness in some areas required improvement. For example: a sluice located in the Dennett Unit was not maintained in accordance with infection prevention and control measures. Other matters relating to infection prevention and control related to the cleanliness of the trolleys used for attending to the delivery of personal care. The standard of cleanliness was unsatisfactory and continence items were removed from their original packaging. This has been identified as an area for improvement.

Some areas of the home to include floor coverings had been damaged due to issues with plumbing. Arrangements were in place to fix the problem and repair the damage incurred as a result. Control measures were in place to ensure minimal disruption to patients living in the home. At the time of the incident RQIA had been notified accordingly.

The Dennett unit is registered to provide dementia care for 38 persons. There were sufficient dayrooms and lounges, bath/shower rooms and toilets. However, the environment could be developed further so that it is a more enabling environment for persons with dementia. For example; there was a lack of aids to orientate patients and define the use of space. This matter was discussed with the registered manager & registered nurses who agreed to complete an environmental audit with reference to best practice guidelines for Dementia. The registered manager agreed that a copy of the audit and the proposed actions would be shared with RQIA. The outcomes of the audit will be reviewed at a subsequent care inspection.

Within the Dennett Unit (nursing dementia), food thickening agents were observed being stored in patients’ bedrooms. The potential risks associated with this practice were discussed with the registered nurses working in this unit, given the category of care of the patients living here. The registered nurses agreed that the food thickening agents would be stored within a locked area. It was agreed that this practice should be risk assessed and monitored by management and registered nurses to ensure patients safety. This practice will be monitored during subsequent inspections to ensure actions taken have been fully embedded.

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 staffing, induction, training, adult safeguarding, risk management and the home’s general environment.

Areas for improvement were identified in relation to specific infection prevention and control issues.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

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. There was evidence that risk assessments informed the care planning process. However, it was noted that some assessments and care plans had not been completed for up to and including twelve days for one of the care records reviewed. This has been identified as an area for improvement under the standards.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. 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.

Care records reviewed in relation to the management of wounds indicated that when a patient required wound care and or pressure management appropriate actions were taken. These included wound assessment and care plans being updated on a regular basis. There was evidence that the care and treatment provided was reflective of that outlined in the care plan. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds. Pressure relieving equipment was in place and being used appropriately.

Care records pertaining to the management of accidents and incidents including fall prevention were reviewed. The accident/ incident forms were completed to a satisfactory standard and there was evidence that registered nurses had monitored the patients for any adverse side effects following the falls. Falls risk assessments and care plans had been reviewed and updated. CNS observation records were maintained appropriately.

Supplementary care charts such as repositioning, bowel management and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislation.

A review of information evidenced that patients' weights were being monitored and recorded accordingly. Records reviewed identified any weight loss and/or gain and subsequent actions taken. A monthly weights audit was also completed which included an analysis of the weight loss which considered any mitigating factors. The audit also included evidence of any actions taken. This is good practice.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. Additional systems were also in place to aid communications.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), SALT, dietician and TVN. A 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.

Staff were satisfied that there was good teamwork within the home. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues, patients, relatives and other visitors to the home.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff and management.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, audits and reviews, communication between residents, staff and other key stakeholders.

Areas for improvement

An area for improvement under the standards has been made in regards to the completion of risk assessments and care plans which should be completed within five days of the patient's admission to the home.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

Observations throughout the inspection evidenced that there was a busy but calm atmosphere in the home and staff attended to the patients' needs. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients and their relatives as was required from time to time. Staff demonstrated knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients were observed to be sitting in the lounges, or resting in their bedroom, as was their personal preference. A number of patients were observed nursed in bed and discussion with staff and a review of care records evidenced that the decisions made for this intervention were in the patient's best interest. Discussion with some of the patient's representatives confirmed that they were satisfied with the care arrangements in place.

During the inspection, activities were provided to meet the needs of patients. The home has two staff employed to organise and deliver activities. A discussion with both staff demonstrated that they had a good understanding in their approach to this integral part of the care process.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Discussion with five patients individually and with others in smaller groups, confirmed that they were content living in the home. These are examples of some of the comments received:

- "very kind"
- "Staff are very good can't remember their names but know staff faces"
- "Some (staff) are better than others"
- "Staff look after us very well."

We spoke with five relatives during this inspection. Ten questionnaires for relatives were issued; three were returned within the timescale for inclusion in this report. All responses received indicated that they were either "very satisfied" or "satisfied" with the care provided.

Additional comments included;

- "Feel staff treat mum well and appear caring towards her. I feel happy with the care she is getting".

We also spoke with eight staff. There were no concerns raised. Staff were also provided with an opportunity to respond to an online survey. No responses were received.

One visiting professional spoken with commented positively about the standard of care provided the staff's ability to respond appropriately to patients' needs and the management and leadership of the home.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. 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.

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 their representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team.

Discussion with the registered manager and review of records and observations evidenced that the home was operating within its registered categories of care. An application has been received by RQIA to register the residential dementia unit under a separate registration as per legislative requirements. This application is currently being progressed by RQIA.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered manager and a 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, wound management, care records, incidents and accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been embedded into practice.

A review of information identified that the 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 were not sufficiently robust. This had also been raised at the last inspection and assurances were given that this would be addressed. However the actions taken are still not adequate and an area for improvement under the standards has been identified.

Discussion with the registered manager and review of records evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations. An action plan was generated to address any areas for improvement and was reviewed at subsequent visits.

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

Areas of good practice

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

Areas for improvement

An area for improvement under the standards has been made in regards to the management of urgent and safety alerts.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Annie Frobisher, 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 Care Standards for Nursing Homes (2015).	
Area for improvement 1 Ref: Standard 4 Criteria 1 Stated: First time To be completed by: 30 April 2018	<p>The registered person shall ensure that risk assessments and care plans are completed within five days of admission to the home.</p> <p>Ref: Section 6.5</p> <hr/> <p>Response by registered person detailing the actions taken: A process is now in place for the senior nurse on each unit to ensure the risk assessments and careplans are in place within five days of admission</p>
Area for improvement 2 Ref: Standard 46 Stated: First time To be completed by: 30 April 2018	<p>The registered person shall ensure that the environment is maintained to minimise the risk of infection for staff, patients and visitors. This includes but not limited to:</p> <ul style="list-style-type: none"> • sluice area in the Dennett unit • changing trolleys <p>Ref: Section 6.4</p> <hr/> <p>Response by registered person detailing the actions taken: The Senior house keeper now inspects the sluice rooms daily to ensure continued cleanliness. The trolleys are now part of the regular decontamination programme.</p>
Area for improvement 3 Ref: Standard 35 Criteria 18 Stated: First time To be completed by: 30 April 2018	<p>The registered person shall ensure that the arrangements in place for dealing with urgent communications, safety alerts and notices are developed and records are maintained.</p> <p>Ref: Section 6.7</p> <hr/> <p>Response by registered person detailing the actions taken: Files are now in place for all aerts, urgent communication, safety alerts and notices which are signed of by the Registered Manager</p>

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



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