Unannounced Care Inspection Report
3 and 4 August 2016

Park Manor

Type of Service: Nursing Home
Address: 6 Thornhill Road Dunmurry BT17 9EJ
Tel No: 029 9030 7700
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Park Manor took place on 3 and 4 August 2016 from 10:00 to 16:50 hours on day one and from 10:00 to 16:00 hours on day two.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The home was commended for the improvements made to their recruitment processes, for the development of a comprehensive and robust care assistant induction programme and the level of compliance with mandatory and other training for staff. There was clear evidence that the registered provider ensured the right person was recruited and provided with the right skills to deliver quality care to patients. It was evident that patients' safety, health and well-being were protected and of paramount importance to management and staff.

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, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts.

There were no requirements or recommendations made.

Is care effective?

It was evident that systems and processes were in place to ensure the delivery of effective care. For example, care records were maintained in accordance with professional and regional standards and kept under review to ensure they were reflective of patients' needs.

Staff were commended for the detailed knowledge they had of their patients which enabled them to deliver effective care. In addition, staff stated that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection. Staff also stated they were 'proud' to be a part of their team and to 'make a difference.' Each staff member clearly knew their role, function and responsibilities.

Staff said that the registered manager knew them and the patients well and was 'on the floor' every day. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their relatives was evident on a one to one basis as recorded in the care records and through observations of interactions between staff and patients. Patients confirmed that the registered manager was available to them on a daily basis. One patient said, 'I know Clare and I trust her.'

There were no requirements or recommendations made.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. As stated in sections 4.4 patients and relatives' were very positive in the comments regarding the staffs' ability to deliver care and respond to needs and or requests for assistance.

As stated previously staff clearly demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. This ensured the safe, effective and compassionate delivery of care. This was also linked to the work on patients' Life Story Booklets.' There was also evidence of consultation with patients and their relatives on the day to day running of the home and that management considered consultation responses when making changes to practice or improving the service provision.

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. Patients unable to attend to their own personal hygiene and dress were all well presented and it was evident that staff paid attention these details.

A comprehensive, inclusive and varied activity programme was in place. Patients and staff commented positively regarding the positive impact this had on the day to day life within the home.

There were no requirements or recommendations made.

Is the service well led?

Based on the inspection findings detailed in each domain, review of records, systems and processes; and comments from patients, relatives and staff it was evident that Park Manor Nursing Home was well led. The registered manager clearly demonstrated consistently how she ensured the delivery of safe, effective and compassionate care, and that this is an integral part of her day-to-day operational control of the home. This was commended.

There were no requirements or recommendations made.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Miss Clare Black, Registered Manager, and Mrs Christine Thompson, Regional 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 16 December 2015. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistleblowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Macklin Group Mr Brian Macklin and Mrs Mary Macklin	**Registered manager:** Miss Claire Black
Person in charge of the home at the time of inspection: Clare Black – Registered Manager	**Date manager registered:** 14 April 2016
Categories of care: NH-I, PH and DE RC-I and PH A maximum of 26 persons in category NH-DE, a maximum of 26 persons in NH-I and PH and a maximum of 26 persons in categories RC-I and PH.	**Number of registered places:** 78

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection the inspector spoke with 15 patients individually and greeted others in small groups, seven care staff, four registered nurses, two catering staff, one member of staff from housekeeping, one relatives, the activity therapist, the company health and safety manager, a visiting healthcare professional and the home's hairdresser.

In addition questionnaires were provided for distribution by the registered manager; 10 for relatives, eight for patients and 10 for staff not on duty during the inspection. Seven relatives, three patients and eight staff questionnaires were returned. Refer to section 4.5 for details.

The following information was examined during the inspection:

- three patient care records
- six patients' charts regarding repositioning and food and fluid intake
- staff roster 11 – 31 July 2016
- staff training and planner/matrix for 2016
- one staff recruitment record
- records evidencing the recruitment and staff induction process
- complaints record
- random selection of incident and accident records
- random selection of the record of quality monitoring visits carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit/governance
- registration checks for nursing and care staff
- staff appraisal and supervision planners 2016
- records pertaining to consultation with staff, patients and relatives.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 16 December 2015

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP, will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 26 November 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 33 **Stated:** First time **To be Completed by:**31 January 2016	Management should review the recording of do not attempt resuscitation/cardio pulmonary resuscitation orders to ensure records are maintained in accordance with national and regional guidelines. **Action taken as confirmed during the inspection**: Review of three patient records and discussion with nursing staff confirmed that this recommendation had been met.	**Met**

4.3 Is care safe?

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 from 11 to 31 July 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The registered manager confirmed that her senior staff team included two senior registered nurses and a care assistant supervisor. The senior nurses work half of their hours supernumerary and opposite each other to ensure a member of the home's senior team was available seven days a week. The care assistant supervisor also had supernumerary hours. The registered manager confirmed that the senior staff would provide 'cover' for short notice sick leave or annual leave rather than working supernumerary, if required.

Discussion with the registered manager and review of documents evidenced that the organisation had a robust recruitment process. This process had been developed further to ensure the home recruited the 'right person for the job'. The recruitment process included, for example, initial application screening, face to face interviews, practical tests and personality/aptitude testing. If a candidate was success and progressed to employment they were provided with a comprehensive induction programme supported by a mentor.

The care assistant induction programme had been reviewed by the home's care assistant supervisor and a senior care assistant. They developed a new programme supported by the management team. The new programme included a staff guide and welcome pack, an identified 'buddy' who supported the inductee, including the taking of breaks together, and a series of power point presentations which the inductee and buddy worked through. A training booklet was also developed and provided to the inductee for use throughout their period of employment. This booklet enabled the care assistant to record training undertaken and learning outcomes in line with the re registration requirements for the Northern Ireland Social Care Council (NISCC). The registered manager reviewed the progress of the induction programme and as required addressed any concerns raised by either the 'buddy' or the inductee.

The development of the recruitment programme including the development of the care assistant induction was commended as it clearly evidenced that the registered provider ensured the safety, health and well being of their patients by recruiting the right person for the job and providing that person with the skills and knowledge to deliver quality care to patients. The registered manager also confirmed that the new induction programme was to be disseminated throughout the organisation and that they were also looking at developing similar induction programmes for nursing and ancillary staff.

Discussion with the registered manager and review of electronic records evidenced that a robust system was in place to ensure staff attended mandatory training. Training was kept under review by the registered manager and the senior management team. During discussion with an employee, who is not involved in direct care provision, it was evident they had not attended update training in adult safeguarding and moving and handling recently. This was discussed with the registered manager who arranged for the person identified to receive their training the next day. This was possible because the home had developed staff to be able to deliver training 'in house'.

Training was also planned in advance, using the electronic system, to ensure that mandatory training requirements were met for all staff. Staff confirmed that they were required to complete mandatory training. Records confirmed that 99% staff had, so far this year, completed their mandatory training requirements; this was commended by the inspector.

In addition to the mandatory training staff were also required to attend additional training to ensure they were able to fulfil their role and function in the home. For example one senior care assistant completed a trainers' course on customer service. The trainer then delivered this training to all staff in the home. This training was described by management as very important because staff needed to be aware of how to conduct themselves with patients and relatives to 'build up trust' with the person that staff would ensure the safety of patients and 'do the right thing at the right time'. The inspector also commended the development of links with the Open University and the support provided to staff which enabled them to undertake their registered nurse training. Three care assistants had been identified and were awaiting notification of acceptance on to the course.

Observation of the delivery of care and patient records evidenced clearly that training had been embedded into practice. A planner was in place to manage staff supervision and annual appraisals.

The registered manager and staff spoken with clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities, in general, and specifically in relation to adult safeguarding. Staff described their role and responsibilities with and said that they were enabled to 'make a difference'. Patients and one relative spoken with confirmed that they were assured and confident of the staffs' ability to care for them or their loved ones and that they 'trusted' staff to always do the right thing.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). Safety and medical alerts were reviewed on a regular basis and relevant notices were 'actioned' and/or disseminated to staff as required.

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.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since April 2016 confirmed that these were managed appropriately. Audits of falls and incidents were maintained and clearly evidenced analysis of the data to identify any emerging patterns or trends and action plans were in place as required. For example, falls were identified to increase during staff break times. Management addressed this by reviewing staffing levels and deployment during staff breaks which led to a reduction in the number of falls during the subsequent months. Audit outcomes regarding falls and incidents also informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

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, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts. Infection prevention and control measures were adhered to. The registered manager confirmed that following a recent review of the environment from the Public Health Authority (PHA) the only action identified was the replacement of toilet brushes. There was evidence that this had been addressed.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.4 Is care effective?

Patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer a care plan was in place to direct staff on the management of this risk and evaluations of the wound were recorded appropriately. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds.

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. Registered nurses assessed planned, evaluated and reviewed care in accordance with NMC guidelines.

There was evidence that the care planning process included input from patients and/or their relatives, if appropriate. There was evidence of regular communication with representatives within the care records.

One relative and patients stated they had confidence in the staff to deliver the right care at the right time. This ensured the best possible outcome for patients.

Supplementary records such as reposition, food intake and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

Observations evidenced that call bells were answered promptly and patients requesting assistance in one of the lounge areas or their bedrooms were responded to in a calm, quiet and caring manner. Patients were confident of the ability of staff to meet their need effectively and in a timely manner. For example, one patient when asked about staff responding to call bells said, 'they come when I press the buzzer.'

Observations evidenced that staff 'adapted' to the changing needs of patients. For example, one patient was unable to remain at the dining table, the staff member assisting the patient enabled the patient to move to another area of the unit to relax and enjoy their meal. This was undertaken discreetly and quietly to ensure the patient was not upset and continued to enjoy their meal.

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the handover reports at the beginning of their shift. Staff also confirmed that regular staff meetings were held, that they contributed to the agenda and that minutes were made available.

Staff were commended for the level of knowledge they had regarding their patients. For example, building on the document from the Royal College of Nursing (RCN) 'getting to know you' a more comprehensive 'Life Story Record' had been developed. Patient, relatives and staff worked together on this record. Staff were able to describe how this knowledge enabled them to deliver a better quality of care and the positive impact this had on patients' experience, in particular within the dementia unit. The registered manager described the comments from one relative in that the relative said that working through the 'life story' had taught them more about their loved one and had provided the extended family with their history. The registered manager also confirmed that working on the life story had proven effective in assisting relatives deal with the impact of their loved one's admission to a care home and to help the relative to build trust in staff ability to care.

Staff stated with enthusiasm that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection. Staff stated they were 'proud' to be a part of their team and to 'make a difference'. Each staff member clearly knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. Staff said that the registered manager knew them and the patients well and was 'on the floor' every day. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their relatives was evident on a one to one basis as recorded in the care records and through observations of interactions between staff and patients. Patients confirmed that the registered manager was available to them on a daily basis. One patient said, 'I know Clare and I trust her.'

There was information available to staff, patients, representatives in relation to advocacy services.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. As stated in section 4.4 patients and relatives' were very positive in the comments regarding the staffs' ability to deliver care and respond to needs and or requests for assistance.

As stated previously in section 4.4 staff clearly demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. This ensured the safe, effective and compassionate delivery of care. One staff member when asked how long they had worked in the home stated they wished they could say for longer because they loved working in the home, 'because it was so good.'

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. Patients unable to attend to their own personal hygiene and dress were all well presented and it was evident that staff paid attention these details.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their relatives and staff on the running of the home. For example, patients, relatives, visitors to the home and staff were invited to provide feedback on an ongoing basis. Questions were also asked in questionnaire form regarding satisfaction levels with the care and general services provided. Views and comments recorded were analysed and if required an action plan was developed and shared with staff, patients and relatives. One example of consultation was; the registered manager was planning to meet with the catering team and additional training was organised with a hotel chef around how to improve the presentation of meals including therapeutic diets. Prior to the delivery of this training questionnaires specifically relating to meals and mealtime experience were to be issued to patients and their relatives to help inform the staff training.

All patients and relatives spoken with commented positively regarding the care they received and the staffs' caring and kind 'nothing is any trouble' attitude. A number of staff names were repeated during conversations with patients and in particular the registered manager was mentioned for her calm, quiet, caring and professional attitude. It was evident good relationships had been developed and that there was a high level of confidence in the staffs' ability to deliver care and to address concerns effectively. Details of staff spoken about were provided to the registered manager and the attitude and actions of staff were commended.

Discussion with patients and staff evidenced that the home provided a varied and comprehensive programme of activities which was considerate of various levels of patients' participation. Patients spoke highly in relation to the staff attitude and enthusiasm for activities. It was evident from discussions with the activity therapist and other staff that activities were considered extremely important and were of benefit to the staff as well as patients and relatives.

Details of various activities were provided by the activity therapist which included:

- links with the local community with attendance at tea dances and senior lunches
- a 'Posh Tea Party' which offered various flavoured teas – although patients said they preferred the 'brown tea'!
- chocolate tasting
- a virtual tour of Belfast organised as part of the home's 'Alzheimer's Society Week'
- a cinema night with popcorn etc.
- the home was organising their own Olympics with an opening ceremony and events planned

The activity therapist also explained that in the lead up to a special event the patients and staff would work on associated arts and crafts to help decorate the home. A weekly newsletter was produced for patients and relatives and one was in development for staff.

The level of commitment, enthusiasm and motivation of staff was commended.

In addition RQIA provided questionnaires for distribution by the registered manager to patients, staff and relatives. At the time of writing this report, seven relatives, three patients and eight staff had returned their questionnaires.

Comments and outcomes were as follows:

Patients: respondents indicated that they were very satisfied that care was safe, effective and compassionate. Patients also recorded 'very satisfied' in relation to the question, is the service well led? There were no additional comments recorded.

Relatives: one respondent indicated that they were very satisfied that care was safe, effective and compassionate; and recorded 'satisfactory' in response to the question is the service well led? Six relatives indicated that they were very satisfied in relation to all four domains. Additional comments recorded included:

- '…is being very well cared for and I so thank the hard working staff…'
- 'This is the best home my …has been in… The management and staff are excellent and it is quite evident from their care, kindness and support to the patients that they take their occupations serious.'

Two relatives commented regarding staffing levels suggesting that at times staff did not always have time to care due to staff shortages. Staffing was reviewed as part of the inspection process and the inspection findings did not raise any concerns about staffing levels. Please refer to section 4.3 for details.

Staff: respondents indicated that they were very satisfied across all areas questioned. One comment recorded indicated concern regarding how sick leave was covered. As stated previously, staffing was reviewed as part of the inspection process and the inspection findings did not raise any concerns about staffing levels. Please refer to section 4.3 for details.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff confidently described their role and responsibility in the home. In discussion patients were aware of the roles of the staff in the home and to whom they should speak to if they had a concern. Patients and relatives spoke in very positive terms in relation to the registered manager and their confidence in her leadership skills. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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 DHSSPS Care Standards for Nursing Homes 2015. Patients and staff spoken with confirmed that they were aware of the home's complaints procedure. Patients/relative confirmed that they were confident that staff and management would address any concern raised by them appropriately.

Staff were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function. 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 review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents/accidents. Records also evidenced that the results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Review of reports and discussion with the registered manager evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

There was an effective system in place to ensure nursing staff were registered with the nursing and Midwifery Council (NMC); and that care staff were registered with the Northern Ireland Social Care Council (NISCC). New care staff not registered with NISCC were required and supported to register.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed.

Discussion with the registered manager and observations evidenced that the home was operating within its registered categories of care.

Based on the inspection findings detailed in the preceding domains, review of records, systems and processes; and comments from patients, one relative and staff it was evident that Park Manor Nursing Home was well led. The registered manager clearly demonstrated consistency in how she ensured the delivery of safe, effective and compassionate care, and that this is an integral part of her day to day operational control of the home. This was commended.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered person/manager from their responsibility for maintaining compliance with the regulations and standards.

The Regulation and Quality Improvement Authority

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