The Regulation and Quality Improvement Authority

Inspection Report

20 October 2022

Cornfield Care Centre

Type of Service: Nursing Home
Address: Green Lane and Castle Lane Suites, 51a Seacoast Road, Limavady, BT49 9DW
Tel no: 028 7776 1300

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: Cornfield Care Centre **Registered Person:** Mr. Marcus Jarvis Nutt	**Registered Manager:** Mrs.Claire Gormley **Date registered:** 13 January 2017
Person in charge at the time of inspection: Mrs.Claire Gormley	**Number of registered places:** 52 A maximum of 26 patients in categories NH-I, NH-PH and NH-PH(E) accommodated within the general nursing unit and a maximum of 26 patients in category NH-DE accommodated within the dementia unit. The home is also approved to provide care on a day basis to 2 persons.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 51
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 52 patients. The home is divided in two units over one ground floor level. One unit provides care for patients living with dementia and the other unit provides care under the general category of care.	

2.0 Inspection summary

This unannounced inspection took place on 20 October 2022, from 9.35am to 3.30pm by a care inspector.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

There was safe, effective and compassionate care delivered in the home and the home was well led by the Manager.

It was evident that staff promoted the dignity and well-being of patients. It was evident that staff were knowledgeable and well trained to deliver safe and effective care.

No areas requiring improvement were identified during this inspection.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

RQIA were assured that the delivery of care and service provided in Cornfield Care Centre was safe, effective, compassionate and that the home was well led.

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.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires 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 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.

The findings of the inspection were discussed with Mrs. Claire Gormely at the conclusion of the inspection.

4.0 What people told us about the service

Patients said that they were very happy with their life in the home, their relationship with staff, the provision of meals and the provision of activities.

Four visiting relatives spoke with praise and gratitude for the standard of care provided for. One relative raised issues of concern relating to a healthcare appointment which on agreement was referred to the Manager to assist.

Staff spoke in positive terms about the provision of care, their roles and duties, staffing levels, teamwork, training and managerial support.

5.0 The inspection

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

The last inspection to Cornfield Care Centre was undertaken on 11 November 2021 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. A review of two staff members' recruitment records confirmed that these were in accordance with Schedule 2 of The Nursing Care Homes Regulations (Northern Ireland) 2005.

A check is carried out on a monthly basis to ensure all staff are up-to-date with their registration with the Nursing & Midwifery Council (NMC) or the Northern Ireland Social Care Council (NICSS). These checks were maintained appropriately.

Staff said there was good team work and staff morale and that they felt well supported in their role, were satisfied with the staffing levels and the level of communication between staff and management.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the nurse in charge when the Manager was not on duty. Any nurse who has responsibility of being in charge of the home in the absence of the Manager has a competency and capability assessment in place. Review of a staff member's assessment found this to be comprehensive in detail to account for the responsibilities of this role.

Staff said that there was enough staff on duty to meet the needs of the patients. It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day.

It was also observed that staff responded to requests for assistance promptly in a caring and compassionate manner. Two patients made the following comments: “All’s very good. The staff are excellent.” and “I can’t praise the staff enough.”

There were systems in place to ensure staff were trained and supported to do their job. A range of mandatory and additional training was completed by staff on a regular basis. The Manager had good oversight of the training needs of staff. Staff spoke positively about their training as well as their induction received when newly appointed.

5.2.2 Care Delivery and Record Keeping

Staff interactions with patients were observed to be pleasant, polite, friendly and warm. One patient made the following comment: “It’s very pleasant here. So far everything is very good. No complaints.”

Patients’ care records were maintained which accurately reflected 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. Expressions of consent were evident with statements such as “Are you okay with…” or “Would you like to …” when dealing with care delivery. Patients were dressed nicely with attention to personal hygiene and care.

Some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails, alarm mats. It was established that safe systems were in place to manage this aspect of care, through up-to-date audits and care planning.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients.

The dining experience was an opportunity of patients to socialise and the atmosphere was calm, relaxed and unhurried. Tables were nicely set with choice of condiments. The menus were suitably and accessibly displayed. It was observed that patients were enjoying their meal and their dining experience. Staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

There was choice of meals offered, the food was attractively presented and smelled appetising, and portions were generous. There was a variety of drinks available.

There was evidence that patients’ weights were checked at least monthly to monitor weight loss or gain. Records were kept of what patients had to eat and drink daily. Patients who had specialist diets as prescribed by the Speech and Language Therapist (SALT) had care plans in place which were in accordance with their SALT assessment. Discussions with staff confirmed knowledge of these assessments. The Manager audits these assessments on a quarterly basis so to ensure that the care plans are correct and that the current assessment and guidance is readily available to staff. This is good practice.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs; and included any advice or recommendations made by other healthcare professionals. One patient was able to describe in detail how their assessed needs pertaining to diabetes, choking, mobility and psychological needs were met by the staff and how they had also seen other patients being well cared for. Another patient described how they felt very apprehensive about coming into a home but now when they see how things are and how the staff engage with patients, they feel relieved that they made the right choice.

Care records were held confidentially.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs.

Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patient's care needs and what or who was important to them.

Daily progress records were kept of how each patient spent their day and the care and support provided by staff. These records were well maintained with detail of the patient's well-being. Any issues of assessed need had a recorded statement of care / treatment given with effect of same recorded.

The outcomes of visits from any healthcare professional were also recorded.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean, tidy and fresh smelling throughout, with a good standard of décor and furnishings. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were suitably furnished and comfortable. Bathrooms and toilets were clean and hygienic.

The grounds of the home were well maintained, with good accessibility for patients to avail of.

Cleaning chemicals were stored safely and securely.

The laundry department was found to be clean, tidy and well organised.

All staff were in receipt of up-to-date training in fire safety. Fire safety records were appropriately maintained with up-to-date fire safety checks of the environment and, fire safety drills.

The home's most recent fire safety risk assessment was dated 9 May 2022. There was corresponding evidence recorded of the actions taken in response to the four recommendations made from this assessment.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control measures and the use of PPE had been provided.

5.2.4 Quality of Life for Patients

Patients were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. It was observed that staff offered choices to patients throughout the day which included food and drink options, and where and how they wished to spend their time. One patient said: “It’s lovely here. A very nice peaceful atmosphere. Staff can’t do enough for you.”

The genre of music and television channels played was appropriate to patients’ age group and tastes.

The atmosphere in the home was relaxed and homely with patients seen to be comfortable, content and at ease in their environment and interactions with staff. One visiting relative made the following comment: “It’s definitely a good place here. They (the staff) are all very attentive and good.”

Programmes of organised activities were in place for which patients were seen to be in enjoyment from. A planned visiting music entertainer was in place in the afternoon of this inspection, for those patients who wished to partake in.

5.2.5 Management and Governance Arrangements

Mrs. Claire Gormley is the Manager of the home. Discussions with the Manager confirmed that she had a good understanding and knowledge of patients’ needs. Staff commented positively about the Manager and described them as supportive, approachable and always available for guidance.

Discussions with staff confirmed knowledge and understanding of the safeguarding policy and procedure. There were good systems and processes were in place to manage the safeguarding and protection of vulnerable adults. Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home’s safeguarding policy. The Operations Manager is the home’s safeguarding champion.

It was established that the Manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to patients’ next of kin, their care manager and to RQIA. Advice was given to ensure that it is clearly recorded in these reports when RQIA has been notified of an event.

There was evidence that the Manager ensured that complaints were managed correctly and that good records were maintained.

There was a comprehensive system of audits and quality assurance in place. These audits included; monthly falls audits, food safety audits, infection prevention and control audits and care equipment audits.

The home was visited each month by a representative of the Responsible Individual to consult with residents, their relatives and staff and to examine all areas of the running of the home.

The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Claire Gormley, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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