The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
19 October 2017

Carryduff Nursing Home

Type of Service: Nursing
Address: 19 Church Road, Carryduff, BT8 8DT
Tel No: 02890814862
Inspector: Sharon Mc Knight

www.rqia.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 for up to 23 persons.

3.0 Service details

Organisation/Registered Provider: Carryduff Nursing Home Responsible Individuals: Gerald William Beattie Edwin Samuel Johnston	Registered Manager: See Below
Person in charge at the time of inspection: 09:20 -11:00 hours Sherin Tito, registered nurse 11:00 hours Gail Chambers, manager	Date manager registered: Gail Chambers, Registration pending
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	Number of registered places: 23

4.0 Inspection summary

An unannounced inspection took place on 19 October 2017 from 09:20 to 16:20.

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

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the provision and development of staff, adult safeguarding, infection prevention and control and the home's environment.

There was good practice with regard to the assessment of patients' needs on admission and communication between staff. There were examples of good practice in relation to the culture and ethos of the home and taking account of the views of patients and relatives.

An area for improvement with regard to health and safety was identified under the regulations.

Areas requiring improvement under the care standards were identified regarding the information contained in staff recruitment files, wound care records and follow up of referrals to healthcare professionals.

Patients said they were happy living in the home.

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	1	3

Details of the Quality Improvement Plan (QIP) were discussed with Gail Chambers, 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 04 September 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 4 September 2017. There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with eight patients individually and with others in small groups, four staff and two patients' visitors/representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives were left for distribution.

The following records were examined during the inspection:

- duty rota for all staff for week commencing 16 October 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- four patient care records
- two patient care charts including food and fluid intake charts and reposition charts
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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 04 September 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 31 January 2017

There were no areas for improvement identified as a result of the last care inspection.

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 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 roster for week commencing 16 October 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Observation of the delivery of care and discussion with patients evidenced that their needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; none were returned following the inspection.

Patients and relatives spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in timely manner.

We sought relatives' opinion on staffing via questionnaires; one was returned in time for inclusion in this report. The relative was satisfied that there was sufficient staff to meet the needs of their loved one.

A nurse was identified to take charge of the home when the manager was off duty. The nurse in charge was clearly identified on the staff rota. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessments were signed by the manager to confirm that the assessment process was complete and that they were satisfied that the nurse was capable and competent to be left in charge of the home. A review of records evidenced that registered nurses, supplied from an employment agency, completed an orientation programme at the commencement of their first shift; this orientation included a tour of the building and the actions to take in the event of emergencies. The manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of two staff recruitment records evidenced that the reason for leaving employment, in positions where the candidates had worked with children or vulnerable adults, had not been recorded. This was identified as area for improvement under the standards. Records confirmed that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work.

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

We discussed the provision of mandatory training and the manager explained that all training was delivered face to face. Training records evidenced good compliance with manual handling, adult safeguarding and infection prevention and control training. The manager confirmed that they had systems in place to facilitate compliance monitoring.

The manager was knowledgeable regarding her role and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the 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 and the policy was currently being updated to reflect the new terminology and roles.

Review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

A review of completed accident and incident reports for the period 17 May to 19 October 2017 evidenced that these had been appropriately notified and managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, lounges and dining rooms. The home was found to be tidy, warm, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment.

We observed a number of bedroom floors which had been washed but no 'wet floor' sign had been displayed to alert people that the floor was wet. Patients, who were independently mobile, were in their bedrooms as the floors were washed. We spoke to the member of housekeeping staff who was knowledgeable of the need to display signs in the communal areas of the home but was unsure if there enough signs for each bedroom. We were concerned that the identified member of staff failed to recognise the importance of displaying appropriate signage. We spoke to the nurse in charge who took appropriate action to ensure patient safety.

We discussed the issue with the manager and it was agreed that the identified staff member would receive additional training in health and safety; monitoring arrangements must be put in place to ensure that the training is embedded into practice and ensure that as far as is reasonably practical unnecessary risks to the health and safety of patients are identified and as far as possible eliminated. This was identified as an area for improvement under regulation.

Infection prevention and control measures were adhered to. Systems were in place to ensure contaminated and infected linen was handled appropriately. Discussion with a member of staff who worked in the laundry confirmed that staff adhered to best practice in the management of linen. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the provision and development of staff, adult safeguarding, infection prevention and control and the home's environment.

Areas for improvement

One area for improvement under regulation was identified in relation to health and safety. An area for improvement was identified under the care standards with regard to the records of staff recruitment.

	Regulations	Standards
Total number of areas for improvement	1	1

6.5 Is care effective?

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

A review of three patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

We reviewed the management of wound care for two patients. A body map was completed for each patient detailing the location of individual wounds. Care plans for wound care were in place and included the size of the wound and, were applicable, the grade of a pressure wound. The care plans had not been effectively evaluated and were not reflective of the number of wounds each patient was receiving treatment for. The nurse confirmed the current skin condition of each patient and that they both were receiving treatment for a single wound; other skin breaks were now healed. Patients should have an individual care plan for each wound and each care plan should be re-evaluated in response to patient's changing needs. This was identified as an area for improvement under the care standards.

An ongoing wound assessment chart was completed for each wound and contained an assessment of the wound as observed during change of dressings. A review of the completed wound assessment charts evidenced that wound care was delivered as prescribed.

Repositioning charts were completed to evidence that patients were regularly assisted to change their position for pressure relief.

We discussed the monitoring of patients weights and were informed that all patients were weighed on a monthly basis. We reviewed the recording of weights for all of the patients for the period June to October 2017. We identified one patient with significant weight loss. Review of this patient's care records evidenced that a care plan was in place for nutritional needs and the monthly evaluations of the care plan referenced the patient's weight loss. A nutritional risk assessment was completed monthly and reflected that that patient's risk of malnutrition had increased in May 2017 when a referral was made to the dieticians in the local health and social care trust. At the time of the inspection the patient had not been seen by a dietician. Records evidenced that the GP had reviewed the patient in July 2017 and that the care manager and family were aware of the patient's weight loss and general decline in their condition. However, it was concerning that the records and staff spoken with could not confirm that they had followed up the referral given that five months had elapsed since the referral was first made.

Prior to the conclusion of the inspection the registered nurse confirmed that they had contacted the patient's GP, as matter of urgency, to discuss the referral to the dietician. Referrals made to healthcare professionals must be followed up to ensure any advice, treatment and support is obtained in a timely manner. This was identified as an area for improvement under the standards.

Discussion with the manager confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

The manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting was held on 11 October 2017 shortly after the manager took up her position.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This registered provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the assessment of patient need on admission and communication between staff.

Areas for improvement

Areas for improvement were identified in relation to care plans for wound care and the follow up of referrals to healthcare professionals.

	Regulations	Standards
Total number of areas for improvement	0	2

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 calm atmosphere in the home and staff were quietly attending to the patients' needs. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. The staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day.

There was evidence that patients were involved in decision making about their care. Patients were consulted with regarding meal choices and were offered a choice of meals, snacks and drinks throughout the day.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Discussion with 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:

"Everything's perfect."
"They are all very good."
"Everything is good so far."
"They give me all the help I need."
"I'm happy."

Quality assurance questionnaires were also issued annually to relatives; these were recently issued with a response rate of 33%. Generally the responses were positive; for example 100% of the respondents felt the needs of their relatives were being met, that they were involved in decisions about their care and were happy to approach the home manager or nurse in charge if they had concerns. There was a summary section at the end of the report which included additional comments provided and the actions taken by management.

We issued ten relative questionnaires; one was returned within the timescale for inclusion in this report. The relative was satisfied with the care provided across the four domains.

We issued ten questionnaires to staff; none were returned prior to the issue of this report.

Any comments from relatives and staff in returned questionnaires received after the return date will be 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, and taking account of the views of patients and relatives.

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 manager and observation of patients evidenced that the home was operating within its registered categories of care. The most recent certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. In discussion patients and relatives were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The manager's hours were clearly recorded in the home. Discussion with patients and staff evidenced that the manager's working patterns provided good opportunity to allow them contact as required.

Discussion with the manager and review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

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

"…you're such a brilliant bunch of people and I will never forget just what you all did for me."
"Thank you to all the staff for the wonderful care my mum received."

The manager confirmed that monthly audits were completed, for example care records. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement.

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

There were 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.

Discussion with the manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Gail Chambers, 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 14(2)(c) **Stated:** First time **To be completed by:** 16 November 2017	The registered person shall ensure that as far as is reasonably practical unnecessary risks to the health and safety of patients are identified and as far as possible eliminated. The identified member of staff must receive additional training in health and safety; monitoring arrangements must be put in place to ensure that the training is embedded into practice and that warning signs are displayed to alert people when floors are wet. Ref: Section 6.4
	Response by registered person detailing the actions taken: The identified member of staff has recieved additional training on health and safety on 23.10.2017 and it was highlighted the importance of maintaining this at all times. Monitoring arrangements have been put in place to ensure compliance.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 16 November 2017	The registered person shall ensure that staff recruitment files include the reason for leaving employment, in positions where the candidates have worked with children or vulnerable adults. Ref: Section 6.4
	Response by registered person detailing the actions taken: The HR department and all staff involved in the recruitment process have been made aware of the area for improvemnet and will embed this into our application process.
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 16 November 2017	The registered person shall ensure that patient have an individual care plan for each wound and that each care plan is re-evaluated in response to patient's changing needs. Ref: Section 6.5
	Response by registered person detailing the actions taken: All Registered Nurses have been given instruction and guidence to ensure that individual care plans for all wounds are constructed and re-evaluated to respond to residents changings needs.

Area for improvement 3 **Ref**: Standard 21.7 **Stated:** First time **To be completed by:** 16 November 2017	The registered person shall ensure that referrals made to healthcare professionals are followed up to ensure any advice, treatment and support is obtained in a timely manner. Ref: Section 6.6
	Response by registered person detailing the actions taken: The Registered Manager will monitor all referrals made to healthcare professionals to ensure that they are followed up in a timely manner and that any adivce or treatment is fully implemented and recorded in the resident's care file. .

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