Unannounced Care Inspection Report
7 November 2017

Castleview

Type of Service: Nursing Home (NH)
Address: 761 Antrim Road, Belfast, BT15 4EN
Tel No: 028 90 777804
Inspector: Donna Rogan

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 35 persons.

3.0 Service details

Organisation/Registered Provider: Tona Enterprises Ltd **Responsible Individual:** Robert Maxwell Duncan	**Registered Manager:** Jacqueline Felicitas
Person in charge at the time of inspection: Jacqueline Felicitas	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) MP(E) - Mental disorder excluding learning disability or dementia – over 65 years 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:** 35 comprising: 34 –NH-I, NH-PH, NH-PH(E), NH-TI 1 – NH-MP(E)

4.0 Inspection summary

An unannounced inspection took place on 7 November 2017 from 10.00 to 16.30 hours.

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 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 training and development, monitoring of nursing/care staff registrations, accident management, governance arrangements, communication between patients, staff and other key stakeholders and 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 requiring improvement were identified in relation to management of pain records, the management of bedrails and crash/buzzer mats and updating the statement of purpose.

Patients described living in the home in positive terms. 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 Jacqueline Felicitas, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent inspection dated 13 February 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 13 February 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
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with approximately 15 patients, seven staff and three patients' representatives. Questionnaires were also left in the home to obtain feedback from patients' representatives and staff not available during the inspection. Ten questionnaires for staff and relatives were left for distribution.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

The following records were examined during the inspection:

- duty rota for the period from 16 October to 29 November 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
- one staff recruitment and induction file
- three patient care records

- three patient care charts including bowel management, personal care, food and fluid intake charts and repositioning charts
- staff supervision and appraisal planners
- a selection of minutes from staff meetings
- a selection of governance audits
- records pertaining to safeguarding
- 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

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

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met or not met.

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 13 February 2017

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

6.2 Review of areas for improvement from the last care inspection dated 13 February 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 registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to a regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the period 16 October to 29 November 2017 evidenced that the planned staffing levels were generally adhered to. Discussion with patients' representatives evidenced that there were no concerns regarding staffing levels. Consultation with six staff, five patients, and three relatives were satisfied with the staffing arrangements within the home. Observation of the delivery of care during the inspection evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff recruitment information was available for inspection. Records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Supernumerary hours were in place during this time to enable new staff members to work alongside a more experienced staff member to gain knowledge of the home's routines and policies and procedures.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. The majority of staff were compliant with mandatory training requirements. Compliance with training was monitored on the monthly monitoring inspections conducted by the registered person.

Discussion with the registered manager and staff and a review of records evidenced that staff supervision and appraisals had been conducted appropriately and a system was in place to ensure completion.

Competency and capability assessments for the nurse in charge of the home in the absence of the registered manager had been completed appropriately.

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).

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.

An adult safeguarding champion had been identified and had attended training pertaining to the role.

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 a review of one patient described as being in pain and receiving pain relief did not have their pain assessment updated since 7 August 2017. An area for improvement is made in this regard under the care standards.

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. A review of accident records evidenced that the appropriate actions were taken following the accident and that the records had been maintained appropriately. RQIA had been suitably notified of accidents. This information 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 number of bedrooms, bathrooms, lounges, dining rooms and storage areas. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Bedrooms and communal areas were clean and spacious. The home was found to be warm, appropriately decorated, fresh smelling and clean throughout. Fire exits and stairwells 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 training and development, monitoring of staff registrations, accident management and the homes environment.

Areas for improvement

An area for improvement is made in relation to the management of pain assessment records.

	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 two patient's care records pertaining to the management of wounds evidenced that registered nurses were adhering to the regional guidelines and the care planning process in respect of these patients was appropriate.

Supplementary care charts such as nutritional/dietary intake, bowel management and repositioning records evidenced that they were being maintained in accordance with best practice guidance and care standards and legislation. The records had been recorded contemporaneously.

One patient identified as requiring bedrails was observed in bed, the care plan stated that the bed rails were only to be in the upright position whilst in bed at night. On observation the patient was observed in bed; one side of the bed rails was in the upright position and the other side was partially up. The registered manager explained that the domestic may have raised the bedrails following them cleaning the floor under the bed and did not put them down again. The registered manager also stated that a fall out mat and buzzer mat should be in place whilst the patient was in bed during the day. An area for improvement is made that the care plan reflects this and that the plan of care it is implemented by staff.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including general practitioners, speech and language therapists, dieticians and/or tissue viability nurses.

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.

Discussion with staff and a review of minutes of staff meetings confirmed that regular staff meetings had been conducted. Minutes of meetings were available for review and included dates, attendees, topics discussed and decisions made.

The registered manager confirmed that they operate an 'open door policy' and are available to discuss any issues with staff, patients and/or relatives. The registered manager also confirmed that they would undertake a recorded daily walk around the home and would avail of the opportunity to engage with patients and relatives at this time. A relatives' noticeboard was maintained at the entrance to the home. The registered manager also confirmed that they hoped to achieve two patient meetings a year and that questionnaires requesting information on service provision were sent to patients annually. This was last conducted in July 2017. There was a poor returned response. The results of the survey were displayed for staff, patients and families.

Patients spoken with expressed their confidence in raising concerns with the home's staff/management.

Areas of good practice

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

Areas for improvement

An area for improvement under the care standards was identified in relation to the management of bedrails and crash/buzzer mats.

	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.

Staff interactions with patients were observed to be compassionate, caring and timely. 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.

The serving of lunch was observed in the main dining room on the ground floor. Lunch commenced at 12.45 hours. Patients were seated around tables which had been appropriately laid for the meal. Food was served from a heated trolley when patients were ready to eat or be assisted with their meals. Staff sat alongside patients when assisting with meals and patients were observed to be assisted in an unhurried manner. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors where required. The food served appeared nutritious and appetising. The mealtime was well supervised. Food was covered when transferred from the dining room. A range of drinks were offered to the patients. Patients appeared to enjoy the mealtime experience.

The provision of activities was reviewed during the inspection. Discussion with the registered manager and a review of the activity records evidenced that activities were conducted with all patients accommodated in the home. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

The views and opinions of patients and patients' representatives, on the service provision of the home, were collected as discussed in section 6.5. The registered manager also confirmed that feedback to patients and/or their representatives of the opinions raised was provided during patient/relative meetings.

Seven staff members were consulted to determine their views on the quality of care within Castleview. Ten staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Nine of the questionnaires were returned within the timescale for inclusion in the report. Five stated that they were very satisfied, and four stated that they were satisfied that care was safe, effective and compassionate, within a well led service.

Some staff comments were as follows:

"I like working here"
"I think the home is well managed"
"Jackie does a good job"
"It is an old building, however the care is good"
"I am happy working here it is busy but rewarding"

Fifteen patients were consulted during the inspection. Some patient comments were as follows:

"The food is marvellous"
"The staff are kind to me"

"This place is top notch"
"We are all well looked after"
"I cannot speak highly enough of the food, it is great"

Three patient representatives were consulted during the inspection. All three representatives were positive in their feedback regarding the care provision in the home. Ten relative questionnaires were left in the home for completion. Three of the relative questionnaires were returned within the timeframe for inclusion in the report. All three respondents indicated that they were 'very satisfied' with the care provision in 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 in this domain.

	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. The nurse in charge was identified on the duty rota.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager evidenced that the home was operating within its registered categories of care.

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 copy of the complaints procedure was displayed at the reception area in the home.

A compliments file was maintained to record and evidence compliments received.

Some examples of compliments received are as follows:

“Excellent care provided to my mum, by a great bunch of people”
“The care provided was exceptional”
“I want to thank you and all your staff very sincerely for all the care and attention provided to ….”

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, regular audits were completed in accordance with best practice guidance in relation to accidents; incidents; complaints; care plans; medication; staff training and infection prevention and control. Infection prevention and control audits were reviewed. The audits were conducted monthly and an action plan had been developed to address shortfalls identified within the audits. There was evidence that the action plans had been reviewed to ensure completion.

Staff consulted confirmed that they would be confident in raising any concerns with the home’s management.

The home’s statement of purpose is required to be updated to reflect the current categories of care and details of the home’s registered manager. An area of improvement is made in this regard under the care standards.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies 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 registered 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, quality improvement and the management of complaints and incidents.

Areas for improvement

An area of improvement is made under the care standards to ensure the statement of purpose is updated.

	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 Jacqueline Felicitas, 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 21 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure pain assessments are up to date, particularly when a patient is in pain. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: Discussed with all nurses re: the importance of up to date daily pain and monthly assessments.
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that the identified patient's care plan is updated to accurately reflect the plan of care in relation to the management of bed rails and fall out/buzzer mats. The care as planned should also be implemented. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: The care plan has been updated to acurately reflect the plan of care and and staff have been reminded of the importance of adherring to care plans.
Area for improvement 3 **Ref**: Registration Part 1 **Stated:** First time **To be completed by:** 30 November 2017	The registered person shall ensure the statement of purpose is updated to reflect the correct categories of care of the home, and should include the registered manager details. **Ref: Section 6.7**
	Response by registered person detailing the actions taken: Statement of purpose amended and updated to include the details of the registered manager.

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

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