Unannounced Care Inspection Report
13 February 2017

Castleview

Type of Service: Nursing Home
Address: 761 Antrim Road, Belfast, BT15 4EN
Tel no: 028 9077 7804
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Castleview took place on 13 February 2017 from 09:40 to 13:00 hours.

This inspection was carried out to follow up on information received by RQIA from the Belfast Health and Social Care Trust (BHSCT). Issues had been raised by the Trust as part of an adult safeguarding process and related to the management of nutrition and patient weight loss.

There was evidence of the proactive management of patients' needs in relation to nutrition and weight loss. Based on the inspection findings it was evident that the care delivered in relation to nutrition and the management of weight loss was effective and well led.

There were no requirements or recommendations made as a result of this inspection. Details of the inspection process and findings can be viewed in the body of this report.

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 Ms Jacqueline Felicitas, registered 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 care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 12 October 2016. Details can be viewed in section 4.2.

2.0 Service details

Registered organisation/registered person: Tona Enterprises Ltd Mr Robert Maxwell Duncan	**Registered manager:** Ms Jacqueline Felicitas
Person in charge of the home at the time of inspection: Ms Jacqueline Felicitas – registered manager	**Date manager registered:** 01 April 2005
Categories of care: NH-I, PH,PH(E), TI and NH-MP(E) for 1 identified individual only	**Number of registered places:** 35

3.0 Methods/processes

This inspection was carried out to follow up on information received by RQIA from the Belfast Health and Social Care Trust (BHSCT). Issues had been raised by the Trust as part of an adult safeguarding process and related to the management of nutrition and patient weight loss.

It is not the remit of RQIA to investigate complaints or adult safeguarding allegations made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. Following discussion with senior management, it was agreed that an unannounced care inspection would be undertaken to review the following areas:

- the management of nutrition and weight loss.

Prior to inspection we analysed the following information:

- he registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the previous care inspection report
- the returned QIP from the previous care
- notifications received since the previous care inspection.

The following records were examined during the inspection:

- five patients' care records
- records of patients' menu choices and food eaten
- patients' weight management records.

We also undertook a general inspection of the premises which included a review of a number of bathrooms/shower rooms and patients' bedrooms and all lounge/dining rooms. We spoke with six patients individually and with others in smaller groups and observed the serving of the lunch time meal. We also spoke with one registered nurse and three care assistants.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 October 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP was validated during this inspection. Refer to the section below for details.

4.2 Review of requirements and recommendations from the last care inspection dated 12 October 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 30 December 2016	The registered provider should ensure that the issues identified in the laundry are addressed. This area should be redecorated.	**Met**
	Action taken as confirmed during the inspection: Observation and discussion with the registered manager confirmed that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 7 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure patient and relatives meetings are undertaken. Records should be held of the minutes and any issues arising should be addressed.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of minutes confirmed that a relatives meeting had been held in November 2016.	

4.3 Inspection Findings

4.3.1 Management of nutrition and weight loss

Review of records evidenced that patients' menu choice and food eaten at each meal was recorded on a daily basis. Records also indicated if patients required a therapeutic diet. Those patients identified as being at a high risk of malnutrition had a detailed record of their daily food and fluid intake recorded and evaluated by nursing staff.

Nutritional screening was carried out using a validated nutritional risk assessment tool. Initial assessment was carried out on a patient's admission to the home and thereafter on at least a

monthly basis. More frequent screening/monitoring of a patient's weight was undertaken where a weight loss was identified. Monthly and weekly weight records were reviewed.

Five patients risk assessments and care plans relating to the management of weight and nutrition were reviewed. It was evident that nursing staff prescribed nutritional care in accordance with patients' specific needs and that the risk assessment undertaken informed this process. Risk assessments and care plans were kept under review and were reflective of Department of Health's (DoH) regional nutritional guidance and recommendations from other healthcare professionals such as the dietician and speech and language therapist (SALT).

Discussion with the registered manager confirmed the procedure followed when a patient, assessed as being at risk of malnutrition, experienced a weight loss. Nursing staff commenced the patient on weekly weights, provided a fortified diet, recorded daily food and fluid intake and re-evaluated the patient's weight one week later. If a weight gain was achieved the procedure was continued until the patient's weight loss was regained and stable. If a further weight loss occurred the patient's General Practitioner (GP) was asked to make a referral to the Trust's dietician.

The registered manager confirmed that the waiting time for a dietician assessment was up to 12 weeks and the interim arrangements implemented by the nursing staff. These included the following:

- weekly monitoring of the patient's weight and if further weight loss identified continue to escalate to GP while awaiting dietician assessment
- daily food intake monitoring
- fortification of the patient's diet. For example, the patient was offered full fat milky drinks, high calories snacks and where possible additional calories were added to their meals by adding butter/cream to main meals and desserts.

The registered manager confirmed that not all GPs prescribed nutritional supplements before a dietician's assessment had been undertaken; therefore the interim fortification of food and monitoring was important to try to reduce or stop the weight loss. If a GP did prescribe nutritional supplements then these were administered, as prescribed, in addition to the fortification of food undertaken by the home.

Review of patient records evidenced that this approach to managing weight loss was effective.

Patients spoken with were complimentary regarding the menu choices and the food served. Patients also confirmed that they were offered fresh fruit, fruit smoothies, cakes, buns, pancakes, fruit breads, extra desserts and plenty of tea and coffee, milk, juice. Observation confirmed that variety of fluids were available in communal areas and in the bedrooms for those patients who choose to remain in their bedroom.

The lunch time meal consisted of a choice between braised steak or roast chicken with turnip, cabbage and potatoes; dessert was jelly and ice cream. The menu was displayed in the dining room and patients were aware of their choice and the alternatives. The lunch looked and smelt appetising.

Fluid intake charts recorded for all patients were monitored by nursing staff throughout their shift. Nursing staff and care assistant confirmed that if a patient had not attempted to reach their daily fluid or food targets then the review would alert staff to encourage them to do so from midday rather than later in the day when the patient could be too tired to eat or drink more. This is good practice.

The registered manager was very aware of patients at risk of malathion/weight loss and dehydration as she also works as a nurse the nurse in charge of the shift on a regular basis.

Advice was provided that the registered manager should ensure, as part of the governance process, that she records a regular assessment/evaluation of the effectiveness or otherwise of the management of nutrition and weight loss and include any actions taken by her in response to identified deficits or delays.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

4.3.2 Additional areas inspected

Patients register

Review of the registered confirmed that it was accurately maintained.

The registered manager confirmed that if a patient was admitted to hospital or another care home a letter of transfer and a copy of the patient's medication prescription record was sent with them. The transfer form was duplicated and a copy of the information sent was retained in the home.

The registered manager also confirmed that new patients, admitted from outside the home's area, were registered with a local GP as was their wish. Review of patient records confirmed they were registered with GPs.

Notification to RQIA

Review of notifications received since the last care inspection in October 2016 and review of accidents and incident records confirmed that RQIA were appropriately notified.

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 provider from their responsibility for maintaining compliance with the regulations and standards.

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