Unannounced Care Inspection Report
10 May 2017

Cherryvalley Care Home

Type of Service: Nursing Home
Address: 14-24 Kensington Drive, Belfast, BT6 6NU
Tel No: 028 9040 1564
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Cherryvalley Care Home took place on 10 May 2017 from 10:00 to 17:00 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

There were no areas for improvement identified in this domain.

Is care effective?

We reviewed the management of pressure area care, care of the ill patient, nutrition and weight loss. Care records contained details of the specific care requirements in each of the areas reviewed and a contemporaneous record was maintained to evidence the delivery of care. Care records also reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT), dieticians and General Practitioners (GPs).

Supplementary care charts such as repositioning, food 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 and information. A recommendation was made in relation to how staff recorded the status of patient's skin/pressure areas.

Is care compassionate?

We arrived in the home at 10:00 hours and were greeted by staff who were helpful and attentive. Patients were enjoying either finishing a late breakfast or a morning cup of tea/coffee in the sitting areas/lounge or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice depending of which they preferred and staff were observed assisting patient to drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

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. Discussion with patients confirmed that living in Cherryvalley Care Home was a positive experience.

A recommendation was made in relation to the management of patient information.

Is the service well led?

The certificate of registration issued by RQIA was clearly displayed in the foyer of the home.

Review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided.

Unannounced quality monitoring visits were completed on a monthly basis by an external person on behalf of the provider. Copies of the quality monitoring visits were available in the home.

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

The home has a keypad locking device to exit the home. A requirement was made to the review the use of keypad locks within the nursing home in conjunction with guidance from the Department of Health on human rights and the deprivation of liberty safeguards (DoLs); and the home's registration categories.

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	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Catalina Puiu, 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.

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 30 December 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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.

2.0 Service details

Registered organisation/registered person: Dr Maureen Claire Royston	**Registered manager:** See below
Person in charge of the home at the time of inspection: Nurse Romalyn Montinola from 10:00 hours Ms Catalina Puiu from 11:15 hours	**Date manager registered:** Ms Catalina Puiu - acting
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 46

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 we met with 10 patients individually and with others in small groups; one registered nurse, five care staff, one domestic staff, two catering staff and two relatives. Questionnaires were also left in the home to obtain feedback from patients, relatives and staff not on duty during the inspection. Eight patient and 10 questionnaires for staff and relatives were left.

The following information was examined during the inspection:

- duty rota for all staff from 1 to 14 May 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 food and fluid intake charts and reposition charts
- consultation with patients, relatives and staff
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability insurance
- monthly quality monitoring reports undertaken in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 30 December 2016

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 7 June 2016

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

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 rota from 1 to 14 May 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 evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; nine were returned following the inspection. Eight respondents answered 'yes' to the question, "Are there sufficient staff to meet the needs of the patients?" One respondent recorded that there were "not enough staff" but indicated that they were "very satisfied" that care was safe.

Patients spoken with during the inspection commented very positively regarding the staff and the care delivered, and that they were satisfied that when they required assistance staff attended to them in timely manner. We also sought the patients' opinions on staffing via questionnaires; three were returned indicating that there was sufficient staff to need their needs.

Two relatives spoken with confirmed that they had no concerns and felt assured that their loved one's needs were being met. We sought other relatives' opinion on staffing via questionnaires; three completed questionnaires were returned. All respondents indicated that staff had enough time to care for their relatives.

Staff recruitment information was available for inspection and 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 and records were maintained; and that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that the manager had a process in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2017. Records were maintained in accordance with Standard 39 of The Care Standards for Nursing Homes 2015. Mandatory training compliance was monitored by the manager and also reviewed by senior management as part of the monthly quality monitoring process. Additional training was also available to staff to ensure they were able to meet the assessed needs of patients.

Observation of the delivery of care evidenced that training, such as moving and handling training, had been embedded into practice. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager, confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedures into practice. A safeguarding champion had been identified and training was arranged.

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process and that these assessment were reviewed regularly and informed the care planning process.

Review of accidents/incidents records from 1 January 2017 and notifications forwarded to RQIA confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and personal protective equipment (PPE) such as gloves and aprons were available throughout the home. One staff member was observed to be wearing 'flip flops', this was discussed with the staff member and advice was provided in relation to safety at work. The staff member was aware that they should not be wearing this type of footwear and agreed to change their shoes. Details were discussed with the manager during feedback.

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?

Review of three patient care records evidenced that care plans were in place to direct the care required. Nursing staff spoken with were aware of professional requirements to review and update care plans as the needs of patient changed. Nursing staff also demonstrated awareness of the need to review and update care plans when recommendations were made by other healthcare professionals such as, the speech and language therapist (SALT) or the tissue viability nurse (TVN) were changed.

We reviewed the management of pressure area care, care of the ill patient, nutrition and weight loss. Care records contained details of the specific care requirements in each of the areas reviewed and a contemporaneous record was maintained to evidence the delivery of care. Care records also reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT), dieticians and General Practitioners (GPs). The manager had also introduced an dietary overview document for staff to refer to on a daily basis. This record was regularly reviewed to ensure it reflected any changes in care needs.

A care plan reviewed to assess the management of pressure area care/repositioning of the patient indicated that the care plan had been reviewed on at least a monthly basis. A review of the patients' repositioning chart evidenced that the required care was being delivered. However, the care plan did not reflect the patient's current nursing needs in relation to repositioning. Details were discussed with nursing staff, the care plan was rewritten and the manager agreed to follow up with nursing staff.

Supplementary care charts such as repositioning, food 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 and information.

A record made on a patient's reposition chart stated "skin red". This was brought to the attention of nursing staff who agreed to check what this entry meant as any red area noted could indicate a grade one pressure ulcer. Feedback confirmed that the patient did not have a grade one pressure ulcer and it was agreed that this entry was unclear and not in keeping with good practice guidelines relating to pressure area care and grading. A recommendation was made.

Discussion with staff evidenced 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.

Staff spoken with confirmed that staff meetings were held and records were maintained of the staff who attended, the issues discussed and actions agreed.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their immediate line manager, the manager or the regional manager.
All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

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 register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

A recommendation was made that any staff member carrying out an assessment of a patient's skin is aware of how to do so and record their observations. Refer to NICE guidelines on the management and prevention of pressure damage; clinical guideline 179.

Number of requirements	0	**Number of recommendations**	1

4.5 Is care compassionate?

We arrived in the home at 10:00 hours and were greeted by staff who were helpful and attentive. Patients were enjoying either finishing a late breakfast or a morning cup of tea/coffee in the sitting areas/lounge or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice depending of which they preferred and staff were observed assisting patient to drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. However, displayed on the wall in the small dining room on the first floor were lists of patients' names and dietary requirements. The manager was unaware that the information was displayed and immediately removed it. A recommendation was made.

Patients able to communicate their feelings indicated that they enjoyed living in Cherryvalley Care Home. 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.

Discussion with the manager and review of records confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home.

Ten relative questionnaires were issued; three were returned within the timescale was and all indicated that they were very satisfied with the care provided across the four domains. There were no additional comments recorded.

Ten questionnaires were issued to staff; nine were returned prior to the issue of this report. Staff members were either very satisfied or satisfied with the care provided across the four domains.

One staff member recorded comments which were discussed with the manager by telephone on 26 May 2017. RQIA were provided with assurances that the issues discussed were being managed appropriately.

Eight questionnaires were issued to patients; three were returned prior to the issue of this report. Patients responded that they were very satisfied with their care across the four domains.

Any comments from patient representatives 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 for improvement

A recommendation was made that patient information and records should be maintained in a confidential manner to ensure the privacy and dignity of patients is upheld.

Number of requirements	0	**Number of recommendations**	1

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home. However, the insurance certificate had expired. The manager agreed to email RQIA a copy of the new certificate and this was received on 12 May 2017.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered.

A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the manager's working patterns provided good opportunity to allow them to have contact as required.

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.

Review of records evidenced that monthly audits were completed to ensure the quality of care and services was maintained. For example, audits were completed for accidents/incidents, complaints and infection prevention and control. The records of audit evidenced that any identified areas for improvement had been addressed and checked for compliance. Audit outcomes informed the monthly quality monitoring process undertaken by the regional manager.

Review of records for March and April 2017 evidenced that quality monitoring visits were completed on a monthly basis. Recommendations were made within the report to address any areas for improvement. Copies of the quality monitoring visits were available in the home.

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

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with staff evidenced that there was a clear organisational structure within 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.

We also discussed the registration process with the manager who is currently in an acting position. The manager confirmed that she would not be coming forward for registration at this time and that she continues to be supported, in her role, by senior managers.

Discussion with the manager took place regarding the use of the keypad locking systems to exit the home. Based on the home's registered categories of care a requirement was made to review the use of keypad locks.

Areas for improvement

A requirement was made in relation to the review the use of keypad locks within the nursing home in conjunction with guidance from the Department of Health on human rights and the deprivation of liberty safeguards (DoLs); and the home's registration categories.

Number of requirements	1	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Catalina Puiu, manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13 (1) **Stated:** First time **To be completed by:** 15 June 2017	The registered provider must review the use of keypad locks within the nursing home in conjunction with guidance from the Department of Health on human rights and the deprivation of liberty safeguards (DoLs); and the home's registration categories. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: The keypads locks have been removed on the 30th of May 2017 and push buttons have been put in place.
Recommendations	
Recommendation 1 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 10 April 2017	The registered provider should ensure that any staff member carrying out an assessment of a patient's skin is aware of how to do so and how to record their observations. Refer to NICE guidelines on the management and prevention of pressure damage; clinical guideline 179.
	Response by registered provider detailing the actions taken: I have issued the staff with NICE guidline on Managment and Prevention of Skin Damage 179 and I have scheduled training sesions for all the staff with our tissue viability nurse by the end of June.
Recommendation 2 **Ref**: Standard 5 **Stated:** First time **To be completed by:** 31 May 2017	The registered provider should ensure that patient information and records should be maintained in a confidential manner to ensure the privacy and dignity of patients is upheld. **Ref: Section 4.5**
	Response by registered provider detailing the actions taken: Supervision with all the staff on Confidentiality and Data Protection by the end of June.

Please ensure this document is completed in full and returned to the RQIA Web Portal from the authorised email address

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