Unannounced Care Inspection Report
5 October 2016

Clandeboye

Type of Service: Nursing Home
Address: 35 Cardy Close, Bangor, BT19 1AT
Tel No: 028 9127 1011
Inspector: Donna Rogan

1.0 Summary

An unannounced inspection of Clandeboye Care Home took place on 5 October 2016 from 10.30 to 18.00 hours.

The inspection sought to assess progress with issues raised during and since the previous 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 environment of the home was warm, well decorated, fresh smelling and clean throughout. There was evidence of competent and safe delivery of care on the day of inspection. Staff were required to attend mandatory training and the observation of care delivery evidenced that knowledge and skills gained, through training, was embedded into practice. Staff also confirmed that there were good communication and support systems in the home, including; staff appraisal and staff supervision systems. Staff confirmed they are required to attend a 'handover meeting' when commencing duty. Two recommendations are made in relation to selection and recruitment records and the management of the nurse call system for patients being nursed in bed.

Is care effective?

With the exception of one care record, care records reviewed, accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals. There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with patient representatives within the care records, in relation to any changes in the patients' condition. One care record required to be updated with regards to the management of a patient's skin condition. A requirement is made in this regard. Personal care records evidenced that personal care was delivered in line with their care plans. Discussion took place regarding the provision of personal care records in patients' bedrooms, whilst they are being nursed in bed. The registered manager agreed to carry out a review. Patients' confidentiality was respected by staff and the staff consulted confirmed that communication between all staff grades was effective. Staff, patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management. The registered manager also agreed to review the supply of equipment to aid patients' dexterity whilst managing mealtimes in order to maintain patients' independence and their dignity a recommendation is made in this regard.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

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.

Responses received from three patients, seven patients' representatives and 11 staff in the returned questionnaires would indicate a high level of satisfaction with this service.

There were no requirements or recommendations made in this domain.

Is the service well led?

There was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. Complaints were managed appropriately. There were systems in place to monitor and report on the quality of nursing and other services provided. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. There were also 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. All incidents had been managed appropriately and reported in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. Monthly monitoring visits were also completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. A recommendation is made that the registered manager recommences regular staff and relatives meetings.

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 DHSS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**1**	**4**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Joanne Roy, registered 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 announced estates inspection undertaken on 26 April 2016. There were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered provider: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Joanne Roy
Person in charge of the home at the time of inspection: Joanne Roy	**Date manager registered:** 9 December 2010
Categories of care: NH-DE	**Number of registered places:** 52

3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report
- pre inspection assessment audit.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with 20 patients, six care staff, the deputy manager, two registered nurses and three patient's representatives.

The following information was examined during the inspection:

- staffing arrangements in the home
- four patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to adult safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 26 April 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider, as recorded in the QIP will be validated at the next estates inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 08 March 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 4.1 **Stated:** First time	There should be a robust system in place to monitor the development of patients' risk assessments and care plans, to ensure that these are completed within 5 days of admission to the home. The system should also be shared with the registered nurses who have responsibility of being in charge of the home.	**Met**
	Action taken as confirmed during the inspection: A review of four care records evidenced that risk assessments and care plans were completed within five days of admission to the home. Registered nurses spoken with were aware of this system.	
Recommendation 2 **Ref**: Standard 16.6 **Stated:** First time	Staff should be provided with training on dealing with complaints to ensure that they understand that a complaint is any expression of dissatisfaction with the service provided in the home and that they know how to initially deal with complaints. A record of the training provided, in whatever format, should be retained in the home.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that training was provided to staff on how to deal with complaints. A record of the training is retained in the home.	

4.3 Is care safe?

There were systems in place for the recruitment and selection of staff. A review of two personnel files evidenced that these were reviewed by the registered manager and checked for possible issues. However neither of the two files reviewed contained pre-employment health assessments. The registered manager stated that there was a system in place to receive health assessments and agreed to address why they were not retained on file. A recommendation is made in this regard. Where nurses and carers were employed, their personal identification numbers (PIN) were checked monthly with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC) if applicable, to ensure that their registration status was current. The review of recruitment records evidence that enhanced criminal records checks were completed with Access NI and a record was maintained which included the reference number and date received.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. This ensured that they had the basic knowledge needed to begin work.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed training on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adults safeguarding. Observation of the delivery of care evidenced that training had been embedded into practice. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota commencing 3 October 2016 and 16 October 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained and that appropriate information was communicated in the shift handover meetings.

There were a number of patients being nursed in bed, there were various reasons explained by the deputy manager as to why patients were observed in bed. There were however no nurse call leads provided for these patients and the registered manager agreed that this should be reviewed to ensure patients are appropriately assessed to use the nurse call system; where necessary a means for calling for help is provided for patient and staff use. A recommendation is made in this regard.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The registered manager demonstrated good knowledge regarding adult safeguarding and confirmed that any potential safeguarding concern would be managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures and that RQIA would be notified appropriately. There were no ongoing safeguarding issues in the home.

A range of risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails and restraint, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate; assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were updated following each incident; care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. The areas reviewed were found to be clean, tidy, well decorated and warm throughout. . Infection prevention and control measures were adhered to and equipment was stored appropriately. The domestic staff were commended on this occasion for maintaining a clean and fresh welcoming environment. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

There were two recommendations made in relation to selection and recruitment records and the management of the nurse call system for patients being nursed in bed.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

Patients' needs were evidenced to be assessed on admission and care plans were developed and reviewed on a regular basis. A review of three patient care records evidenced that risks to patients were assessed. Examples included moving and handling assessments and risk of falls; bedrails and other restraints; risk of developing pressure damage and assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. One care record required to be updated to reflect the identified patient's condition and a care plan should be put in place to manage the condition. Wound care should also be managed in keeping with best practice. A requirement is made in this regard.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

The care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records, in relation to any changes in the patients' condition.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. Discussion took place regarding the provision of personal care records in patients' bedrooms, whilst they are being nursed in bed. The registered manager agreed to carry out a review.

Where patients required the use of a lap belt, whilst seated in their chairs, the review of records evidenced that these were checked and released on a regular basis, in line with the care plan.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to discussing patients' details in front of other relatives.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and it provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Consultation with staff confirmed 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 line manager and /or the registered manager. Information leaflets were available for patients or relatives they were displayed in the front entrance of the home. Advocates or patient representatives can represent the views for patients who are unable or not confident in expressing their wishes.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon. Four Seasons Health Care (FSHC) have introduced a' Quality of Life' programme which provides patients, relatives and visitors an opportunity to have their say about their experiences regarding the home. The registered manager also informed the inspector that she formally seeks views from two patients and their relatives at least weekly. The findings are recorded in the home's 'TRaCA system'.

Observation of the lunch time meal confirmed that patients were given a choice in regards to, food and fluid choices and the level of help and support requested. Staff were observed to offer patients reassurance and assistance appropriate to their needs. The daily menu was displayed in the dining rooms and offered patients a choice of two meals for lunch and dinner. A choice was also available for those on therapeutic diets. Some patients were observed to choose homemade tomato soup for their lunch. The soup was served in coloured bowls. Not all patients were observed to manage to eat their soup from the bowls in a dignified way. The registered manager agreed to review the supply of equipment to aid patients' dexterity whilst managing mealtimes in order to maintain their independence and dignity. A recommendation is made in this regard.

Areas for improvement

One requirement was made in relation to the management of care records and wound care and one recommendation is made regarding the provision of appropriate aids at meal times.

Number of requirements	1	Number of recommendations	1

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with approximately 20 patients both individually and in small groups, confirmed that they were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their choices were listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Menus were displayed clearly throughout the building and were correct on the day of inspection. We observed the lunch time meal in the dining room. We saw that the atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were nicely set with tablecloths, condiments and table decorations. As previously stated in section 4.4 specialist cutlery/crockery and plate guards should be made available to assist patients who were able to maintain some level of independence as they ate their meal.

The registered manager stated that there are now two activity coordinators employed over five days a week for a total of 35 hours to assist patients in the both suites with activities. There was a hairdresser who visits weekly and there was also evidence that music and entertainment was a regular occurrence in the schedule of activities.

Staff confirmed that the spiritual needs of patients were catered for and there was evidence of regular visits by ministers of different faiths.

A review of patient care records confirmed information about the patient's background. Each patient had a 'Life Story' record, displayed in their bedrooms, which aimed to provide information about their life and interests, before they came to live in the home.

Patients' representatives spoken with confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. The complaints procedure was displayed in the reception area of the building. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received during the inspection and in the questionnaires are detailed below:

Staff

- "I love my job"
- "we all work well as a team"
- "sometimes the manager is too busy to come out of the office"
- "very satisfied that the service is well led, however the manager is too busy working in the office"
- "not all service users are able to converse, when this is the case we refer to care plans and discuss with family"
- "this is a good place to work, the care is excellent"
- "we are well trained and communication is good"
- "I feel listened to"

Patients

- "I like it here"
- "I enjoy the food"
- "my only complaint is that due to allergies, I can't eat a lot and would like more choice"
- "I'm happy here, I am well looked after"
- "It's good"

Patients' representatives

- "I feel my relative is very well cared for"
- "everyone is so kind and approachable"
- "I have never had cause to complain or suggest improvements"
- "staff have time to listen to my relative, but there are times when time is limited"
- "I think the care is excellent"

Areas for improvement

There were no areas for improvement identified during the inspection in this domain.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

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

The registered manager confirmed that the policies and procedures for the home were systematically reviewed. Staff confirmed that they had access to the home's policies and procedures.

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 DHSSPS Care Standards for Nursing Homes 2015. Staff and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Relatives were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- wound management
- medicines management
- care records
- infection prevention and control
- environment audits
- complaints.

The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. For example, an audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. 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 notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

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. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement. Discussion with the registered manager and a review of relevant records, evidenced that all areas identified in the action plan had been addressed.

A review of staff and relatives meetings evidenced that there had been no staff meetings minutes recorded since 23 February 2015 and no relatives meetings have been held since 30 January 2014. A recommendation is made that the registered manager recommences regular staff and relatives meetings. Minutes of the meetings should be retained alongside and any action taken to address any issues raised.

Areas for improvement

One recommendation was raised in respect of the re-establishment of regular staff and relatives meetings.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Joanne Roy, registered 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 through the 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 15 **Stated:** First time **To be completed by:** 30 October 2016	The registered provider must ensure that the care record is updated to reflect the identified patient's condition and a care plan should be put in place to manage the condition. Wound care should also be managed in keeping with best practice. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Unfortunately the identified resident passed away within 24 hours of inspection. However staff supervisons have been held with all RN's in relation to appropriate record keeping for those residents with a wound. This will be reviewed through the audit process and any non-compliance identified will have the appropriate action will be taken.
Recommendations	
Recommendation 1 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure pre-employment health assessments are completed during the selection and recruitment process. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: A recruitment checklist has been implemented which will ensure all required documentation is completed prior to the post being offered. This will be monitored though the audit process. All staff currently employed have a pre-employment health assessment on file.

Recommendation 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should review the provision of the nurse call system in bedrooms where patients are being nursed in bed. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: There is now a Nurse Call located in all bedrooms unless there is an identified risk. If there is a risk identifed then following a discussion with relevant persons a Risk Assessment will be completed, agreed and placed in the residents care file.
Recommendation 3 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should review the supply of equipment to aid patients' dexterity whilst managing mealtimes in order to maintain patients' independence and their dignity. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: The Registered Manager has reviewed the equipment to aid the residents dexterity during mealtimes in order to maintain independence. The crockery in use is currenlty being reviewed and appropriate crockery will be supplied to meet residents needs.
Recommendation 4 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that staff and relatives meetings are reintroduced and are regularly conducted. Minutes and any actions taken as a result should be retained. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: The Registered Manager has re-instated the quarterly meeting planner to year end through to 2017. Minutes will be made available for all staff, relatives and residents following each meeting. Compliance will be monitored via the auditing process.

Please ensure this document is completed in full and returned through the web portal

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