Unannounced Care Inspection Report
19 – 20 April 2016

Clifton Nursing Home

Address: 2a Hopewell Avenue, Carlisle Circus, Belfast
Tel No: 028 9032 4286
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Clifton Nursing Home took place on 19 April 2016 from 09.30 to 15.30 and 20 April 2016 from 09.30 to 16.15 hours.

The inspection sought to assess progress with any 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?

Following discussion with patients, representatives and staff; and a review of records there was evidence of good delivery of care and positive outcomes for patients. To enhance the environment in the Benn suite it is recommended that the chairs used by patients are replaced.

Is care effective?

Following discussion with patients, representatives and staff there was evidence of the effective delivery of care to patients. A recommendation has been stated regarding the care planning process.

Is care compassionate?

There was evidence of good communication in the home between staff and patients and patients and their representatives were very praiseworthy of staff and of the registered manager.

Is the service well led?

There was evidence that effective management systems had been established in the home and that the services provided by the home were regularly monitored. One recommendation has been stated in relation to quality auditing of the services provided by the home.

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	3

Details of the quality improvement plan (QIP) within this report were discussed with Stuart Johnston, 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 unannounced care inspection on 11 August 2015.

Other than those actions detailed in the previous QIP there have been no further actions/enforcement since the previous inspection?

2.0 Service details

Registered organisation/registered person: Runwood Homes	**Registered manager:** Stuart Johnstone
Person in charge of the home at the time of inspection: Stuart Johnston	**Date manager registered:** 16/12/2015
Categories of care: NH-PH, NH-DE, NH-I	**Number of registered places:** 100

3.0 Methods/processes

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

Prior to inspection the following information was analysed:
- 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 returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- 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 19 patients, seven care staff, two activities coordinators, ancillary staff, five registered nurses and six patient's representatives.

The following were examined during the inspection:

- validation evidence linked to the previous QIP
- staff roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- staff supervision and appraisal planner

- complaints and compliments records
- incident and accident records
- records of quality audits and
- records of staff, patient and relatives meetings

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 August 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned to RQIA and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 11 August 2015.

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 16 (1) and Standard 32.1 **Stated:** First time	The registered person must ensure: • information regarding patients end of life wishes, in consultation with patients' representatives, where applicable, is retained in care records • a care plan is written, monitored and evaluated in respect of the palliative or end of life wishes and needs of patients. The care plan should reflect the recommendations of the specialist palliative care team, where applicable.	**Met**
	Action taken as confirmed during the inspection: The review of three care records evidence that, where appropriate, staff had detailed and discussed the end of life wishes with patients and/or their representatives. A care plan had been developed following the discussions. Evidence was present of the recommendations of the specialist palliative care team, where appropriate.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 19.6 and 32.1 **Stated:** First time	A management system should be implemented to evidence staff have read and understood the new policy documentation in respect of communicating effectively and palliative and end of life care.	**Met**
	Action taken as confirmed during the inspection: Staff had signed and dated a record to verify that they had read the policy documentation in respect of communicating effectively and palliative and end of life care.	
Recommendation 2 **Ref:** Standard 19 **Stated:** First time	Training in respect of communicating effectively should be provided for staff. The training should include the areas discussed in standard 19.	**Met**
	Action taken as confirmed during the inspection: Training records evidenced staff had completed training in respect of communicating effectively. Training had been provided in the home in October 2015, November 2015 and December 2015.	
Recommendation 3 **Ref:** Standard 32 **Stated:** First time	Training in respect of palliative and end of life care should be provided for staff. The training should include the areas discussed in Standard 32.	**Met**
	Action taken as confirmed during the inspection: Training records evidenced staff had completed training in respect of palliative and end of life care. Training had been provided in the home in October 2015, November 2015 and December 2015.	
Recommendation 4 **Ref:** Standard 32 **Stated:** First time	Management should ensure that the identified link nurses for palliative and end of life care have completed training to enable them to provide specialist advice and support to the staff team.	**Met**
	Action taken as confirmed during the inspection: Two registered nurses had been identified as the link nurses for palliative and end of life care. Both had completed specialist training in palliative care.	

Recommendation 5 **Ref:** Standard 39.1 **Stated:** First time	Palliative and end of life care should be included in the induction training programme for registered nurses and care staff.	**Met**
	Action taken as confirmed during the inspection: The review of three staff induction training records confirmed that palliative and end of life care was included in the induction programme.	
Recommendation 6 **Ref:** Standard 35 **Stated:** First time	The registered person should ensure that the Regulation 29 monthly monitoring report reflects on one visit to the home to monitor the quality of services.	**Met**
	Action taken as confirmed during the inspection: The Regulation 29 monthly monitoring reports of February 2016, March 2016 and April 2016 were viewed. Evidence was present of the date and duration of the visit.	

4.3 Is care safe?

The registered 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 for week commencing 11 April 2016 evidenced that the planned staffing levels were adhered to.

In addition to nursing and care staff staffing rosters, it was confirmed that administrative, maintenance, catering, domestic and laundry staff were on duty daily. However, in discussion with staff in the Donegal and Toby Hurst suites, staff stated they felt that staffing levels were not sufficient in the afternoon to meet the needs of patients. Four care assistants are rostered from 08.00 to 14.00 hours, per unit. This reduces to three care assistants per unit from 14.00 to 20.00 hours. Staff stated that both units were fully occupied and nursing staff were not always able to provide assistance with patients' personal care or the patients assessed safe moving and handling needs. Discussion with patients and representatives evidenced that there were no concerns regarding staffing levels. The inspector did not observe any impact on patient care on the day of inspection. Staff were observed assisting patients in a timely and unhurried way. This matter was brought to the attention of the manager who agreed to address these concerns with the staff and keep the staffing arrangements under review.

A review of three staff personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. A checklist was in evidence in each file as an aide memoire to ensure all required information was present.

Discussion with staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

Three completed induction programmes were reviewed. The programmes included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The registered manager also signed the record to confirm that the induction process had been satisfactorily completed.

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 registration status of staff was checked by administrative staff on a monthly basis.

Discussion with the registered manager, staff on duty and a review of records confirmed that there are systems in place to ensure that staff received regular supervision and annual appraisal. A review of six records and discussion with the registered manager confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home.

Training was available via an e learning system, internal face to face training arranged by Runwood Homes Ltd and training provided by the local health and social care trust. The registered manager had systems in place to monitor staff attendance and compliance with training. Staff training is also reviewed at the monthly monitoring visit completed by John Rafferty, Northern Ireland Operational Director, Runwood Homes Ltd.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Training records reflected that 93% of staff had undertaken adult safeguarding training in the past 12 months. Annual refresher training was considered mandatory by the home. In discussion with staff it was confirmed that the adult safeguarding training module reflected the Adult Safeguarding Prevention and Protection in Partnership, July 2015 policy document.

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

A review of documentation confirmed that any safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. The registered manager had robust systems in place to monitor the progress of safeguarding issues with the local health and social care trust and the PSNI. This included monthly audits of any incident referred to the Adult Safeguarding Gateway Team to verify if the incident had been screened out by the team and/ or the status of the investigation.

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 the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of falls to identify any trends or patterns.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. Patients, representatives and staff spoken with were complimentary in respect of the home's environment. The registered manager stated that new flooring had been agreed for Donegal suite. Areas of the home had been enhanced to provide a more homely and attractive environment, for example, recessed areas in the corridors. This had been achieved with good effect. However, a number of chairs in the Benn Suite evidenced wear and tear and despite regular cleaning no longer appeared fresh. A replacement programme in respect of the chairs used by patients is recommended. A recommendation has been made.

Fire exits and corridors were observed to be clear of clutter and obstruction. A patient's bedroom door was observed to be wedged open. This was discussed with the registered manager who stated despite the patient being asked not to do so the practice continues. It was agreed the registered manager would address this issue with the patient. Further advice may also be sought from the estates Inspector aligned to Clifton Nursing Home. Personal evacuation plans were in place and were reviewed on a regular basis.

There were no issues identified with infection prevention and control practice.

Areas for improvement

It is recommended a replacement programme of the chairs in the patient lounge areas in Benn suite should be implemented.

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

4.4 Is care effective?

A review of six 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 were evaluated on a monthly basis and informed the care planning process. Care records generally 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.

Two issues arose following the review of care records and were discussed with the registered manager. Firstly, the progress record should reflect the actual delivery of care, for example; staff should not record in a generalised manner and should state the actual care given to patients. Secondly, where a care plan is no longer relevant the care plan should be discontinued. Care plans should reflect the current assessed needs of patients. A recommendation has been made. Refer to section 4.6 for information regarding the auditing of care records.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Care records were computerised and were password protected.

Supplementary care charts including; repositioning charts and food and fluid intake charts evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. These records are also computerised however; manual recording was also maintained where the assessed needs of a patient necessitates this, for example observation/supervision of a patient.

Evidence that the care planning process included input from patients and/or their representatives was not present. This was discussed with the registered manager who agreed to address this. By the conclusion of the inspection a proforma had been developed to evidence consultation in respect of care planning. There was evidence of communication with representatives within the care records; for example, in the event of a patient falling or medical advice being sought.

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. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Discussion with the registered manager confirmed that staff meetings were held on a quarterly basis and records were maintained. Staff confirmed they could contribute to the agenda if they so wished and stated they had the opportunity to raise issues at the time. Staff stated they were comfortable discussing issues with management and stated the registered manager was very 'approachable'. A weekly meeting was also evidenced to be held with the clinical leads of the three units

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals and of how to make appropriate referrals for advice and support.

Discussion with the registered manager and review of records evidenced that patient and/or relatives meetings were held on a quarterly basis. The minutes of the most recent patients and relatives meetings were reviewed and confirmed who attended and the detail of the issues discussed.

Patient and their representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives knew the registered manager and the deputy manager.

A new initiative had recently been introduced whereby two relatives had agreed to become 'home ambassadors' and represent patients in the general nursing and dementia suites. The role of the home ambassadors is to be part of focus groups to help drive improvements in patient care and the life of the home.

There was information available to staff, patients, representatives in the home. The relatives' notice board contained information in relation to planned outings and activities, dates of relatives and patient meetings and a mobile phone number of the registered manager so as he may be contacted, for discussion, if he was not available at the time relatives were in the home.

The serving of lunch was observed in Toby Hurst and Benn suites. Tables were set with cutlery, condiments and napkins. Those patients who had their lunch in the lounge or bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room.

Meals were transported from the kitchen in heated trolleys. A registered nurse was present in the dining rooms and organised the serving of meals. There was a choice of meal available for patients including patients who required a specialised diet.

The serving of the lunch was observed to be well organised with all of the patients being attended to in a timely manner. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch.

Areas for improvement

It is recommended that nursing staff ensure that progress records reflect the actual care given to a patient and if a care plan is no longer applicable, the care plan is discontinued

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

4.5 Is care compassionate?

There was a calm atmosphere in the home throughout the inspection and staff were quietly attending to the patients' needs. Consultation with 19 patients individually and with others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff spoke to them in a polite manner.

Comments received from patients included:
'Staff are very good here.'
'Staff are very helpful.'
'Staff are A1.'
'Meals are fine, not like home but not bad.'
'I'm very comfortable here.'
'Can't complain, couldn't complain about a thing.'

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. A gentlemen's 'lunch club' in the Cunningham room was held on the second day of the inspection. The activities coordinators stated they alternate weekly between a ladies and gentlemen's lunch club. Patients from all three suites attended and it was greatly enjoyed. The home has an active and varied activities programme which is facilitated by long standing and experienced activities coordinators.

Patients appeared well dressed and generally there was evidence of staffs attention to detail regarding patients personal care. However, a small number of patients were observed to have unclean nails and one patient had not had their face washed after having been assisted with a meal. This was discussed with the registered manager and deputy manager who agreed to inform staff of the importance of attention to detail in respect of patients' personal care needs. Observation of care delivery confirmed, with the exception of those discussed above, that patients were assisted appropriately, with respect, and in a timely manner.

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. Staff were able to demonstrate their knowledge of patients' life history and of what was important to individuals.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. Two church services were held in the home during the inspection and were of differing denominations.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Comments received from patient representatives included:

'Staff are very approachable.'
'Staff are excellent.'
'The home is spotless.'
'There has been a lot of positive changes.'
'Can't praise the staff highly enough.'

The registered manager was appointed to the home in July 2015 and comments received from staff and patient representatives were very positive in regard to the management of the home since their taking up this position in the home. Specific comments are detailed in section 4.5 above. Comments received from staff and patient representatives included:

'Management are very approachable.'
'The (manager) is great, the door is always open to you and feel you're listened too.'
'The (manager) comes and asks if everything is okay.'

Questionnaires

As part of the inspection process we issued questionnaires to staff (10), patients (10) and patients' representatives (8). The returned questionnaires were positive regarding the quality of nursing and other services provided by the home. Staff made comment that staffing levels in Benn and Donegal suites had been reduced and this had an impact on how staff completed their work. The registered manager should review these comments and inform RQIA of any action taken in respect of staffing arrangements.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

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.

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. In discussion patients were generally aware of the roles of the staff in the home and whom they should speak to if they had a concern. Staff spoken with were knowledgeable regarding line management within the home and who they would take any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships with management and that management were responsive to any suggestions or concerns raised.

The registered manager was appointed to the home in July 2015 and comments received from staff and patient representatives were very positive in regard to the management of the home since their taking up this position in the home. Specific comments are detailed in section 4.5 above

The registered manager confirmed that the policies and procedures for the home were systematically reviewed. In discussion with staff it was confirmed that staff had access to policy documentation and had read policies as required. This was evidenced by staff signing to confirm the date of reading any policy documentation.

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. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. The complaints procedure was displayed in prominent positions throughout the home. Patients and representatives confirmed that they were confident that management would listen to them and try and resolve any concern raised by them appropriately.

The registered manager discussed the systems in place to monitor the quality of the services delivered, and that a programme of audits was completed on a monthly basis. Areas for audit included care records, infection prevention and control practices, falls, complaints and the environment. A review of the record of audits evidenced that where an area for improvement was identified, an action plan was developed, improvements implemented and the area re-audited to check that the required improvement has been completed and sustained. However, following the review of the auditing of care records it was recommended that a more systematic approach should be implemented and that the audits should evidence that the remedial action identified had been actioned. The registered manager agreed with the recommendation and stated it is anticipated that in the future the clinical leads for each unit will participate in the auditing of care records.

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 for example; medication and equipment alerts. Alert information was observed displayed in the nurses' station in each of the three suites in the home.

Discussion with the registered manager and review of records evidenced that the monthly monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes 2015. Copies of the monitoring reports were available for patients, their representatives, staff and trust representatives. An action plan was generated following each monitoring audit 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 plans had been addressed.

Areas for improvement

It is recommended that management implement a systematic approach to the auditing of care records. Where shortfalls are identified the audit should evidence that remedial action had taken place.

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

5.0 Quality improvement plan

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

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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 person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to Nursing.Team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the service. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 43.2 **Stated:** First time **To be completed by:** 31 July 2016	The registered person must implement a programme of replacing chairs/seating in the Benn suite. **Ref: 4.3**
	Response by registered person detailing the actions taken: All furniture within the Home has been quality assured to ensure all items are presented and available to expected standards. The chairs in question from the Benn (EMI Nursing) Unit, will be removed post 3 replacement chairs arriving from our provider.
Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 31 May 2016	The registered person should ensure that patients' progress records reflect the actual care given to a patient and if a care plan is no longer applicable, the care plan is closed. **Ref: 4.4**
	Response by registered person detailing the actions taken: Communication has been provided to all nursing staff to action the archiving of care plans no longer active within a residents file. The archived care plans will be available for staff to peruse and utilise for a historical perspective but not active. Only current plans of care will remain within the file.
Recommendation 3 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 30 June 2016	The registered person should ensure that management implement a systematic approach to the auditing of care records. Where shortfalls are identified the audit should evidence that remedial action had taken place. **Ref: 4.6**
	Response by registered person detailing the actions taken: The care plan audit template has been amended to include an action plan request, timeline for audit and completion date. This is to be signed off by the staff member completing the care plan audit.

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address*

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews