The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
14 December 2016

Clifton Nursing Home

Type of Service: Nursing Home
Address: 2a Hopewell Avenue, Carlisle Circus, Belfast, BT13 1DR
Tel no: 028 9032 4286
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Clifton Nursing Home took place on 14 December 2016 from 09.30 to 17.00 hours.

Information was received by the RQIA duty desk on 6 December 2016 regarding; poor continence management, staff not referring to and talking to patients in an appropriate manner and poor moving and handling procedures and practice by staff. The concerns were referred to the adult safeguarding team in the Belfast Health and Social Care Trust who agreed to review the issues raised through a safeguarding investigation. The adult safeguarding team will keep RQIA informed of any investigation undertaken.

The purpose of this inspection was to seek assurances that the care and welfare of patients was in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes 2015.

On the day of the inspection concerns were identified in relation to the storage of and approach to continence management, care records did not accurately reflect patient needs, the patients dining experience and the management of hydration. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

At this inspection a number of areas for improvement were identified, and are required to be addressed, to ensure that care in the home is safe, effective and compassionate and that the service is well led.

Following the inspection, senior management in RQIA agreed that the registered persons would be required to attend a meeting in the Authority to discuss the findings of the inspection as a number of the identified areas for improvement were previously subject to enforcement action in 2014 and 2015. The meeting was held in RQIA on 21 December 2016. Mr Logan Logeswaran, Managing Director, Runwood Homes, attended the meeting on behalf of John Rafferty, Responsible Individual and Northern Ireland Operational Director of Runwood Homes. An action plan was submitted to RQIA at the meeting detailing how the identified concerns were being addressed by the management of the organisation.

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	4	9*

*Refers to two recommendations stated for a second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Cathy McCorry, Acting 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 care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 19 April 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. As stated in section 1.0 the focus of this inspection was with regard to concerns brought to the attention of RQIA by a whistle blower that did not impinge on the investigation by the adult safeguarding team of the local trust.

2.0 Service details

Registered organisation/registered person: Runwood Homes John Rafferty	**Registered manager:** Cathy McCorry
Person in charge of the home at the time of inspection: Cathy McCorry	**Date manager registered:** Acting – No Application
Categories of care: NH-PH, NH-DE, NH-I	**Number of registered places:** 100

3.0 Methods/processes

Information was received by RQIA on 6 December 2016 which raised concerns in relation to the areas discussed in section 1.0.

It is not the remit of RQIA to investigate complaints or safeguarding allegations made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate actions is required; this may include an inspection of the home.

Following discussion with senior management at RQIA, it was agreed that an inspection would be undertaken to review the following areas:

- continence management
- the management of nutrition and hydration
- moving and handling procedures and equipment

Prior to the inspection we analysed the following information:

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

The following methods and processes used in this inspection include the following:

- discussion with the acting manager
- discussion with staff
- observation of the midday meal
- a review of care records
- a review of menus and records of meals served
- a review of fluid intake recording
- an inspection of the premises

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 April 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. Please refer to section 4.2 for further information.

4.2 Review of requirements and recommendations from the last care inspection dated 19 – 20 April 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 43.2 **Stated:** First time	The registered person must implement a programme of replacing chairs/seating in the Benn suite. **Action taken as confirmed during the inspection**: The observation of the chairs in the Benn suite and discussion with the acting manager confirmed that a replacement programme of the chairs in the Benn suite had not commenced. This recommendation has been stated for the second time.	**Not Met**

Recommendation 2 **Ref:** Standard 4.9 **Stated:** First time	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.	**This recommendation has been subsumed into a requirement**
	Action taken as confirmed during the inspection: The review of patient care records evidenced that further work is required to ensure the care planning process is in accordance with professional and best practice standards. Refer to sections 4.3.1 and 4.3.3. **This recommendation has been subsumed into requirement 1 of this report.**	
Recommendation 3 **Ref:** Standard 35.6 **Stated:** First time	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.	**Partially Met**
	Action taken as confirmed during the inspection: Audits of patient care records in Toby Hurst, Donegal and Benn suites were reviewed. The review confirmed that quality auditing of care records was being completed regularly however the audits did not evidence, in all cases, that where a shortfall had been identified, remedial action had taken place. This recommendation has been stated for the second time.	

4.3 Inspection findings

4.3.1 Continence Management

The storage of continence products were viewed in Benn suite. There was evidence of ample stock of continence products however there were concerns in relation to storage arrangements. Both store rooms in Benn suite were very untidy with the packaging of continence products observed to be open and continence pads lying loose on shelving and trolleys. Continence products should be stored appropriately and not loose. A recommendation has been made. Trolleys were present in both store rooms and there was evidence of a range of creams and topical applications. The creams and topical applications were named for the individual use of a patient. The acting manager stated the patients named on the creams/topical applications were no longer resident in the home. This is not safe practice and staff should only use creams and topical applicants prescribed by a general practitioner for individual use. These practice also contravened infection prevention and control procedures. A requirement has been made.

Discussion took place with staff regarding patients who required support with continence management. The review of one patient's care record, stated by staff as requiring assistance, did not evidence a planned approach to continence management. The continence assessment had not been reviewed from January 2015 and a care plan was not present. Patients care records must accurately reflect the assessed needs of any patient, evidence that assessed need has been reviewed and that care plans have been developed and reviewed to reflect the assessed need of an individual. A requirement has been made.

Continence management should be undertaken by staff in a manner which respects and protects the dignity of patients. In a communal area a staff member was overheard saying to a patient, "I need to change your pad (name of patient)." On this occasion staff were not respecting the dignity of the patient. A recommendation has been made that staff undertake update training in the promotion of continence. Emphasis should be given to ensuring staff understand their responsibilities when assisting with personal care, regarding the core values of privacy, dignity and respect.

Areas for improvement

Patients care records must accurately reflect the assessed needs of any patient and evidence that assessed need has been reviewed and that care plans have been developed and reviewed to reflect the current assessed need of an individual.

Topical applicants and creams must only be used for the named individual and not for communal use.

Staff should undertake update training in the promotion of continence. Emphasis should be given to ensuring staff understand their responsibilities when assisting with personal care, regarding the core values of privacy, dignity and respect.

Continence products should be stored in accordance with infection prevention and control procedures and the manufactures instructions.

Number of requirements	2	Number of recommendations	2

4.3.2 The Dining Experience

We observed the serving of the midday meal in Benn suite with the following comments made:

- The day's menu was not displayed to inform patients. The home's four week rotational menu was displayed outside both dining rooms however the print was very small and not conducive to the needs of older people living with dementia.
- Staff stated the record of patients' meal choice had not been returned from the kitchen and this record was not present in either of the dining rooms in Benn suite. It was therefore not possible to evidence that patients who require a modified diet are afforded choice at mealtimes.
- The presentation of the dining tables was poor. On side of bedrooms 1-20 tablecloths or placemats were not used and dining tables were not set. On side of bedrooms 21 – 40 one table had a tablecloth. Dining tables did not evidence the availability of condiments, napkins or cutlery
- The management of fluids at the mealtime was poor. There was no visual cue for patients regarding fluids as glasses were not on the tables and fluid was not offered to patients when the meal was served.

- A registered nurse was not observed coordinating the dining experience in one of the dining rooms
- A staff member was observed assisting a patient in a lounge with their meal. The patient did not have any fluids available. The staff member stated the patient did not get fluids at this time as they would receive a supplement following the meal. The staff member was observed sitting on the edge of an occasional table in the lounge whilst assisting the patient. This is not good practice.
- The tray service to patients who did not come to the dining room was poor. Trays did not have fluids or condiments and meals were not covered until the point of service, on all occasions
- The dignity protectors in use were in a poor state. The acting manager stated new protectors had been purchased however they had not laundered well.

It was of concern that the issues observed at the meal service had previously been brought to the attention of staff and were subject to a failure to comply notice issued on 22 December 2014.

Areas for improvement

The patients' dining experience must be improved. The dining experience must be regularly audited to ensure adherence with regulatory requirements and best practice guidance.

Patients who require a modified diet must be afforded choice at each mealtime

Dining tables should be appropriately set with tablecloths/placemats and fluid and condiments should be readily available

The day's menu should be present in a suitable format and location to inform older people living with dementia of the menu.

Number of requirements	2	Number of recommendations	2

4.3.3 Management of Hydration

Patient care records were reviewed regarding the management of hydration. Patients' fluid intake was recorded by care staff and nursing staff. Each patient had a desired daily fluid intake target of 1500 millilitres. The review of the progress record in patient care records evidenced registered nurses provided a daily fluid intake total. In discussion with registered nurses and a review of care records we were unable to ascertain at what stage registered nurses took action regarding individuals' fluid intake. Care plans did not provide direction as to what was a suitable fluid intake for patients and when supplementary action was required. A recommendation has been made that care records reflect the desired daily fluid intake for each patient and at what stage further action needs to be taken.

We did not observe the availability of fluids in the lounges for patients. This was discussed with staff who stated that fluids could not be left in the lounges as other patients may drink the fluids. This was poor practice. Staff caring for persons living with dementia should not adopt an approach that is detrimental to the needs of all patients. It is important that fluids are readily available for patients at any time of the day and are also readily available for staff to prompt patients to drink and facilitate good hydration. A recommendation has been made.

Areas for improvement

Care records should reflect the desired daily fluid intake for each patient and at what stage further action needs to be taken.

Fluids should be readily available for patients at any time of the day and also readily available for staff to prompt patients to drink and facilitate good hydration.

Number of requirements	0	Number of recommendations	2

4.3.4 Moving and Handling procedures and equipment

In discussion with staff and observation of practice and available equipment there were no concerns in evidence with the exception of one issue. A staff member was observed assisting a patient to walk. The assistance given was not best practice as the staff member did not walk alongside the patient and afford support. The staff member was observed walking in front of the patient guiding with arms outstretched. A recommendation has been made that all staff complete refresher training regarding safe moving and handling and best practice when supporting a patient to mobilise.

Areas for improvement

Staff should complete refresher training regarding safe moving and handling best practice when supporting a patient to mobilise

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 Cathy McCorry, Acting 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) (a) and (b) **Stated:** First time **To be completed by:** 13 February 2017	The registered provider must ensure that patient care records accurately reflect the assessed needs of any patient and evidence that assessed need has been reviewed and that care plans have been developed and reviewed to reflect the current assessed need of an individual. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: care plans are continually audited and reviewed to accuratley reflect the assessed needs of the patient. Assessments have been updated and care plans implemented for assessed needs. Care plans no longer required have been discontinued. Same discussed at staff meeting and in formal supervisions with staff nurses.
Requirement 2 **Ref:** Regulation 13 (4) (a) and (b) **Stated:** First time **To be completed by:** 16 January 2017	The registered provider must ensure that topical applicants and creams must only be used for the named individual and not for communal use. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: Daily supervision with care staff carried out to ensure creams/ topical applicants are only used for residents who are prescribed same. That said creams are kept in the resident's rooms and are only used for the named resident. Creams that are no longer required for patient use have been removed and disposed. Same discussed at staff meeting 1/2/17.
Requirement 3 **Ref:** Regulation 12 (4) **Stated:** First time **To be completed by:** 13 February 2017	The registered provider must ensure that the patients' dining experience is improved. The dining experience must be regularly audited to ensure adherence with regulatory requirements and best practice guidance. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: The Dining experience is continually audited by the activity team, deputy and Manager on a daily basis. Supervisions on the move are carried out to identify good/poor practise and same discussed with staff. Same discussed at staff meeting 1/2/17 . .

Requirement 4 **Ref:** Regulation 12 (4) (d) **Stated:** First time **To be completed by:** 13 February 2017	The registered provider must ensure that patients who require a modified diet are afforded choice at mealtimes. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Deputy Manager continually oversees the menu before it is given to catering staff to ensure residents on a modified diet are given a choice. Catering staff have been informed of same and to report to manager if menus are not completed accuratley regarding patient choice.Same discussed at staff meeting 1/2/17
Recommendations	
Recommendation 1 **Ref**: Standard 43.2 **Stated:** Second time **To be completed by:** 28 February 2017	The registered person must implement a programme of replacing chairs/seating in the Benn suite. **Ref: section 4.1**
	Response by registered provider detailing the actions taken: New seating purchased and in place in the residents lounges. Furniture not fit for purpose has been removed and disposed.
Recommendation 2 **Ref**: Standard 35.6 **Stated:** Second time **To be completed by:** 31 January 2017	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: section 4.1**
	Response by registered provider detailing the actions taken: Continuous auditing of care plans in place. Action plans in place alongside care plan monitoring forms. Each Nursing unit has a care plan evaulation form that the named nurse has to date and sign each month when completed.
Recommendation 3 **Ref**: Standard 39.4 **Stated:** First time **To be completed by:** 28 February 2017	The registered provider should ensure staff complete update training in the promotion of continence. Emphasis should be given to ensuring staff understand their responsibilities when assisting with personal care, regarding the core values of privacy, dignity and respect. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: Continence training took place in January with care staff. Ongoing supervision on the move carried out by staff nurses and deputy with care staff, in order to identify good/poor practise. Formal supervisions took place with staff and concerns raised in the inspection discussed with staff.

Recommendation 4 **Ref**: Standard 46.2 and 46.4 **Stated:** First time **To be completed by:** 16 January 2017	The registered provider should ensure that continence products are stored in accordance with infection prevention and control procedures and the manufactures instructions. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: Store rooms where incontinence products are kept have been cleared of unrelated equipment, same is kept clean and tidy. There is a store room inspection chart in place for staff to sign daily. Staff nurses and Deputy to oversee this instruction is adhered to.
Recommendation 5 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 16 January 2017	The registered provider should ensure that dining tables are appropriately set with tablecloths/placemats and fluid and condiments should be readily available **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: New table clothes/placemats have been purchased and in use daily. Fluids are offered with all meals and between meals.Fluids are visible throughout the day for residents to obtian and are supervised by staff on duty.
Recommendation 6 **Ref**: Standard 12.6 **Stated:** First time **To be completed by:** 23 January 2017	The registered provider should ensure that the day's menu is available for patients and is available in a suitable format and location. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: New menu folders have been updated and kept in the dining rooms. New magnetic menu boards with individual foods have been purchased and located in the dining rooms, same is updated daily and visible for residents to view.
Recommendation 7 **Ref**: Standard 4.8 **Stated:** First time **To be completed by:** 23 January 2017	The registered provider should ensure that care records reflect the desired daily fluid intake for each patient and at what stage further action needs to be taken. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Fluid target has been implemented in to the nutritional careplans and clearly states at what stage action is to be taken if a resident is unable to meet this target.

Recommendation 8 **Ref**: Standard 12.17 **Stated:** First time **To be completed by:** 16 January 2017	The registered provider should that fluids are readily available for patients at any time of the day and also readily available for staff to prompt patients to drink and facilitate good hydration. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Fluids are visible in the resident's lounges and dining areas. same is supervised by staff on duty to ensure residents are offered fluids through the day.Daily fluid intake is recorded in residents progress notes, in order to alert staff if a resident has not met their fluid target for the day.Residents who prefer to stay in their room have fluids located in rooms.
Recommendation 9 **Ref**: Standard 39.4 **Stated:** First time **To be completed by:** 28 February 2017	The registered provider should ensure that staff complete refresher training regarding safe moving and handling best practice when supporting a patient to mobilise. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: Staff nurses and Deputy carry out ongoing supervision on the move with staff regarding moving and handling. Manager has discussed poor practice with staff at formal supervision meetings and recent staff meetings.Moving and handling training took place 4/2/17.

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

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