The Regulation and Quality Improvement Authority

Unannounced Follow Up Care Inspection Report
19 August 2017

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

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 service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 100 persons.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd Responsible Individual: Gavin O'Hare-Connolly (acting)	Registered Manager: See below
Person in charge at the time of inspection: Mirella Paun - Nurse in Charge Catherine McCorry – Manager, arrived at 14.30 hours	**Date manager registered:** Catherine McCorry – registration pending
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of registered places:** Total number of registered beds: 100 Comprising of : 60 – NH-I 40 – NH-DE A maximum of 4 patients in the category NH-PH

4.0 Inspection summary

An unannounced inspection took place on 19 August 2017 from 14.30 to 18.00 hours.

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.

As a result of serious concerns, in relation to the well-being of patients in a nursing home operated by Runwood Homes Ltd., a lay magistrate issued an order to cancel the home's registration. This inspection was undertaken to provide an assurance that appropriate arrangements were in place for the safety and well-being of patients accommodated in this home.

The following areas were examined during the inspection:

- management arrangements
- care delivery
- staffing arrangements
- equipment
- behaviours that challenge
- environment
- fire safety

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Catherine McCorry, 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.

4.2 Action/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 31 July 2017. Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 31 July 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with 14 patients and 11 staff.

The following records were examined during the inspection:
- staff duty rota for the weeks commencing 7 August 2017 and 14 August 2017
- incident and accident records
- three patient care records
- four patient care charts including food and fluid intake charts and reposition charts
- records and information available relating to adult safeguarding
- nurse in charge management records
- records regarding agency staff induction training
- fire safety records including; personal emergency evacuation plans (PEEP's), fire plan and fire risk assessment and recommendations

Areas for improvement identified at the last care inspection were not reviewed as part of this inspection and are carried forward to the next care inspection.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 31 July 2017

The most recent inspection of the home was an unannounced care inspection. The areas for improvement from the last care inspection on 31 July 2017 were not reviewed as part of the inspection and are carried forward to the next care inspection. The QIP in Section 7.2 reflects the carried forward areas for improvement.

6.2 Review of areas for improvement from the last care inspection dated 31 July 2017

This inspection focused solely on issues previously outlined in section 4.0. The areas for improvement from the last care inspection on 31 July 2017 were not reviewed as part of the inspection and are carried forward to the next care inspection. The QIP in Section 7.2 reflects the carried forward areas for improvement.

6.3 Inspection findings

Management arrangements

The manager of the home, Catherine McCorry arrived at the start of the inspection. Feedback at the conclusion of the inspection was given to Catherine McCorry, senior management representation from the organisation, Gavin O'Hare Connolly, Group Director of Operations and Rosemary Dilworth, Deputy Director of Operations for Northern Ireland.

The management arrangement for the nurse in charge of the home, in the absence of the manager, was displayed in the entrance foyer. The nurse in charge of the home was on duty and was working in Benn unit. The registered nurses on duty in Toby Hurst and Donegal units were able to confirm who was in charge of the home and where the information was displayed for visitors' reference. Information was also present in the three units of contact details for the manager and/or senior management of Runwood Homes. Registered nurses confirmed they were aware of the procedure to follow if they needed to contact senior management out of hours or in the case of an emergency and evidence of the contact details and arrangements were present in each of the three units. Discussion with the nurse in charge evidenced that they were knowledgeable regarding the staffing levels in the home, the numbers of patients in each unit and had current knowledge of wounds, falls and patients' identified as being at risk of poor nutrition and poor fluid intake. Staff stated that they would speak to the manager of the home if they had any issue and were confident they would be listened to.

In discussion staff confirmed the management arrangements of the home and the organisation and were aware that Mr O'Hare-Connolly was the newly appointed Group Director of Operations for Runwood Homes.

Care practice

The nurse in charge of the home and the designated person in charge of each unit were knowledgeable regarding the wellbeing of the patients in their care. Staff were able to discuss patients' current needs including; wound care, falls, food and fluid intake and the management of distressed reactions. Patients identified being at risk of weight loss were weighed on a weekly basis and each unit retained information specifically for those identified patients. Discussion with the registered nurses confirmed that referrals to other health care professionals had been made in a timely manner and the patient care records reflected any recommendations made.

Staff spoken with stated that they felt care delivery was of a good standard and that they felt the staffing arrangements in the home were appropriate to meet the needs of the patients. Patients were observed to be appropriately dressed and observation of care delivery evidenced that patient's hygiene and continence needs were being addressed in accordance to patients' requests or their needs. There were daily personal care records maintained by staff to confirm when patients' personal care needs had been addressed. Staff reported that when there are difficulties in delivering care that they will inform the person in charge. In discussion with registered nurses it was stated that one patient does not comply with prescribed treatment. This had been discussed with the multidisciplinary team. The review of the patient's care records did not evidence that registered nurses were consistently reporting and recording when treatment had been refused. Registered nurses should report, on a daily basis, on patients' response to planned care within the care records. This was identified as an area for improvement.

A review of patient care records evidenced that falls were being appropriately managed. The review of patient care records evidenced that fall risk assessments and corresponding care plans were reviewed and updated on a regular basis or when there was a change in patient needs. Care records reflected that in the event of an accident or incident occurring to a patient, management, the patients General Practitioner and the next of kin had been informed. The review of incidents received by RQIA evidenced two incidents occurring to a patient, on the same day and within a short space of time. One incident report referred to the death of the patient. This was discussed with the manager who investigated the matter and informed that the registered nurse completing the incident notification had not changed the unique identifier number on the incident reporting record and the incidents involved two different patients. Registered nurses should ensure that all information recorded on any documentation is accurate. This was identified as an area for improvement.

Staffing arrangements

The staff duty rosters for the week commencing 7 and 14 August were reviewed. Staffing arrangements in each unit was reflective of the duty roster and planned staffing levels were adhered to. Agency staff were not on duty at the time of the inspection with the exception of an agency care assistant who was providing one to one supervision of a patient, at the request of the commissioning trust. In discussion with the registered nurses it was confirmed that the use of agency staff was minimal at present and the need for agency staff was on night duty where there was a care assistant vacancy. Staff confirmed that agency staff receive induction training when commencing in the home. Evidence was available in the manager's office of the completed induction training records of agency staff. A staff member commented, "This is a good place to work, that's why I chose it, and I worked for an agency before."

Observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty. Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with 14 patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Patients confirmed that they 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.

Equipment

In discussion staff confirmed that they had ready access to equipment, for example; pressure relieving mattresses or alarm/pressure mats. Staff stated that these items of equipment were available in a store in the home. The store was viewed and evidence was present of a range of available equipment, as stated above. The nurse in charge stated that equipment is used when informed by patients' assessed need and stated alarm/pressure mats are not used routinely for all patients. Ms Dilworth stated that a contract with an equipment provider had now been put in place should staff require patient equipment which was not available in the home and an out of hours service would be available by the contractor.

Behaviours that challenge

The nurse in charge was able to demonstrate an understanding of how to recognise and respond to patients who display distressed reactions. The nurse in charge discussed two patients who were displaying distressed reactions. The nurse in charge verbalised how the patients presented and how staff supported the patients, this was discussed sensitively and with empathy. The review of the care records of the patients evidenced person centred care plans had been developed and staff were responding appropriately and maintained the dignity of the patients. There was evidence of good communication with family members in the patients care records. There were out of hours arrangements in place should staff need advice and support regarding the management of distressed reactions.

Environment

A review of the home's environment was undertaken which included a number of bedrooms, bathrooms, shower and toilet facilities, sluice room, storage rooms and communal areas. The areas reviewed were found to be clean and warm and a homely atmosphere was evident throughout. Housekeeping staff were on duty in each unit and confirmed that they had adequate stock of cleaning products and equipment.

Fire safety

There was a fire safety plan in operation, all staff spoken with were aware of the fire plan.

The personal emergency evacuation plan (PEEP's) of patients was identified, by colour coding, on their bedroom door and a written record. The colour coding on a patient's bedroom door was cross referenced to the written record and were accurate. The manager stated that the evacuation plans are reviewed on a monthly basis. Fire evacuation routes were observed to be free from obstruction.

The most recent fire risk assessment was completed in August 2016. The manager stated that the fire risk assessor was expected in the near future. The review of the recommendations of the fire risk assessment report of August 2016 evidenced that the recommendations had been addressed and validated by the manager.

Areas for improvement

The areas identified for improvement, in accordance with the care standards were in relation to ensuring registered nurses report and record the patient's response to planned care including when a patient does not comply with treatment and registered nurses should ensure patient information within any documentation is accurate.

	Regulations	Standards
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Catherine McCorry, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The DHSSPS Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan	
Action required to ensure compliance with The Care Standards for Nursing Homes 2015	
Area for improvement 1 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 11 September 2017	The registered person shall ensure that registered nurses report and record in patient care records of the patient's response to planned care. This includes when the patient refuses planned care or treatment. Ref: Section 6.3
	Response by registered person detailing the actions taken: Registered Nurses have been instructed to record all care that has been accepted or declined by the client. This will be continually monitored by management to ensure accurate records are maintained.
Area for improvement 2 **Ref:** Standard 35.9 **Stated:** First time **To be completed by:** 11 September 2017	The registered person shall ensure that the information on any accident or incident report or any other document, which makes reference to a patient, is accurate. Ref: Section 6.3
	Response by registered person detailing the actions taken: Registered nurses have been instructed to ensure accurate information is recorded on incident reports. Management to oversee compliance with same.

***Please ensure this document is completed in full and returned via Web Portal ***

Due to the focused nature of this inspection, as outlined in section 4.0 of this report, the areas for improvement from the previous care inspection will be carried forward for review at the next care inspection

Areas for improvement from the last care inspection	
Action required to ensure compliance with The Care Standards for Nursing Homes 2015	
Area for improvement 1 **Ref:** Standard 41 **Stated:** First time	The registered person shall ensure that staffing arrangements for the home are calculated following the completion of a patient dependency assessment, using a validated assessment tool.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that the management of hydration is in accordance with professional guidelines. The desired daily fluid target is calculated using a validated and current tool. Care plans should evidence the action to be taken should the desired daily fluid target not be attained. The progress record should reflect the outcome of any action taken regarding the management of hydration.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 3 **Ref:** Standard 4.8 and 4.9 **Stated:** First time	**Action taken as confirmed during the inspection**: The registered person shall ensure that the manager and the team of registered nurses clarify expectations regarding the model of nursing in use so as there is no ambiguity regarding this and a consistent approach to care planning is in evidence.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.

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