The Regulation and Quality Improvement Authority

Inspection Report

13 and 14 December 2022

Corriewood Private Clinic

Type of service: Nursing Home
Address: 3 Station Road, Castlewellan, BT31 9NF
Telephone number: 028 4377 8230

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Corriewood Private Clinic Limited **Responsible Individual:** Mrs Maria Therese McGrady	**Registered Manager:** Mrs Teresa Josephine McClean **Date registered:** 1 April 2005
Person in charge at the time of inspection: Mrs Teresa Josephine McClean	**Number of registered places:** 79
Categories of care: Nursing Home (NH) DE – Dementia MP – Mental disorder excluding learning disability or dementia LD – Learning disability LD(E) – Learning disability – over 65 years I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 75
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides care for up to 79 patients. The home is divided into four units. Wild Forest and Annesley House which provides general nursing care. Spring Well which provides care for people with a learning disability and Oak Tree which provides care for people with a dementia. Patients have access to communal dining rooms, lounges and gardens from each unit.	

2.0 Inspection summary

An unannounced inspection took place on 13 December 2022 from 9.10am to 4.50pm and on 14 December 2022 from 10.45am to 1.35pm by a care inspector.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Patients were well presented in their appearance and spoke positively when describing their experiences on living in the home.

Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff members are included in the main body of this report.

Staff members promoted the dignity and well-being of patients and were knowledgeable and well trained to deliver safe and effective care. There was a good working relationship between staff and management.

One area for improvement was identified in relation to the completion of supplementary care records. Six areas for improvement in relation to medicines management have been carried forward for review at the next medicines management inspection.

RQIA were assured that the delivery of care and service provided in Corriewood Private Clinic was safe, effective and compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services in the home.

The findings of this report will provide the manager and management team with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the management team at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with 12 patients and eight staff. Patients spoke positively on the care that they received and on their interactions with staff describing staff as being 'very good' and 'very nice' to them. Patients also complimented the food provision in the home. Staff members were confident that they worked well together and enjoyed working in the home and interacting with the patients.

There were no questionnaire responses received and we received no feedback from the staff online survey.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 24 March 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that a robust system of audit which covers all aspects of medicines management is implemented to ensure safe systems are in place. **Action taken as confirmed during the inspection**: Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.	**Carried forward to the next inspection**
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall ensure that written confirmation of all new patients' medicines is obtained at or prior to admission to the home. **Action taken as confirmed during the inspection**: Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.	**Carried forward to the next inspection**

<table>
<tr><th colspan="2">Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Standard 46 Criteria (2)

Stated: Second time</td><td>The registered person shall ensure that training provided on infection prevention and control and the use of personal protective equipment is embedded into practice.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that this area for improvement was met.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 12

Stated: Second time</td><td>The registered person shall ensure that patients who require modified meals have a choice of meal at mealtimes.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that this area for improvement was met.</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 29

Stated: First time</td><td>The registered person shall ensure that fully complete and accurate personal medication records are maintained and obsolete records are cancelled and archived.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.</td></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 4

Stated: First time</td><td>The registered person shall develop and update care plans regarding medicines management, in particular, distressed reactions, pain management and insulin.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.</td></tr>
</table>

Area for improvement	Requirement	Validation of compliance
Area for improvement 5 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure epilepsy management plans are in place for all patients prescribed medicines for the management of seizures. **Action taken as confirmed during the inspection**: Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.	**Carried forward to the next inspection**
Area for improvement 6 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that complete records of the administration of medicines are maintained and handwritten medicine administration records are checked and signed by two members of staff. **Action taken as confirmed during the inspection**: Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.	**Carried forward to the next inspection**

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff members were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. Newly employed staff had protected time in which to complete an induction where they would work alongside a more senior member of staff to become more familiar with the home's policies and procedures. Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

A system was in place to monitor staffs' compliance with mandatory training. Training was completed on a range of topics such as adult safeguarding, infection prevention and control (IPC), patient moving and handling and fire safety. Staff confirmed that they were further supported through staff supervisions and appraisals. Records of completed staff supervisions and appraisals had been maintained.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff consulted confirmed they were satisfied that patients' needs were met with the staffing levels and skill mix on duty. Observation of staffs' practices and discussions with patients raised no concerns in relation to the staffing arrangements in the home.

Staff spoke positively on the teamwork in the home. One told us, “We have a strong team here,” and another commented, “The teamwork is good; we all get on well together.” Minutes were available of a recent staff meeting. Agreed actions from the meeting had been shared with all staff. The manager confirmed that, in addition to staff meetings, they planned to host less formal staff engagement meetings which would be staff led to discuss any topics staff felt were important to them.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked. The duty rota identified the nurse in charge of the home when the manager was not on duty. Duty rotas were audited to ensure accuracy in detail.

Patients consulted spoke highly on the care that they received and confirmed that staff attended to them when they needed them and that they would have no issues on raising any concerns that they may have to staff. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through these interactions that the staff and patients knew one another well and were comfortable in each other’s company.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff members were knowledgeable of patients’ needs, their daily routine, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments. Staff confirmed the importance of keeping one another up to date with any changing needs in patients’ care throughout the day.

It was observed that staff provided care in a caring and compassionate manner. Patients told us that they were happy living in the home. One said, “Staff here are very good; they couldn’t do enough for you”. Another patient told us, “It’s dead on here. The staff are very nice and if I buzz they come straight away”.

Patients’ needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients’ needs and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

All patients had a pressure management risk assessment completed monthly. Where a risk of skin breakdown was identified; a care plan was developed to guide staff in how to manage this risk.

An accident book was completed by staff to record any accidents or incidents which occurred in the home. A review of one patient’s accident records, following a fall in the home, evidenced that the appropriate actions had been taken following the fall, the appropriate persons had been informed and the appropriate documentation had been updated. Audits were conducted after all falls in the home to ensure that the appropriate actions had been taken. Falls were reviewed monthly for patterns and trends to identify if any could be prevented.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff.

Staff assisted patients throughout the day with food and fluids in an unhurried manner. Nutritional risk assessments were carried out regularly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST).

Before each meal, staff engaged in a 'Food Safety Pause' where staff got together to consider safety aspects such as which patients had allergies; which patients required assistance and supervision with meals and which patients required to have their meals modified or fortified. In addition to this safety check, the Director of Quality, Assurance and Governance had developed and implemented additional safety measures to improve the safety of patients' with swallowing difficulties at mealtimes. The quality improvement programme aimed at increasing staffs' knowledge of swallowing difficulties and appointing a staff member as a champion. Each staff member now had, included with their identification badge, a list of seven identified rights of patients for eating, drinking and swallowing such as the right consistency of food/fluids; the right posture and the right rate for assisting patients with meals. The incorporation of this additional safety work was commended.

Patients dined in their preferred dining area; the dining room, lounge or their own bedrooms. Food served appeared appetising and nutritious. Meals which had to be modified were well presented. Daily menus were displayed in written and pictorial formats in the Springwell unit. The menu offered a choice of meals and additional options for patients who required to have their meals modified when the main meals could not be modified. There was a good variation of foods on the menus. The mealtime was well supervised. Staff wore the appropriate personal protective equipment (PPE) and patients, who required, wore clothing protectors to maintain their dignity. Staff sat alongside patients when providing assistance with their meals. There was a calm atmosphere and patients spoke positively on the mealtime experience.

Several supplementary care records in relation to repositioning and food intake had not been completed in sufficient detail. For example, many repositioning records did not identify the position in which the patient had been repositioned too. Food intake records did not identify the actual food consumed. This was discussed with the manager and identified as an area for improvement. Fluid intake records had been completed well and included any supplements which the patients had taken. Bowel management had also been recorded well.

Patients' individual likes and preferences were reflected throughout the records. Daily records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. The home was warm, clean and comfortable. There were no malodours detected in the home.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible. A review of the most recent fire risk assessment confirmed that the three areas identified for attention had been completed in a timely manner.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated and suitably furnished. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

Systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. All visitors to the home were required to wear face coverings. Environmental infection prevention and control audits had been conducted monthly. Separate monthly audits were conducted to monitor bathrooms and waste management.

Review of records, observation of practice and discussion with staff confirmed that effective training on IPC measures and the use of personal protective equipment (PPE) had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

5.2.4 Quality of Life for Patients

Patients confirmed that they were offered choice and assistance on how they spent their day. For example, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested. Patients were well presented in their appearance and those, who wished to, were wearing their own jewellery, nail varnish and make up.

An activity therapist oversaw the activity provision in the home. Activities were conducted on a group and on a one to one basis and included chatting, reminiscence, musical themes, chair movements, games, pampering sessions, reflections and external entertainers were arranged to provide musical entertainment. Interdenominational services were conducted each Sunday and patients, who wished, could receive communion, a blessing or scripture reading in their bedrooms. Individual records of activity involvement were maintained in patients' care records. Arrangements were in place for Christmas celebrations to include parties, musical entertainers, carol services and a visit from Santa.

A relatives' meeting had been conducted electronically on 7 June 2022 via a video platform to discuss aspects of care such as visiting, activity provision, food provision and record any suggestions. Another meeting had been scheduled for December 2022.

An annual quality report had been made available to patients/relatives during March 2022 identifying patients' views to the running of the home and statistical data on topics such as accidents, adult safeguarding, staff training, risk management, complaints and planned improvements. In addition, the manager confirmed that a residents'/relatives' survey on the services provided by the home had been conducted in November 2022 and a satisfaction survey analysis report completed which was shared with staff, patients and relatives. It was clear from the report that the vast majority of patients and relatives were satisfied with the service provision.

Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients. There were five care partner arrangements in place and visiting was conducted in line with Department of Health guidelines.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been no change in the management arrangements. Mrs Teresa McClean has been Registered Manager of the home since 1 April 2005. Discussion with the manager and staff confirmed that there were good working relationships between staff and the home's management team. Staff told us that they found the manager and the management team to be 'approachable' and 'would listen to any concerns'.

Staff were aware of who the person in charge of the home was in the manager's absence. Staff told us that they were aware of their own role in the home and how to raise any concerns or worries about patients' safety, care practices or the environment. Staff members were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required. New staff roles of Charge Nurse/Sister had been recently incorporated into each unit and inductions for staff in these new roles was in progress.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Areas audited included patients' care records, wound care, medicines management, restrictive practice, staff training, care reviews, the kitchen, cleanliness, finances and maintenance of staffs' registrations.

The manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

A complaint's file was maintained to detail the nature of any complaints and the corresponding actions made in response to any complaints. There were no recent or ongoing complaints relating to the home. Cards and letters of compliments were maintained. In addition there was a good record maintained of verbal compliments received. The manager confirmed that all compliments received would be shared with the staff.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home.
The reports of these visits were completed; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. Completed reports were available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	2*	5*

* The total number of areas for improvement includes six which are carried forward for review at the next inspection. Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Teresa McClean, Registered Manager, Mr Daniel Oliveira, Director of

Quality Assurance and Governance and Mrs Catherine Lenaghan, Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Ongoing from the date of inspection (24 March 2022)	The registered person shall ensure that a robust system of audit which covers all aspects of medicines management is implemented to ensure safe systems are in place. Ref: 5.1
	Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** Immediately from the date of inspection (24 March 2022)	The registered person shall ensure that written confirmation of all new patients' medicines is obtained at or prior to admission to the home. Ref: 5.1
	Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (24 March 2022)	The registered person shall ensure that fully complete and accurate personal medication records are maintained and obsolete records are cancelled and archived. Ref: 5.1
	Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.

Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (24 March 2022)	The registered person shall develop and update care plans regarding medicines management, in particular, distressed reactions, pain management and insulin. Ref: 5.1
	Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (24 March 2022)	The registered person shall ensure epilepsy management plans are in place for all patients prescribed medicines for the management of seizures. Ref: 5.1
	Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (24 March 2022)	The registered person shall ensure that complete records of the administration of medicines are maintained and handwritten medicine administration records are checked and signed by two members of staff. Ref: 5.1
	Action required to ensure compliance with this area for improvement was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 5 **Ref:** Standard 4 Criteria (9) **Stated:** First time **To be completed by:** 8 January 2023	The registered person shall ensure that supplementary care records in relation to patients' repositioning and food intake reflect: • The position the patient has been repositioned to and from. • The actual foods consumed by the patient. Ref: 5.2.2
	Response by registered person detailing the actions taken: Supervisions were completed with Care Staff in relation to accurate completion of supplementary care records within the Home. Records will be monitored/audited and reviewed regularly to ensure full compliance.

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

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