

# Inspection Report

21 and 22 June 2023



## Corriewood Private Clinic

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

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Assurance, Challenge and Improvement in Health and Social Care

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## 1.0 Service information

<p><b>Organisation:</b> Corriewood Private Clinic Limited</p> <p><b>Responsible Individual:</b> Mrs Maria Therese McGrady</p>	<p><b>Registered Manager:</b> Mrs Charlene Parkin – Not registered</p>
<p><b>Person in charge at the time of inspection:</b> Mrs Charlene Parkin</p>	<p><b>Number of registered places:</b> 79</p>
<p><b>Categories of care:</b> Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia MP – mental disorder excluding learning disability or dementia LD – learning disability LD(E) – learning disability – over 65 years PH(E) - physical disability other than sensory impairment – over 65 years</p>	<p><b>Number of patients accommodated in the nursing home on the day of this inspection:</b> 64</p>
<p><b>Brief description of the accommodation/how the service operates:</b> 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 extensive gardens from each unit.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 21 June 2023 from 9.25am to 4.15pm and on 22 June 2023 from 9.30am to 2.00pm 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.

An area requiring improvement was identified in relation to the management of falls in the home.

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

The findings of this report will provide the manager 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 and 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 patients, staff and a relative. Patients were well presented in their appearance and appeared relaxed and comfortable in their surroundings. Patients told us that they were happy living in the home and complimented the staff and the care provision. One told us, "It's beautiful here; I look forward to getting outside. They (the staff) usually take us out for a walk around the garden". Staff felt that they worked well together and enjoyed engaging with the patients and relatives. The relative told us that their loved one was very settled and content in the home.

There were six patient/relative questionnaire responses received. All respondents indicated satisfaction with the care provision in the home and with the management of the home. We received no feedback from the 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 14 December 2022		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		Validation of compliance
<b>Area for Improvement 1</b>  <b>Ref: Standard 4 Criteria (9)</b>  <b>Stated: First time</b>	The registered person shall ensure that supplementary care records in relation to patients' repositioning and food intake reflect: <ul style="list-style-type: none"> <li>• The position the patient has been repositioned to and from.</li> <li>• The actual foods consumed by the patient.</li> </ul>	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> There was evidence that this area for improvement was met.	

## 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. Staff confirmed that the length of time for staff induction was dependent on the inductee's abilities and understanding.

Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC).

A system was in place to monitor staffs' compliance with mandatory training. The majority of staff were compliant with training requirements. Staff were satisfied with the range of training offered. Training was completed on topics, such as, infection prevention and control (IPC), moving and handling of patients and fire safety. Staff completed training electronically and face to face. When staff commenced employment, identified training was completed as part of their induction prior to working on the floor. Staff told us that they could request additional training relevant to their role.

Staff confirmed that they were further supported through staff supervisions and appraisals. Supervision and appraisal trackers were regularly reviewed to ensure that staff received, at minimum, two recorded supervisions and an appraisal on an annual basis.

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 that there was enough staff on duty to meet the patients' needs. Patients did not raise any concerns on the staffing arrangements. Observation of care delivery on the day of inspection identified no concerns. Care was delivered in a timely, caring and compassionate manner.

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. The nurse in charge completed a competency and capability assessment on taking charge of the home prior to commencing the role.

Minutes were maintained of staff meetings in the home to allow for staff, unable to attend the meeting, be kept up to date with discussions had and decisions made. The meeting minutes included a list of all staff who attended the meeting.

Staff were happy with the teamwork in the home and were observed to work well and communicate well with one another during the inspection.

## 5.2.2 Care Delivery and Record Keeping

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. Where a patient was required to be repositioned to maintain skin integrity; records of the repositioning had been recorded well to evidence the position the patient was repositioned to and to evidence that the patient's skin was checked when they had been repositioned.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bedrails. It was established that safe systems were in place to manage this aspect of care.

An accident/incident report was completed by staff to record any accidents or incidents which occurred in the home. The Director of Governance and Quality Assurance was in process of engaging with staff in enhancing the detail included within incident reports.

Two patients' accident records reviewed evidenced that both patients had not been monitored properly following a fall where a head injury, or the potential for a head injury, had occurred. This was discussed with the manager and identified as an area for improvement. Falls were reviewed monthly for patterns and trends to identify if any further falls 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. A pictorial menu clearly displayed the food options for the mealtimes. Meal choices were offered to all patients including those who required to have their food modified. Patients dined in their preferred dining area; the dining room, lounge or their own bedrooms. Food served appeared appetising and nutritious. Staff were knowledgeable of patients' nutritional requirements. Eating and drinking care plans were available to staff and were reflective of speech and language therapy recommendations. Nutritional risk assessments were completed monthly to monitor for weight loss and weight gain.

The mealtime in the dining room was well supervised. Staff wore personal protective equipment (PPE) and patients, who required, wore clothing protectors to maintain their dignity. A range of drinks were served with the meals. There was a calm atmosphere at mealtime and several patients consulted were all complimentary on the food provision.

When patients were at risk of weight loss and required to have their food and fluid intake monitored; this had been recorded well. In addition, patients' bowel management was recorded well utilising the Bristol Stool Score.

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. A 24 hour daily handover was shared with the manager identifying any significant changes in the care of any of the patients in the home.



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. It was clear through patient and staff interactions that they knew one another well and were comfortable in each other's company. One patient said, "This is a good home. I like it here and the food's good". The relative described the care delivery as, "Fantastic".

### 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. Patients' bedrooms were personalised with items important to them. Bedrooms were suitably furnished and decorated. There was evidence within the homes internal monthly monitoring report of additional planned redecoration in the home. Appropriate doors leading to rooms which contained hazards to patients had been locked. The home was warm, clean and comfortable. There were no malodours detected in the home. A patient commented, "I love it here and love my room. Staff are really nice".

Fire safety measures were in place to ensure the safety of patients, staff and visitors to the home. Corridors were clear of clutter and obstruction and fire exits and stairwells were also maintained clear. Fire extinguishers were easily accessible.

There were extensive gardens and walks on the grounds which were well maintained and had seating areas for patients to enjoy the outdoors. One patient told us, "I love looking out at all the lovely plants". Another commented, "It's beautiful here; powerful views".

Review of records and observation of staffs' practice confirmed that effective training on IPC measures and the use of PPE had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. Environmental infection prevention and control audits had been conducted monthly and reviewed laundry, housekeeping, bathroom and bins, PPE, hand hygiene, commodes and bedrails.

### 5.2.4 Quality of Life for Patients

Patients confirmed that they were offered choices in how and where they spent their days in the home. Visiting had returned to pre-covid arrangements in line with Department of Health guidelines. Patients were free to leave the home with family members if they wished.

Patients told us that they enjoyed engaging in activities and that these were carried out regularly. Activities were conducted on a group and on a one to one basis. A monthly programme of activities was displayed identifying planned activities. Activities included arts and crafts, stories, bingo, games, gardening, movies, reminiscence, music and quiz. Special days, for example, birthdays were celebrated. A record of each patient's activity engagements was recorded within their care records.

During the inspection 10 patients were observed enjoying music and games in one of the dayrooms. One to one walks through the gardens were taking place. Three patients had gone out for a picnic to the local park with staff at lunchtime.

Spiritual needs were met through interdenominational services. Communion was administered in the home. There were notices on display informing of separate Presbyterian and Catholic services planned.

Some of the patients within the Spring Well Unit spoke fondly of their attendance at a recent Formal in the Slieve Donard Hotel. There were pictures of the patients in formal dress enjoying the event.

### 5.2.5 Management and Governance Arrangements

Since the last inspection there had been a change to the management arrangements. Mrs Charlene Parkin has been managing the home since 12 March 2023. 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 'visible on the floor'.

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. Staff demonstrated good knowledge of the organisational structure in the home.

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, restrictive practice, infection management, medicines management, staff training and the environment.

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 and completed reports were available for review by patients, their representatives, the Trust and RQIA. Where improvement actions were required, an action plan was included within the report. The manager evidenced the actions taken in response to the identified actions within the action plan. The action plan would be reviewed at the subsequent monthly monitoring visit to ensure completion.

A complaint's file was maintained and records included the nature of the complaint and any actions taken in response to the complaint including any correspondence to or from the complainant. Complaints received were analysed to determine if any learning could be shared with staff. Cards and letters of compliments were maintained in a compliments file. The manager confirmed that all compliments received would be shared with the staff.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The responsible individual was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.



Where patients were required to be deprived of their liberty; a deprivation of liberty safeguards register was maintained to evidence the decision making around this and the authorisations to do so. A restrictive practice register was maintained in the home.

**6.0 Quality Improvement Plan/Areas for Improvement**

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

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	1	0

The area for improvement and details of the Quality Improvement Plan were discussed with Charlene Parkin, Manager and the management team as part of the inspection process. The timescales for completion commence from the date of inspection.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</b>	
<p><b>Area for improvement 1</b></p> <p><b>Ref:</b> Regulation 13 (1) (b)</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> With immediate effect</p>	<p>The registered person shall ensure that patients are appropriately monitored following a fall in the home where a head injury, or the potential for a head injury, has occurred.</p> <p>Ref: 5.2.2</p>
	<p><b>Response by registered person detailing the actions taken:</b></p> <p>The home has a protocol in place which is guided and reflective of the current Regional Falls Pathway. All Registered Nurses have been reminded of this pathway and the importance of its full implantation into practice</p>

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