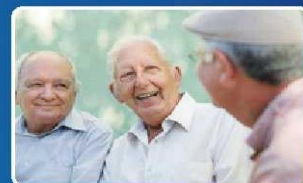


Unannounced Follow Up Care Inspection Report 11 November 2019



Corriewood Private Clinic

Type of Service: Nursing Home
Address: 3 Station Road, Castlewellan, BT31 9NF
Tel No: 028 4377 8230
Inspector: Gillian Dowds

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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

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.

1.0 What we look for



2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 79 persons.

3.0 Service details

<p>Organisation/Registered Provider: Corriewood Private Clinic Anne Monica Byrne M.I (Imelda) McGrady</p> <p>Responsible Individual: Anne Monica Byrne</p>	<p>Registered Manager and date registered: Catherine Lenaghan Acting Manager</p>
<p>Person in charge at the time of inspection: Catherine Lenaghan</p>	<p>Number of registered places: 79 comprising: NH-DE,NH-MP,NH-LD,NH-LD(E),NH-I,NH-PH,NH-PH(E),NH-TI.</p> <p>A maximum of 7 patients in category NH-DE to be accommodated in the Oak Tree Suite, a maximum of 23 patients in category NH-LD/LD (E), to be accommodated in the Spring Well Suite and 4 identified persons in category NH-MP accommodated in the Wild Forest Suite. The home is also approved to provide care on a day basis to 2 persons.</p>
<p>Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. LD – Learning disability. LD (E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.</p>	<p>Number of patients accommodated in the nursing home on the day of this inspection: 75</p>

4.0 Inspection summary

An unannounced inspection took place on 11 November 2019 from 10.00 to 18.30 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.

The inspection sought to assess progress with issues raised during the last care inspection.

Patients spoke positively about the service they received in Corriewood Private Clinic for example;

- “Can’t beat it with a big stick.”
- “I like it here.”
- “All good girls, plenty of staff.”
- “Good food.”

The findings of this report will provide Corriewood 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	1	5*

*The total number of areas for improvement includes three which have been stated for the second time.

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

4.2 Action/enforcement taken following the most recent inspection dated 5 August 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 5 August 2019. Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 5 August 2019.

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 eight patients, one patient’s relatives and three staff. Questionnaires were also left in the home to obtain feedback from patients and patients’ representatives. Ten patients’/ relatives/representatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the registered manager with ‘Have we missed you cards’ which were then placed in a prominent position to allow patients and their relatives/representatives, who were

not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- cleaning schedules
- staff Induction
- six care records
- complaint management
- governance audits such as accident / incident audits, care plan audit
- staff training
- supervision and appraisal

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

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 previous inspection(s)

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 13 (7) Stated: First time	<p>The registered person shall ensure suitable arrangements are in place to minimise the risk of infection and spread of infection between patients and staff.</p> <p>This area for improvement is made with particular focus to:</p> <ul style="list-style-type: none"> • ensuring staff use appropriate personal protective equipment at all times and discard it appropriately • ensuring staff take the opportunity for hand hygiene at the appropriate times • ensuring a robust environmental cleaning and equipment cleaning schedule is in place and adhered to • ensuring all patient equipment is effectively decontaminated if soiled 	Met

	<ul style="list-style-type: none"> ensuring the laundry area of the home is maintained clean, tidy and free from clutter. 	
	<p>Action taken as confirmed during the inspection: We identified through observation that staff were using personal protective equipment (PPE) appropriately and hand washing was undertaken at appropriate times.</p> <p>The laundry was tidy and clutter free. An environmental and equipment cleaning schedule was in place and no equipment appeared contaminated.</p>	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
<p>Area for improvement 1 Ref: Standard 43.1 Stated: First time</p>	<p>The registered person shall ensure effective signage is used to orientate patients within the home.</p> <p>Action taken as confirmed during the inspection: New signage was in place in the dementia unit.</p>	Met
<p>Area for improvement 2 Ref: Standard 29 Stated: First time</p>	<p>The registered person shall ensure that MARs sheets are fully and accurately completed.</p> <p>Action taken as confirmed during the inspection: MAR sheets viewed identified in some cases that handwritten entries were not signed or countersigned.</p> <p>This area for improvement has been partially met and will be stated for a second time.</p>	Partially Met
<p>Area for improvement 3 Ref: Standard 28 Stated: First time</p>	<p>The registered person shall closely monitor inhaled and anticonvulsant medicines to ensure that they are administered as prescribed.</p> <p>Action taken as confirmed during the inspection: Records reviewed confirmed a new auditing system was in place to ensure anticonvulsants were administered as prescribed. One inhaler reviewed identified gaps in the recording as discussed.</p>	Partially met

	This area for improvement has been partially met and will be stated for a second time.	
Area for improvement 4 Ref: Standard 39.1 Stated: First time	The registered person shall ensure all staff who are newly appointed, including agency staff and students, complete a structured orientation and induction and records are retained.	Met
	Action taken as confirmed during the inspection: A sample of induction records were reviewed on the day of inspection and evidenced that this area for improvement has now been met.	
Area for improvement 5 Ref: Standard 4 Stated: First time	The registered person shall ensure oversight of the supplementary care records by the registered nurses, in relation to fluid intake and bowel management. Nursing staff must evaluate the effectiveness of care delivery.	Partially met
	Action taken as confirmed during the inspection: Records reviewed identified 24 hour total for fluids were recorded. However the evaluation of bowel monitoring records was not recorded. This area for improvement has been partially met and will be stated for a second time.	

6.2 Inspection findings

Environment

The home's environment was clean, tidy, and comfortably warm throughout. We observed that fire safety measures were in place and corridors and fire exits were free from obstruction and clutter.

We reviewed the laundry arrangements in the home and improvements had been identified in how the laundry was maintained.

Staff were observed using personal protective equipment and disposing of the same appropriately. We observed staff washing their hands at appropriate intervals and between patient contact.

Cleaning records observed were generally well maintained and this was evident in the cleanliness of the environment in the home.

We did, however, identify some loose toilet seats in two identified ensuite bathrooms and these were attended to by maintenance staff on the day of inspection.

We observed that the yellow clinical waste bins incorporated lids which had not been fitted correctly. This in turn meant that the foot control pedals were ineffective and the bin lids had to be lifted by hand. This was discussed with the manager for their review and action. Information provided post inspection assured RQIA that appropriate action had been taken. This will be reviewed at the next care inspection.

Care Records

We reviewed six patients' care records which evidenced that relevant risk assessments were completed when each patient was admitted to the home and that care plans had been developed to manage the identified care needs. Risk assessments and care plans had been reviewed at least every month. Records reviewed lacked sufficient detail in some instances and were not always patient centred. An area for improvement was identified.

Records reviewed identified that there was partial oversight of supplementary care records with the recording of the 24 hour fluid intake for patients. However, one patient's bowel monitoring records were not evaluated on a daily basis and on one occasion a gap of 10 days in recording was evident. An area for improvement in relation to the oversight of supplementary care will be stated for a second time.

We reviewed the recording of repositioning for one patient and we identified gaps in the recording particularly during the night. We discussed this with the nurse who confirmed that the patient's skin integrity was not compromised and it was a deficit in record keeping. We also identified that a care plan for a patient requiring the use of a pressure relieving device did not have the setting for the device recorded in the care plan; therefore, no evaluation of the setting was available. We confirmed that the device was at the correct setting. An area for improvement was identified.

We reviewed one care plan for a patient, who was assessed by the speech and language therapist (SALT), and who required a modified diet. The care plan was not reflective of the current guidelines, however, it was confirmed that the patient was receiving the correct diet. An area for improvement was identified.

We discussed the care record deficits identified with the home's management who submitted an action plan to RQIA to provide assurances on how they would address these.

A review of falls management evidenced that nursing staff correctly managed the risk of a patient falling and the care of a patient when they had sustained a fall.

We reviewed the medicine administration record (MAR) and identified that two hand written entries were not signed by two staff. We also identified deficits in the management of one inhaled medicine; this was discussed with the nurse who assured the patient received the medication when they consented. Two areas for improvement in regard to these identified areas will be stated for a second time.

Governance

Since the last care inspection there had been no change to the management arrangements in the home. The manager described a planned future change of management.

We reviewed a sample of governance records to assure us that robust systems were in place to regularly review the quality of the nursing care and other services provided to patients. We found that audits were undertaken regularly and any deficits identified were addressed in a timely manner and there was evidence of the manager's evaluation of the information produced by the audits. For example, we saw that the manager analysed the incidence of falls occurring in the home on a monthly basis. This review or analysis enabled the manager to identify any patterns or trends which could be addressed to reduce the number of falls.

We discussed the further development of care record audits in the home. The records reviewed showed that the care record audit had identified some of the deficits picked up on inspection and actions to be taken.

We saw that there was a plan in place to ensure all staff receives regular supervision and appraisal. It was also confirmed staff meetings were held on a regular basis.

The responsible individuals' monthly quality monitoring reports from August 2019 were available in the home. We reviewed a sample of these reports and found that any areas for action identified were followed up during the next visit to ensure the action had been addressed.

Areas for improvement

Areas for improvement were identified in relation to care record reviews,

	Regulations	Standards
Total number of areas for improvement	1	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 Lenaghan, Acting 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 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.

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 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.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 1 (a) (b) Stated: first time To be completed by: 30 January 2020	<p>The registered person shall ensure the following in relation to the provision of pressure area care to patients:</p> <ul style="list-style-type: none"> • The care plans in place which prescribe the required pressure area care and refer, if appropriate to the use of pressure relieving equipment. The required settings /operating instructions for such equipment should also be available within the care record, as appropriate. • That all supplementary repositioning records are completed contemporaneously, comprehensively and accurately in keeping with legislative and best practice guidance. <p>Ref: 6.2</p> <p>Response by registered person detailing the actions taken: Pressure area care with specific reference to pressure relieving equipment is described in the care plans including instructions for use. Supplementary records are being recorded in accordance with legislative and best practice guidelines.</p>
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 Ref: Standard 29 Stated: Second time To be completed by: 1 February 2020	<p>The registered person shall ensure that MARs sheets are fully and accurately completed.</p> <p>Ref: 6.1</p> <p>Response by registered person detailing the actions taken: MARS sheets are being recorded accurately. Audits are regular and ongoing with specific attention to this area</p>
Area for improvement 2 Ref: Standard 28 Stated: Second time To be completed by: 1 February 2020	<p>The registered person shall closely monitor inhaled medicines to ensure that they are administered as prescribed.</p> <p>Ref: 6.1</p> <p>Response by registered person detailing the actions taken: Regular audits are ongoing with specific attention to Inhaled medication</p>
Area for improvement 3 Ref: Standard 4	<p>The registered person shall ensure oversight of the supplementary care records by the registered nurses, in relation to bowel management. Nursing staff must evaluate the effectiveness of care delivery.</p>

Stated: Second time	Ref: 6.1
To be completed by: 30 January 2020	Response by registered person detailing the actions taken: Registered Nurses document in the daily progress notes the bowel management of individual residents and act accordingly.
Area for improvement 4 Ref: Standard 4 Stated: First time To be completed by: 20 February 2020	The registered person shall ensure that care records are maintained in a person centred, sufficiently detailed and meaningful manner at all times this relates specifically to the daily and monthly evaluation of care. Ref: 6.2
	Response by registered person detailing the actions taken: Registered nurses are instructed to complete daily records that are meaningful and specifically relates to the daily and monthly evaluation of care.
Area for improvement 5 Ref: Standard 12 Stated: First time	The registered person shall ensure that the identified patient's nutritional care plans are reflective of current SALT guidelines. Ref: 6.2
To be completed by: 3 February 2020	Response by registered person detailing the actions taken: The identified patient care plan had the nutritional care plan changed to reflect the current SALT guidelines on 12/11/2019

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



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