Unannounced Care Inspection Report
6 April 2016

Cairnmartin Court

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Inspectors: Sharon McKnight and Lyn Buckley

1.0 Summary

An unannounced inspection of Cairnmartin Court took place on 6 April 2016 from 10.30 to 16.30 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

In March 2016 RQIA received correspondence from a whistle blower raising concerns regarding issues within the home. At that time the responsible person was contacted and it was agreed that the issues would be investigated by the regional manager and a written response provided to RQIA. A response was received on 18 March 2016 and we were satisfied with the outcomes of the investigation and with the assurances given of the action taken.

It is not the remit of RQIA to investigate complaints 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 action is required; this may include an inspection of the home.

An inspection to Cairnmartin Court had been scheduled for April 2016. Following discussion with RQIA senior management, it was agreed that the focus of the inspection would subsume the alleged areas of concerns. The outcome of the inspection did not substantiate any of the concerns raised.

Is care safe?

Two recommendations for improvement were identified with the safe delivery of care.

Is care effective?

One recommendation for improvement was identified with the effective delivery of care.

Is care compassionate?

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

Compliance with the recommendations made in the two previous domains will improve the overall services provided, the experience of service users and leadership within the home.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes, April 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**3**

Details of the QIP within this report were discussed with Ms Michelle Montgomery, Registered 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 inspection

The most recent inspection of the home was an announced estates inspection on 11 November 2015. The completed QIP was returned and approved by the estates inspector.

Other than those actions detailed in the previous QIP there were no further actions required.

2.0 Service details

Registered organisation/registered person: Priory Elderly Care Ltd	**Registered manager:** Michelle Montgomery
Person in charge of the home at the time of inspection: Michelle Montgomery	**Date manager registered:** 8 April 2014
Categories of care: NH-PH, NH-DE, NH-I, NH-PH(E)) A maximum of 31 patients in categories NH-I and NH-PH(E) and a maximum of 31 patients in category NH-DE. Category NH-PH for 2 identified patients only.	**Number of registered places:** 62

3.0 Methods/processes

Prior to inspection we analysed 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 quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with seven residents individually, three registered nurses, four care staff and three resident's visitors/representative.

The following records were examined during the inspection:

- three patient care records
- staff roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- staff supervision and appraisal planner
- complaints and compliments records
- incident and accident records
- records of audit
- records of meetings

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent care inspection

The most recent care inspection of the home was an unannounced inspection on 21 October 2015. The QIP is detailed below.

4.2 Review of requirements and recommendations from the last care inspection dated 21 October 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 47.1 **Stated:** First time **To be completed by**: 30 November 2015	It is recommended that the nursing and care staff are made aware of the importance of ensuring that the mattress depth does not compromise the function or purpose of the bedrails when bedrails are deployed. **Action taken as confirmed during the inspection**: Staff spoken with were knowledgeable regarding mattresses and the use of bedrails. Mattresses observed were compatible with the bedrails in place. This recommendation has been met.	**Met**

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for weeks commencing 14 and 23 March 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff staffing rosters it was confirmed that administrative, maintenance, catering, domestic and laundry staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Relatives commented positively regarding the staff and care delivery.

There was extensive use of correction fluid on the duty rosters reviewed. This was discussed with the registered manager and a recommendation was made.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Two completed induction programmes were reviewed. The programmes included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The registered manager also signed the record to confirm that the induction process had been satisfactorily completed.

Review of four records and discussion with the registered manager confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home. The registered manager stated that a new competency and capability assessment tool had recently been introduced by the organisation. While it was acknowledged that the registered manager had signed the top of the front cover of one of the records reviewed; a formal declaration of her oversight and satisfaction as to the outcome of the assessment was missing. A recommendation was made to ensure that the new competency and capability assessment tool was completed with all nurses who are left in charge of the home in the absence of the registered manager; the completed records should include a signed declaration by the registered manager to confirm that the assessment process has been completed and that they are satisfied that the registered nurse is capable and competent to be left in charge of the home.

Training was available via an e learning system known as “Foundations of Growth”, internal face to face training arranged by Priory Elderly Care Ltd and training provided by the local health and social care trust. The registered manager had systems in place to monitor staff attendance and compliance with training. Review of staff training records for 2016 evidenced that the attendance/compliance levels with mandatory training was, for many areas, 100% compliance. This was commended.

Discussion with the registered manager, staff on duty and a review of records confirmed that there are systems in place to ensure that staff received supervision and appraisal. .

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed.

A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Training records reflected that 100% of staff had undertaken safeguarding training in the past 12 months. Annual refresher training was considered mandatory by the home.

A review of documentation confirmed that any safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home’s policies and procedures. RQIA were notified appropriately. The registered manager had robust systems in place to monitor the progress of safeguarding issues with the local health and social care trust and the PSNI.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient’s individual care plans.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of falls to identify any trends or patterns.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for Improvement

It was recommended that any alteration to records should be made in a way that the original entry could still be read.

It was recommended that the new competency and capability assessment tool should be completed with all nurses who are left in charge of the home in the absence of the registered manager. The completed assessments should contain a signed declaration by the registered manager to confirm that the assessment process has been completed that they are satisfied that the registered nurse is capable and competent to be left in charge of the home.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.4 Is care effective?

Review of patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information. A comprehensive, holistic assessment of one patient's nursing needs was not commenced at the time of admission to the home. A recommendation was made. As previously discussed a range of validated risk assessments were completed as part of the admission process.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians and palliative care nurse facilitators. Care records were regularly reviewed and updated, as required, in response to patient need.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

It was observed that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) directives were recorded on an internal pro-forma. This was discussed with the registered manager and it was agreed that a review of the current pro-forma would be completed to ensure it was in keeping with the Resuscitation Council (UK) guidelines. The registered manager agreed to inform RQIA of the outcome of the review.

There was evidence within the care records that patients and/or their representatives were involved in the care planning process. There was also evidence of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with the registered manager, deputy manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Discussion with the registered manager confirmed that staff meetings were held regularly and that records of these meeting were maintained. The registered manager explained that they set the initial agenda and then staff could add items to the agenda. A review of records evidenced that the signatures of the staff attending, issues discussed and any agreed outcomes were recorded. The registered manager confirmed that the record of each meeting was made available to staff

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the registered manager.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. The registered manager explained that she held monthly meetings with relatives. The minutes of relatives meetings held in January, February and March 2016 were reviewed and confirmed who attended and the detail of the issues discussed.

A notice board displaying information for relatives was provided on each floor of the home. Information displayed included the Statement of Purpose, Patient Guide, dates of the relatives meetings for 2016, how to make a complaint and the adult safeguarding procedure.

The serving of lunch was observed in both units. Tables were set with cutlery, condiments and napkins. Those patients who had their lunch in the lounge or bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. Patients were enabled to choose which dish they preferred at the point of service. This is good practice.

Meals were transported from the kitchen in heated trolleys and served by the kitchen staff; this left the registered nurses and care staff free to attend to the nutritional needs of the patients.

The serving of the lunch was observed to be well organised with all of the patients being attended to in a timely manner. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch.

Ten questionnaires were issued to patients; four were returned prior to the issue of this report. Patients' responded positively regarding all aspects of care and the leadership in the home.

Ten relative questionnaires were issued to relatives; four were returned prior to the issue of this report. All of the respondents indicated a high level of satisfaction with the delivery of safe, effective and compassionate care and the leadership in the home.

The following comments were provided:

"The staff are wonderful and the home is spotless."
"My mum loves this home! She says it's like a hotel and we feel the same."
"Management is very nice and approachable at all times."

Ten questionnaires were issued to nursing, care and ancillary staff; four were returned prior to the issue of this report. The responses to the questions were all positive.

Areas for Improvement

A comprehensive, holistic assessment of patients' nursing needs should be commenced at the time of admission to the home.

Number of requirements	**0**	**Number of recommendations**:	**1**

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"He couldn't have been in a better place."
"Many thanks to all the staff for the care and compassion and support shown to … and his family during his time in Johnston House."
"…for the years that she was in your care, for taking time to talk to her, for the love and dignity and thoughtfulness you all showed her again and again."

Areas for Improvement

No areas for improvement were identified in the delivery of compassionate care during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were displayed and available in each unit.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. The organisational structure was displayed at the nursing office on each floor.

Staff spoken with were knowledgeable regarding line management within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients and their representatives confirmed that they were confident that staff and /or management would address any concern raised by them appropriately. Patients were aware of who the registered manager was. As previously discussed information on how to make a complaint was displayed in the home.

A record of complaints was maintained by the registered manager. The record included the date the complaint was received, the nature of the complaint, details of the investigation and a copy of the letter sent to the complainant. We discussed at length how the registered manager assessed that the complainant was satisfied with the outcome of the complaint and how this satisfaction was evidenced. After the inspection the registered manager forwarded additional evidence to RQIA by email which confirmed that a system for recording complainant's satisfaction was in place.

Any contract compliance issues raised by the local health and social care trust were recorded as complaints. In these instances the trust inform the registered manager if the complainant is satisfied with the outcome. Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

There were numerous thank you cards and letters received from former patients and relatives. The registered manager explained that initially these would be displayed in the home. Complaints and compliment records were also recorded electronically and forwarded to the human resource department for monitoring. The registered manager demonstrated how some of the compliments received by Cairnmartin Court were available in the "testimony" section of the corporate website.

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. The registered manager explained that a programme of audits was completed on a monthly basis. Areas for audit included care records, infection prevention and control practices, falls, complaints and the environment. A review of the record of audits evidenced that where an area for improvement was identified and an action plan was

developed, completed and the area re-audited to check that the required improvement has been completed.

We discussed further with the registered manager how patients and relatives were involved or consulted with regards to issues which affected them. As previously discussed the registered manager held monthly meetings with relatives and displayed information for relatives on dedicated notice boards. The registered manager also explained that the corporate website had a facility to allow anyone to "Have their say" about Cairnmartin Court. The registered manager would receive an email to alert her that someone has left feedback; if it was an area for improvement she would complete an action plan and forward this to the human resource department.

Discussion with the registered manager and review of records evidenced that the unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any areas for improvement. The importance of recording the time of the unannounced visit was discussed.

Areas for Improvement

Areas for improvement were identified in the previous domains of safe and effective care. Compliance with these recommendations will improve the overall services provided, the experience of service users and leadership within the home.

Number of requirements	**0**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Michelle Montgomery, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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 person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to Nursing.Team@rqia.org.uk and assessed 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 4 May 2016	It is recommended that any alteration to records should be made in a way that the original entry can still be read.
	Response by registered person detailing the actions taken: Correction fluid is no longer permitted for changes on rotas. The rotas for all units are printed and laminated with a sharpie pen now being used for any alterations.
Recommendation 2 **Ref**: Standard 41.7 **Stated:** First time **To be completed by:** 18 May 2016	It is recommended that the new competency and capability assessment tool should be completed with all nurses who are left in charge of the home in the absence of the registered manager. The completed assessments should contain a signed declaration by the registered manager to confirm that the assessment process has been completed that they are satisfied that the registered nurse is capable and competent to be left in charge of the home.
	Response by registered person detailing the actions taken: A review of our corporate documentation is being completed. Cairnmartin Court has added an extra declaration summarising the above recommendations. All nursing staff have the new competencies fully completed, including staff who had completed the previous priory documentaion. .
Recommendation 3 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** 4 May 2016	It is recommended that a comprehensive, holistic assessment of nursing needs should be commenced on the day of admission and completed within five days of admission to the home.
	Response by registered person detailing the actions taken: A new comprehensive nursing assessment is now in place for the day of admission. Amore are reviewing this corporate document and any amendments RQIA will be informed.

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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