Unannounced Care Inspection Report
25 January 2018

Culmore Manor Care Centre

Type of Service: Nursing Home (NH)
Address: 39 Culmore Road, Londonderry, BT48 8JB
Tel No: 028 7135 9302
Inspector: Bridget Dougan

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 56 persons.

3.0 Service details

Organisation/Registered Provider: Larchwood Homes (NI) Ltd **Responsible Individual:** Christopher Walsh	**Registered Manager:** Ciaran Burke
Person in charge at the time of inspection: Ciaran Burke	**Date manager registered:** 28 December 2012
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment	**Number of registered places:** 56 comprising: 46 - NH-I 10 - NH-PH

4.0 Inspection summary

An unannounced inspection took place on 25 January 2018 from 10.30 to 17.00 hours.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

There were good examples of practice found throughout the inspection in relation to staff recruitment; induction, training, adult safeguarding, risk management processes; care records; communication between patients, staff and other key stakeholders. There was also evidence of good governance and management systems.

No areas of improvement were identified at this inspection.

Patients and relatives said that they were satisfied with the care and services provided and described living in the home, in positive terms. Two comments received from relatives (staffing) and one comment received from a patient (personal care products) were shared with the registered manager for follow up as necessary.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ciaran Burke, registered manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 12 April 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 12 April 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which may include information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with twenty six patients, seven staff, three patients' visitors/representatives and two visiting professionals. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was also displayed for staff inviting them to provide online feedback to RQIA.

The following records were examined during the inspection:

- duty rotas for nursing and care staff
- staff training records
- a sample of incident and accident records
- complaints record
- one staff recruitment and induction file
- three patient care records
- supplementary care charts for example; repositioning charts, food and fluid charts, bowel records
- a selection of governance audits
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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 the most recent inspection dated 12 April 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and was validated at this inspection.

6.2 Review of areas for improvement from the last care inspection dated 12 April 2018

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 12 (1) (a) **Stated:** Second time	The registered persons must ensure that where patients require specialist equipment to be used, this is provided and the specific instructions for its use are included in the care plan.	**Met**
	Action taken as confirmed during the inspection: There was evidence of specialist equipment (hand splints) being used as recommended by the occupational therapist and specific instructions for the use of this equipment were included in the care plans.	
Area for improvement 2 **Ref**: Regulation 19 (1) (a) **Stated:** Second time	The registered persons must ensure that contemporaneous notes of all nursing provided are maintained. Fluid balance charts must be accurately completed.	**Met**
	Action taken as confirmed during the inspection: Fluid balance charts had been accurately completed and included drinks taken at supper time.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 22.4 **Stated:** Second time	The registered persons should ensure that the patients' falls risk assessments are completed following each fall.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of three care records evidenced that falls risk assessments had been completed following each fall.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** Second time	The registered persons should ensure that care plans are developed in response to acute infections patients may have.	**Met**
	Action taken as confirmed during the inspection: There was evidence that care plans had been developed in response to acute infections.	
Area for improvement 3 **Ref**: Standard 35.4 **Stated:** Second time	The registered persons should ensure that there are robust systems in place to discharge, monitor and report on the delivery of nursing care, in particular, the auditing processes in relation to care records, including supplementary care records.	**Met**
	Action taken as confirmed during the inspection: A suite of quality audits were in place to monitor the quality of nursing care and other services provided in the home. There was evidence that these were completed regularly and any shortfalls identified were included in an action plan. These included; care planning; supplementary care records, falls, accidents and incidents; infection control and environmental.	
Area for improvement 4 **Ref**: Standard 13 **Stated:** First time	The registered persons should ensure that arrangements are put in place to embed the new regional operational safeguarding policy and procedures.	**Met**
	Action taken as confirmed during the inspection: The adult safeguarding policy and procedure had been reviewed and updated to reflect the regional safeguarding operational policy and procedures. There was evidence that the	

	updated policy and procedure had been disseminated to all staff. An adult safeguarding champion had been identified for the group and staff had received update training in adult safeguarding.	
Area for improvement 5 **Ref**: Standard 45 **Stated:** First time	The registered persons should ensure that the system in place to monitor the settings of pressure relieving mattresses is further developed, to ensure that settings are recorded on a daily basis.	**Met**
	Action taken as confirmed during the inspection: The system for monitoring the settings of the pressure relieving mattresses had been reviewed and there was evidence of a record of daily checks.	
Area for improvement 6 **Ref**: Standard 4 **Stated:** First time	The registered persons should ensure that where bedrails are required, risk assessments are undertaken, to ensure their safe use, and care plans are developed accordingly. Records of safety checks when bedrails are in use must also be maintained.	**Met**
	Action taken as confirmed during the inspection: Bed rail risk assessments and care plans had been developed and there was evidence of routine safety checks of bedrails having been maintained.	
Area for improvement 7 **Ref**: Standard 4 **Stated:** First time	The registered persons should ensure that care plan evaluations are meaningful and reflect the effectiveness of the care provided. Evidence of how this matter is addressed with registered nurses must be retained in the home for inspection.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of three patients' care records evidenced that care plan evaluations were meaningful and reflected the effectiveness of the care provided. Three registered nurses confirmed that this matter had been discussed during a staff meeting and in supervision.	

Area for improvement 8 **Ref**: Standard 4 **Stated:** First time	The registered persons should ensure that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records.	**Met**
	Action taken as confirmed during the inspection: There was evidence that bowel records had been well maintained. Registered nurses confirmed that they review patients' bowel records on a daily basis and record any actions taken in the patients daily progress notes.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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. A review of the staffing rotas for weeks commencing 8, 15 and 22 January 2018 evidenced that planned staffing levels were adhered to.

Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. We also sought patients, relatives and staff opinion on staffing via questionnaires; two relatives commented that the home was sometimes short staffed. This information was shared with the registered manager for consideration and actions as deemed appropriate.

Observation of the delivery of care at the time of this inspection evidenced that patients' needs were met by the levels and skill mix of staff on duty.

A review of one recruitment record evidenced that it was maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. The record confirmed that an enhanced Access NI check was sought, received and reviewed prior to staff commencing work.

The registered manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. A review of induction programmes evidenced that these were completed within a meaningful timeframe.

The provision of mandatory training was discussed with staff and training records were reviewed for 2017. Training records evidenced good compliance. The registered manager confirmed that they had systems in place to facilitate compliance monitoring.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. Where any shortcomings were identified safeguards were put in place.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, adult safeguarding and the management of falls.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning, bowel charts, food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislation.

Review of three patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

The registered manager confirmed that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered. There was evidence of regular monthly audits of a number of areas including care records, falls management and infection control. Action plans had been developed and there was evidence that the actions had been embedded.

Discussion with the registered manager and review of records evidenced that patient and/or relatives meetings were held on a regular basis. Patients and relatives expressed their confidence in raising concerns with the staff and registered manager.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records and the culture of the home which promoted a sense of teamwork.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Observation of the lunchtime meal confirmed that patients were given a choice in regards to where they preferred to dine, food and fluid choices and the level of help and support requested. Staff treated patients with dignity and respect, affording patients adequate time to make decisions and choices and offered reassurance and assistance appropriately.

Patients who were able to communicate their feelings indicated that they enjoyed living in Culmore Manor Care Centre and that staff were caring and attentive.

Comments included:

"Staff are all very good. This home is A1."
"I am very happy here; everyone is more than good to me."
"Staff very caring and no request too much. Very happy with Culmore Manor."

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. There was evidence that suggestions for improvement had been considered and used to improve the quality of care delivered. A copy of the most recent annual report and action plan were available.

We spoke with three relatives during this inspection all of whom were complimentary regarding the management, staff and the care provided to their loved ones. Two visiting professionals (Acute Care at Home Team) confirmed their satisfaction with the multidisciplinary working arrangements and the care provided in the home. These are examples of some of the comments received from the visiting professionals:

"We are in here often and we find the staff are excellent. We have no concerns."
"Staff always follow our recommendations."

Twelve questionnaires were issued for relatives and patients who were not consulted during the inspection. In total, eleven questionnaires were returned; patients (seven) and relatives (four). The majority of responses received were positive, with respondents indicating they were either "very satisfied" or "satisfied" with the quality of care and services provided. Two written comments received in regards to staffing levels have been included in section 6.4 of the report. One further written comment was received in respect of incontinence aids. This was discussed with the registered manager, who agreed to follow up these issues.

Some comments received from relatives included:

"X feels the food is brilliant and we are very pleased with the care and attention he receives."
"Happy with mummy's care since the very start and continue to be. Praise all staff for their love and care."

A poster was also displayed for staff inviting them to provide online feedback to RQIA. No feedback was received following the inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff awareness of patients' needs, wishes and preferences; patient and staff interactions.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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 available in the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

Discussion with the registered manager and review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015. A copy of the complaints procedure was displayed in various locations within in the home.

A review of records evidenced that robust governance arrangements were in place. Areas audited included but were not limited to; trend analysis of accidents and incidents, care planning; supplementary care records, infection control and environmental audits.
The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was included within the report to address any areas for

improvement and was reviewed at the next visit. Copies of the quality monitoring reports were available in the home.

Discussions with the staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Seven patients and four relatives returned questionnaires. They identified they were either satisfied or very satisfied in response to the question "is care well led?" They referenced they know who is in charge; the service is well managed; their views are sought and they know how to make a complaint.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

The Regulation and Quality Improvement Authority

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