Unannounced Care Inspection Report
6 June 2016

Castlehill

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Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Castlehill took place on 6 June 2016 from 09:50 hours to 16:20 hours.

The inspection sought to assess progress with any 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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were aware of their responsibilities in relation to adult safeguarding and who to report concerns to within the home. One area of improvement was identified with regard to the role of the nurse in charge and clarification of safeguarding concerns reported whilst not straying into investigation. A recommendation was made.

A general inspection of the home confirmed that the premises and grounds were well maintained.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that the outcome of care delivery was positive for patients. A review of care records confirmed that patients were comprehensively assessed and care plans were created to prescribe care. There were arrangements in place to monitor and review the effectiveness of care delivery. We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Relatives and staff were of the opinion that the care delivered provided positive outcomes.

Areas of improvement were identified regarding care records. Two recommendations were made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff were also observed to be taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to living in the home.

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

Is the service well led?

There was a clear organisational structure evidenced within Castlehill and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

There was evidence of good leadership in the home and effective governance arrangements. Staff spoken with were knowledgeable regarding the line management structure 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. There were systems in place to monitor the quality of the services delivered.

One area for improvement was identified with the recording of audits. A recommendation was made.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**4**

Details of the QIP within this report were discussed with Isobel Johnston, Registered Nurse in charge of the home, as part of the inspection process and with the Registered Manager, Bernadette O'Neill following the inspection. 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 unannounced care inspection undertaken on 28 September 2015.

Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/ registered person: Safecare Chrysalis Ltd	**Registered manager:** Bernadette O'Neill
Person in charge of the home at the time of inspection: Registered Nurse Isobel Johnston	**Date manager registered:** 27 January 2011
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 34

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 we met with fourteen patients individually and with the majority of others in small groups, two registered nurses, three care staff and with the relatives of three patients.

Ten questionnaires were issued to relatives and staff with a request that they were returned within one week from the date of this inspection.

The following records were examined during the inspection:

- three patient care records
- staff duty roster
- staff training records
- staff induction records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- records of patient meetings
- reports of monthly visits undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 28 September 2015.

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

4.2 Review of requirements and recommendations from the last care inspection dated 28 September 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32.5 **Stated:** First time **To be Completed by: 31 October 2015**	The registered manager should ensure that a written protocol has been developed for timely access to any specialist equipment or drugs out of hours. **Reference: Section 5.2**	**Met**
	Action taken as confirmed during the inspection: Written directions were available for the access of specialist equipment and medications out of hours. Staff were knowledgeable of the processes.	

4.3 Is care safe?

We were advised of 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 nurse in charge provided examples which demonstrated to them that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 5 June 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, 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. Observation of care delivery and responses by staff to requests made by patients evidenced that care was delivered in a timely manner.

The registered nurses spoken with were aware that a nurse was identified to be in charge of the home when the registered manager was off duty.

The nurse in charge was clearly identified on the staffing roster. The registered nurse in charge of the home during the inspection confirmed that a competency and capability assessment to undertake the role had been completed with them by the registered manager.

The arrangements in place to confirm and monitor the registration status of registered nurses with the Nursing and Midwifery council (NMC) were reviewed. Records evidenced that the arrangements were appropriately managed. Care staff spoken with confirmed that they were required to register with the Northern Ireland Social Care Council (NISCC) and had provided evidence to the registered manager of their registration.

Discussion with a registered nurse, a member of staff undertaking induction and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. The member of staff undergoing induction was working in a supernumery capacity and confirmed that they had a written record to complete of the areas covered.

Mandatory training was provided by the home in classroom based sessions. The registered manager had a staff training and development plan in place for 2016 to ensure that training was spread throughout the year. Training opportunities were also provided by the local health and social care trust. Each member of staff had an individual training records; the registered manager also had a training matrix in place to facilitate an over view of compliance with training. A review of attendance at mandatory training evidenced good compliance with first aid training held in February 2016 and safeguarding vulnerable adults in March and April 2016. Mandatory training for 2016 was ongoing.

A review of the supervision and appraisal schedule confirmed that there were systems in place to ensure that staff received supervision and appraisal.

The registered nurses and staff spoken with clearly demonstrated an awareness of their responsibilities in relation to adult safeguarding and were aware of whom to report concerns to within the home. Annual refresher training on safeguarding was considered mandatory by the home. Staff described types of abuse and were able to provided examples of what could be considered as abuse. There was some ambiguity with regard to the role of the nurse in charge and clarifying concerns reported whilst not straying into investigation, which is role of the safeguarding team. It was recommended that the registered manager revisit this element of safeguarding training with registered nurses to ensure staff are clear on their role in this area.

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.

We reviewed the management of restrictive practice and were assured that staff were aware of what restrictive practice was and how it should be managed. A review of one patient's care records evidenced that relatives and a range of healthcare professionals were involved in the decision making process. A care plan was in place which included the rationale for the practice and the action to be taken if the restriction was agitating the patient; the detail in this care plan was commended. The care records evidenced a regular review of the intervention by healthcare professionals and registered nurses in the home.

A 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 accidents 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

The registered manager should revisit the identified element of safeguarding training with registered nurses who are in charge of the home in their absence.

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

4.4 Is care effective?

We reviewed one patient's care records with regard to the admission process. At the time of admission to the home a range of assessments were completed for patients admitted for intermediary care/rehabilitation; these records were supplemented by assessments provided by the referring health care trust. There were some areas of patient need identified in the completed assessments which did not have care plans in place, a recommendation was made. A record of the care provided and a review of the patient's condition was recorded daily. These records evidenced good communication with relevant healthcare professionals and with the patient's family. Records clearly identified the recommendations made by visiting healthcare professionals and that these recommendations were adhered to.

We reviewed two care records with regard to the day to day maintenance of care records. Both care records contained a range of assessments. The assessments contained good detail of the patients' individual needs and preferences. Care interventions were prescribed to meet the needs of the patients. The evaluation of the prescribed care interventions varied between the two records; the need to ensure that evaluations contain an individualised statement of the patient's condition since the previous review was discussed at the conclusion of the inspection and following the inspection with the registered manager. A recommendation was made.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Patient confidentiality in relation to the storage of records was maintained.

Patients' rights were considered and recognised in the care records reviewed.

A form entitled “Resident bedroom door consultation form” was completed to identify those patients who would prefer to keep their bedroom door locked; patients who choose to keep their door locked were provided with a personal key. We spoke with one patient who chose to lock their door when they were out of their room. This patient had their own key and the sense of empowerment this arrangement provided to the patient was obvious when they spoke with us. This practice was commended.

There was evidence within the care records 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.

Staff spoken with confirmed that they 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 and confirmed that information shared at handovers was relevant.

A review of records confirmed that staff meetings were held regularly, and staff were enabled to contribute to the agenda. The most recent meeting was held on 8 April 2016; the minutes of this meeting were available. Staff confirmed that the record of each meeting was made available to them.

Staff advised 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 observed the serving of lunch in the main dining which was situation off the reception area, adjacent to the kitchen. The dining room tables were nicely set and the serving of lunch was calm and well organised. Patients were assisted in timely manner. Staff confirmed there was a choice of two dishes at each meal. Patients spoken with all enjoyed their lunch.

Areas for improvement

A detailed plan of care should be drawn up from the completed assessments.

Review of prescribed care interventions should include an individualised statement of the patient’s condition since the previous review.

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

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. There various areas throughout the home for patients to spend time. One lounge was supervised by staff at all times. Those patients with complex needs or who were identified as high risk of falls were encouraged to sit in this lounge. Music, television and activities were provided in this lounge.

The reception area of the home also provided a selection of seating for those patients who choose to spend time there. We met two patients who were watching television in their bedrooms.

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 and were happy in their surroundings. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

We spoke with the relatives of three patients who all commented positively with regard to the standard of care, the attentiveness of staff and communication in the home. These are examples of comments provided;

"They treat her so well with the upmost respect and dignity."
"Staff go over and beyond their duty."
"We are so happy we found somewhere like this."

We discussed how patients and relatives were consulted about the issues which affected them. Staff confirmed that the registered manager had regular, daily contact with the patients and any visitors and was available, throughout the day, to meet with both on a one to one basis if needed. Staff explained that many of the patients' relatives did not visit regularly.

A quality assurance questionnaire is sent out annually to relatives of each patient. These were last sent on 16 February 2016 with a 75% return rate. The questionnaire asked relatives opinion on the quality of care, provision of activities, meals, celebrations such as birthdays, communication with staff and staff. The following are examples of comments included in the returned questionnaires:

"It's a wonderful home and they are doing a great job with my brother."

"Excellent nursing home and residents are extremely well looked after."

"All I can say to management and staff is, keep up the good work. It is obvious that the clients in your care are very important to each and every one of you …"

Staff explained that, in addition to the activities provided in the supervised lounge, activities were also provided for patients in a separate building located in the grounds to the rear of the home. Staff stated that patients enjoyed the change of environment. The registered nurse in charge of the home showed us the recent addition of the raised vegetable beds where, assisted by staff, patients had planted a selection of vegetables and herbs, for example potatoes and carrots. When the vegetables are ready to be picked it is hoped that patients will be able to enjoy eating what they have grown.

Two patient questionnaires were issued; none were returned prior to the issue of this report.

Ten relative questionnaires were issued; none were returned prior to the issue of this report.

Ten questionnaires were issued to nursing, care and ancillary staff; none were returned prior to the issue of this report.

Areas for improvement

No areas for improvement were identified with 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 available in the home.

Staff spoken with were knowledgeable regarding line management 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; staff stated that management were responsive to any suggestions or concerns raised.

Relatives spoken with confirmed that they were aware of the home's complaints procedure and confirmed that they were confident that staff and/or management would address any concern raised by them appropriately. A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint and details of the investigation/actions undertaken.

The registered manager had systems in place to monitor the quality of the services delivered. A programme of audits was completed on a regular basis. Areas for audit included accidents, medicines management and internal records, for example the patient register. The registered manager also audited the home's compliance with identified standards taken from DHSSP Care standards for nursing homes, April 2015. There was no evidence in the audit records that when areas for improvement were identified that there had been a re-audited to check compliance. The audit process should be further developed to include a re-audit of the areas for improvement to check compliance has been achieved. A recommendation was made.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

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 identified areas for improvement. The importance of ensuring that all areas identified are followed up and commented on during the next visit was discussed.

It was observed that the registered manager had robust systems to ensure they had oversight of the governance systems in the home. In the registered managers absence there was easy access to the information required. Files were observed to be well organised and clearly labelled.

Areas for improvement

The audit process should be further developed to include a re-audit of the areas for improvement to check compliance has been achieved.

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

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the nurse in charge of the home as part of the inspection process and the registered manager following the inspection. 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 weaknesses that exist in the service. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the service.

Quality Improvement Plan

No requirements were made as a consequence of this inspection.

Recommendations	
Recommendation 1 **Ref**: Standard 13.11 **Stated:** First time **To be completed by:** 4 July 2016	It is recommended that the registered manager revisit safeguarding training with registered nurses who are in charge of the home when the registered manager is off duty to ensure staff are clear on their role in this area. **Ref section 4.3**
	Response by registered person detailing the actions taken: Clinical supervision is ongoing for all Registered Nurses and the management of Safeguarding is being revisited.
Recommendation 2 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** 4 July 2016	It is recommended that a detailed plan of care for all assessed needs should be drawn up from the completed assessments. **Ref section 4.4**
	Response by registered person detailing the actions taken: Review of all careplans is ongoing and discussionof careplan documentation with the Registered Nurses has occured through clinical supervision.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 4 July 2016	It is recommended that review of prescribed care interventions should include an individualised statement of the patient's condition since the previous review. **Ref section 4.4**
	Response by registered person detailing the actions taken: The Registered Nurses on reviewing exisiting careplans must record if there has been a change in a residents care needs as assessed but sometimes there can be no change to their condition and no change to the prescribed nursing intervention as recorded. On discussion with the Inspector they have recommended an elboration of how this conclusion was derived. Nurse Manager has discussed the recommendation with the Registered Nurses through clinical supervision.

Recommendation 4 **Ref**: Standard 35.16 **Stated:** First time	It is recommended that the audit process should be further developed to include a re-audit of the areas for improvement to check compliance has been achieved. **Ref section 4.6**
To be completed by: 4 July 2016	**Response by registered person detailing the actions taken:** Audits continue to be ongoing and re-auditing of any areas for improvement will be included as when required.

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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