Unannounced Care Inspection Report
19 June 2017

Castlehill

Type of Service: Nursing Home
Address: 14 Bellshill Road, Castledawson, BT45 8HG
Tel No: 028 7946 8730
Inspector: Sharon Mc Knight

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 34 persons.

3.0 Service details

Registered organisation/ registered person: Cathal McAteer Safecare Chrysalis Ltd	**Registered manager:** Bernadette O'Neill
Person in charge of the home at the time of inspection: Bernadette O'Neill	**Date manager registered:** 27 January 2011
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of registered places:** 34 places

4.0 Inspection summary

An unannounced inspection took place on 19 June 2017 from 10:00 to 16:30.

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.

Evidence of good practice was found in relation to staffing and the empathy displayed to patients, adult safeguarding, infection prevention and control and fire safety. The home's environment was fresh smelling and clean throughout and the level of attention to personalising patients' bedrooms was commended. We observed good practice in communication between staff and between patients and staff. Our observations confirmed that staff were knowledgeable of patients' wishes and preferences. There were good working relationships between staff and good support from management.

Areas requiring improvement under the standards were identified with care records. We also identified the need to the monitor the working arrangements of the registered manager to ensure they have sufficient time to undertake the day to day operational management of the home effectively.

All patients spoken with happy living in the home. 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.

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**	***4**

*The total number of areas for improvement include two which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Bernadette O'Neill, 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.

4.2 Action/enforcement taken following the most recent inspection dated 24 January 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 24 January 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.

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 we met with all of the patients, four staff and two patients' relatives. Questionnaires were also left in the home to obtain feedback from patients' relatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives were left for distribution.

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

The following records were examined during the inspection:

- duty rota for staff for week commencing 18 June 2017
- duty rota for registered manager weeks commencing 4, 11 and 18 June 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- accident records
- two staff recruitment files
- two staff induction
- three patient care records
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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.

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 24 January 2017

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 during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 24 January 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4.1 **Stated:** Second time	It is recommended that a detailed plan of care for all assessed needs should be drawn up from the completed assessments.	**Met**
	Action taken as confirmed during the inspection: A review of three care records evidenced that a detailed plan of care had been drawn up for all assessed needs. This area for improvement has been met.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** Second time	It is recommended that review of prescribed care interventions should include an individualised statement of the patient's condition since the previous review	**Met**
	Action taken as confirmed during the inspection: A statement of the patient's condition and care interventions provided was recorded daily. This area for improvement has been met.	
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	It is recommended that care plans are updated to accurately reflect the needs of the patient.	**Met**
	Action taken as confirmed during the inspection: A review of care plans evidenced that this recommendation has been met.	

Area for improvement 4 **Ref**: Standard 4 **Stated:** First time	It is recommended that assessments are reviewed regularly to ensure they accurately reflect the patient's needs.	**Partially met**
	Action taken as confirmed during the inspection: The assessments viewed had all been update since their initial completion however they were not reviewed regularly and there was no consistency between files to evidence how frequently they were due to be reviewed. This area for improvement has been assessed as partially met and is now stated for a second time.	
Area for improvement 5 **Ref**: Standard 4.9 **Stated:** First time	It is recommended that care records are dated and signed by the registered nurse at the time of completion.	**Met**
	Action taken as confirmed during the inspection: Care records reviewed had been dated and signed. This area for improvement has been met.	
Area for improvement 6 **Ref**: Standard 35.6 **Stated:** First time	It is recommended that the registered manager undertake regular audits of care records to ensure that the required improvements are made and that care records are maintained in accordance with best practice.	**Partially met**
	Action taken as confirmed during the inspection: The registered manager evidenced that a small number of audits of care records had been undertaken since the previous inspection. Whilst it is good to note the improvement in care records to ensure the improvements are sustained a regular programme of audits is required. This area for improvement is assessed as partially met and is stated for a second time.	

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 staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 18 June 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Staff were employed to oversee activities and drive the bus. Observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty. At the time of the inspection the registered manager was generally rostered to work as a registered nurse; this is further discussed in section 6.7.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; none were returned in time for inclusion in the report.

We spoke with the relatives of two patients who commented positively with regard to staffing and the care delivery in the home. We also sought relatives' opinion on staffing via questionnaires; one was returned in time for inclusion in this report. The relative responded that they were very satisfied with staffing.

A nurse was identified to take charge of the home when the registered manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

A review of two staff recruitment records evidenced that they were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records confirmed that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

The registered manager confirmed that a record of staff including their name, address, contact number, position held, contracted hours, date of receipt of Access NI certificate, date commenced and date position was terminated (where applicable) was held electronically and could be accessed if required through the administrator. This additional detail supplements the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager. A review of the records of NMC registration evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The record of the checks of care staff registration included the expiry date of their registration with NISCC. The registered manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe.

We discussed the provision of mandatory training which is all delivered by trainers on a face to face basis with signing in sheets to evidence attendance. Training records evidenced good compliance with mandatory training; for example on 2016/17 seven out of the eight registered nurses and 20 out of 21 care assistants have completed training in safeguarding, manual handling and first aid. Mandatory training compliance was monitored by the registered manager. Staff spoken with confirmed that, in addition to training provided by the home, training opportunities were also offered by the local health and social care trust and that they were encouraged and facilitated to attend by the registered manager.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. The registered manager confirmed that they had attended training on the role of the safeguarding champion in February 2017 and there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

Review of three patient 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 are further discussed in section 6.5.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since January 2017 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients' bedrooms were individual and personalised to reflect the patients' likes and interests. The level of attention to detail was commended. A number of bedroom doors were locked. As identified during previous inspections were we were assured through discussion with patients and staff and a review of care records, that this practice was in response to individual requests from patients and/or families and did not constitute restrictive practice.

Infection prevention and control measures were adhered to. We observed that equipment such as mops, buckets and cloths were provided in accordance with the National Patient Safety Agency (NPSA) national colour coding scheme for equipment. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the management of staffing, adult safeguarding, infection prevention and control and fire safety. The home's environment was fresh smelling and clean throughout and the level of attention to personalising patients' bedrooms was commended.

Areas for improvements

No areas for improvement were identified with the delivery of safe care.

	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.

A review of three patients care records evidenced that a comprehensive assessment and a range of validated risk assessments were completed for each patient; these assessments informed the care planning process. As previously discussed, whilst assessments had all been reviewed since their initial completion they were not reviewed regularly and there was no consistency between files to evidence how frequently they were due to be reviewed. This area for improvement was identified during the previous care inspection and is now stated for a second time. Care plans were in place to direct the care required and were updated to reflect changes to the patients' condition, however they were not regularly reviewed and again, there was no consistency with the how frequently they were required to be reviewed. Care plans should be reviewed regularly to ensure that continue to meet the needs of the patients. This was identified as an area for improvement under the standards.

Patients who had been identified as being at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as TVN, SALT and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Observations of staff interactions evidenced that communication was good within the home and that there was effective team work. Staff confirmed that they were provided with the relevant information in response to patients' daily needs and changing needs. 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 or the responsible person who was in the home regularly. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Discussion with the registered manager confirmed that staff meetings were held a minimum of quarterly and that the minutes were maintained of the staff who attended, matters discussed and agreed actions. The most recent meeting was held on 5 March 2017. A review of records also evidenced that patient meetings were held approximately every six months and that minutes were available. The most recent meeting was held on 17 September 2016 when discussions took place regarding activities over the summer, the fun day and possibilities for Christmas outings and events. A meeting was scheduled for 20 June 2017 and the agenda focused on activities and events over the summer.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication within the home between staff and between patients and staff.

Areas for improvement

An area for improvement under the standards was identified in relation to the regular reviewing of care plans.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

We arrived in the home at 10:00 hours. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were observed either in their bedrooms as was their personal preference, walking around the home or seated in the foyer or lounge areas, again in keeping with their personal preference and safety needs. Staff interaction with patients was observed to be compassionate, caring and timely. Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. 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.

A prospective patient visited the home on the morning of the inspection. Staff were welcoming and through observations of their interactions it was clear they had been well informed with regard to the patients likes and interests and their current social circumstances. Staff spent time introducing the lady to other patients and staff and providing detail of the daily routine of the home. Staff demonstrated an awareness of the impact moving to long term care can have on patients and the need to ensure patients felt secure and well supported during this time.

There was evidence that patients were involved in decision making about their care. Patients were consulted regarding meal choices and were offered a choice of meals, snacks and drinks throughout the day. Staff encouraged those patients who could express their preference to do so and demonstrated a detailed knowledge of patients' likes and dislikes for those patients who were unable to express their opinion.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients' representatives/relatives on the quality of the service provided. Relatives were provided with the opportunity to complete a satisfaction survey annually. The most recent was completed in March 2017 with an 80% return rate. High levels of satisfaction were indicated with 100% of respondents indicating they were satisfied with the overall care provided in the home and 94% agreeing that they were always informed about important matters affecting their relative; 6% replied sometimes. The analysis of the results were displayed in the reception area of the home. These are examples of some of the comments provided:

"…he is cared for beautifully with empathy and consistency."
"…we feel very lucky to have our relation settled and cared for in an environment like this."
"…I can visit my family member at any time without prior warning and I always find them happy and well cared for."

As previously discussed, ten questionnaires were issued to relatives and staff; none were returned from staff prior to the issue of this report. One relative returned a questionnaire and was very satisfied with all aspects of care. The following comment was included:

"This home is unique and would find it hard to find a better one in the British Isles. It's not the building it's the care and love they have."

Any comments from relatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the atmosphere in the home, listening to and valuing patients, taking account of the views of relatives and staff knowledge of patients' wishes and preferences.

Areas for improvement

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

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.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with relatives and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required. It was obvious from the interactions observed between the registered manager and the patients and relatives that they were familiar with her. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Previously the registered manager's hours were divided between her management role and her role as a registered nurse. Over the past few months the registered manager has been increasingly working as a registered nurse. They explained that whilst recruitment was ongoing for registered nurses there has been a poor response. We were concerned that the registered manager, undertaking the role of a registered nurse for the majority of their contracted hours, has the potential to impact on the time they have to provide day to day operational management and sustain the governance arrangements in the home. The working arrangements of the registered manager should be kept under review to ensure they have sufficient time to undertake the day to day operational management of the home effectively. This was identified as an area for improvement under the standards.

The registered manager discussed the systems in place to monitor the quality of the services delivered. As previously discussed in section 6.2 a small number of audits of care records had been undertaken since the previous inspection. We discussed the importance of regular audit to ensure that the recent improvements to care records were sustained and discussed how these audits could best be undertaken. As a result of the previous inspection an area for improvement was identified under the standards that the registered manager undertake regular audits of care records to ensure that the required improvements are made and that care records are maintained in accordance with best practice. This area for improvement is now stated for a second time.

Relatives spoken with confirmed that they knew who to make a complaint to and 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, detail of the nature of the complaint, details of the investigation and the response provided to the complainant.

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

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

The unannounced quality monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. A copy of the report was maintained and available in the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to working relationships within the team and support from management.

Areas for improvement

An area for improvement under the standards was identified in relation to monitor the working arrangements of the registered manager to ensure they have sufficient time to undertake the day to day operational management of the home effectively.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Bernadette O'Neill, registered 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 DHSSPS 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 to Nursing.Team@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The DHSSPS Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 17 July 2017	It is recommended that assessments are reviewed regularly to ensure they accurately reflect the patient's needs. **Ref: Section 6.2 and 6.4**
	Response by registered person detailing the actions taken: Careplans continue to be undergoing a detailed review.
Area for improvement 2 **Ref**: Standard 35.6 **Stated:** Second time **To be completed by:** 17 July 2017	It is recommended that the registered manager undertake regular audits of care records to ensure that the required improvements are made and that care records are maintained in accordance with best practice. **Ref: Section 6.2**
	Response by registered person detailing the actions taken: A auditing form has been commenced for each care area where the relevant findings is documented for each Named Nurse to complete as required.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 17 July 2017	The registered person shall ensure that care plans are regularly reviewed to ensure they continue to meet the needs of the patients. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: The new care plan auditing form identifies when each careplan has had the assessment of needs updated , when all relevant risk assessments have been updated as required and when the evaluation of care needs has been completed by each Named Nurse on a regular basis.
Area for improvement 4 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 17 July 2017	The registered person shall ensure that the working arrangements of the registered manager are kept under review to ensure they have sufficient time to undertake the day to day operational management of the home effectively. **Ref: Section 6.6**
	Response by registered person detailing the actions taken: The Registered Manager is being provided with management time of the floor to ensure the operational management and governance arrangements are sustained .

Please ensure this document is completed in full and returned via Nursing.Team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews