Unannounced Care Inspection Report
24 January 2017

Castlehill

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

1.0 Summary

An unannounced inspection of Castlehill took place on 24 January 2017 from 10:15 hours to 15:30 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

A review of the staffing roster for week commencing 24 January 2017 evidenced that the planned staffing levels were adhered to. There were no concerns regarding staffing provision within the home raised during discussion with patients, visitors and staff.

A random selection of accidents and incidents recorded since the previous inspection evidenced that we were appropriately notified of events in the home.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The home was fresh smelling, clean and appropriately heated. All of the responses we received in the returned questionnaires confirmed that this was normal for the home. There were no issues identified with infection prevention and control practice.

We observed a number of bedroom doors which were locked. We reviewed the rationale and decision making process regarding this practice. Following discussion with staff and a review of care records for a patient who chose to keep his bedroom door locked we were assured that the practice of locking doors was appropriately managed and did not impact negatively on patients.

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

Is care effective?

We examined the management of enteral feeding for two patients. A review of the dietician's report and the completed fluid intake charts evidenced that the prescribed regimes were adhered to on a daily basis. Care plans were in place for the management of enteral feeding. General areas for improvement in the care records were identified and three recommendations were made. In addition, two recommendations regarding care records which were made as a result of the previous inspection are now stated for a second time.

The registered nurses and care staff informed us that two of the three patients currently receiving enteral feeding were also involved in a programme for swallowing rehabilitation supported by a speech and language therapist (SALT) from the local health and social care trust. This holistic approach to the nutritional needs of the patients and the evident staff commitment to advocating for the patients were commended.

Is care compassionate?

Patients spoken with were content and happy in their surroundings. We spoke with a majority of the patients generally and individually with six patients. It was obvious from the interactions

and non-verbal communications between staff and patients that there were good relations in the home and that patients were treated with dignity and respect.

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

Is the service well led?

Staff commented positively regarding the registered manager and her role within the home. Staff reported that they were well supported in their role and that management were approachable. A visitor spoken with confirmed that knew the registered manager and that she was approachable and regularly available in the home to speak with.

We reviewed the systems the registered manager had in place to monitor the quality of the services delivered. A programme of audits was completed. Due to the issues with care records it was recommended that the registered manager undertake more 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 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	6*

* Two of the recommendations were made as a result of the previous inspection and are now stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with deputy manager Isobel Johnston as part of the inspection process and with the registered manager Bernadette O'Neill on the day after 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 medicines management inspection undertaken on 20 September 2016. There were no further actions required to be taken following the most recent inspection.

2.0 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: Ms Isobel Johnston, deputy manager	**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.

We met with the majority of patients, the deputy manager, a registered nurse, four care staff, a visiting healthcare professional and one patient's visitor.

A poster indicating that the inspection was taking place was displayed in the foyer of the home and invited visitors/relatives to speak with the inspectors.

The following information was examined during the inspection:

- Staffing rota for week commencing 24 January 2017
- audit records
- accident reports
- reports of the monthly quality monitoring visits
- two patients' care records.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 20 September 2016

The most recent inspection of the home was an unannounced medicines management inspection. There were no issues identified during this inspection therefore there was no quality improvement plan (QIP).

4.2 Review of requirements and recommendations from the last care inspection dated 06 June 2016

Last care inspection statutory Recommendation		Validation of compliance
Recommendation 1 **Ref**: Standard 13.11 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The deputy manager and registered nurse on duty confirmed that the registered manager had discussed their role if they received a disclosure of a safeguarding nature. Both staff were fully aware of their role and the action they should take. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 4.1 **Stated:** First time	It is recommended that a detailed plan of care for all assessed needs should be drawn up from the completed assessments.	**Partially Met**
	Action taken as confirmed during the inspection: We reviewed two patients care records. Each care record contained care plans. However not all assessed needs had a care plan in place. Care records are further discussed in section 4.4 of this report. This recommendation is assessed as partially met and is stated for a second time.	
Recommendation 3 **Ref**: Standard 4 **Stated:** First time	It is recommended that review of prescribed care interventions should include an individualised statement of the patient's condition since the previous review.	**Partially Met**
	Action taken as confirmed during the inspection: Care plans reviewed did not consistently include an individualised statement of the patient's condition since the previous review. This recommendation has been assessed as partially met and is stated for a second time.	

Recommendation 4 **Ref**: Standard 35.16 **Stated:** First time **To be completed by:** 4 July 2016	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.	**Met**
	Action taken as confirmed during the inspection: There was evidence in the audits completed in July 2016 of re-audit to check compliance had been achieved. This recommendation has been met.	

4.3 Is care safe?

The deputy 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 roster for week commencing 24 January 2017 evidenced that the planned staffing levels were adhered to. No concerns regarding staffing provision within the home were raised during discussions with patients, relatives and staff.

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.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The home was fresh smelling, clean and appropriately heated. There were no issues identified with infection prevention and control practice.

We observed a number of bedroom doors which were locked. Staff stated that the decision had been taken to lock the bedroom doors of those patients who would become distressed if other patients disturbed their bedroom or belongings. Care records reviewed clearly demonstrated that the practice of locking bedroom doors had been discussed with each patient and as appropriate, their relatives, care manager or representative in the relevant health and social care trust. Records also contained the signature of those patients who were able to sign their name. Staff were knowledgeable of the term 'restrictive practice' and that the best interests of the patient should always take primacy in any decision making. They were also aware of the potential for impact on the patients and the need to ensure that any actions which may be considered restrictive are fully discussed with relevant individuals, for example, the registered manager; nurse in charge; patient; relatives and representatives from the relevant health and social care trust. Following discussion with staff and one patient who choose to keep their bedroom locked along with a review of care records we were assured that the practice of locking bedroom doors had not impacted negatively on the patients affected.

Areas for improvement

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

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

4.4 Is care effective?

We examined the management of the enteral feeding for two patients. The registered nurses spoken with were knowledgeable regarding the prescribed nutritional regime. The dietetic reports which detailed the prescribed nutritional regime were readily available with the patients' medicine administration record (MAR) sheet. Fluid intake charts were maintained for patients who were prescribed enteral feeds. A review of the dietician's report and the completed fluid intake charts evidenced that the prescribed regimes were adhered to on a daily basis. Care plans were in place for the management of enteral feeding, however, the care plan for one patient had not been updated to reflect a change to the prescribed regime. Care plans should be updated to accurately reflect the needs of the patient. A recommendation was made.

We discussed the management of the enteral feeding equipment. The registered nurses confirmed that they had attended training in enteral feeding and where knowledgeable of the actions to take if complications with the patients' enteral feeding occurred. Whilst care records clearly evidenced that the patients' nutritional needs were being met, the care of the enteral feeding equipment and the action to take if complications occurred were not recorded in the care records. During the previous care inspection a recommendation was made that a detailed plan of care for all assessed needs should be drawn up. This recommendation is now stated for a second time.

The registered nurses and care staff informed us that two of the three patients currently receiving enteral feeding were also involved in a programme for swallowing rehabilitation supported by a speech and language therapist (SALT) from the local health and social care trust. Staff spoke compassionately about these individual patients and the enjoyment food had previously given them. Staff explained how they had discussed the patients' holistic needs with their General Practitioner (GP) and SALT and advocated for patients to have the opportunity of swallowing rehabilitation. At the time of the inspection both patients were able to tolerate small amounts of food orally. Staff spoken with were knowledgeable of the SALT recommendations for each patient and the necessity for strict adherence to them. This holistic approach to the nutritional needs of the patients and staff commitment to advocating for the patients was commended.

The care records reviewed evidenced that an assessment to identify patients' daily needs and a range of risk assessments were completed for each patient. Risk assessments were not reviewed regularly and it was unclear when they were due to be reviewed. Assessments should be reviewed regularly to ensure they accurately reflect the patient's need. A recommendation was made. We discussed the importance of ensuring that care records which are were no longer current are removed from the patients active care records and archived.

We noted that not all care records were dated and signed by the registered nurse who had completed them. A recommendation was made.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as the tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. There was evidence within the care records of regular, ongoing communication with relatives.

Areas for improvement

Care plans should be updated to accurately reflect the needs of the patient.

A detailed plan of care for all assessed needs should be drawn up.

Assessments should be reviewed regularly to ensure they accurately reflect the patient's need.

Care records should be dated and signed by the registered nurse at the time of completion.

Number of requirements	0	Number of recommendations	4*

*One of the recommendations was made as a result of the previous inspection and is now stated for the second time.

4.5 Is care compassionate?

We arrived in the home at 10:15 hours. There was a calm atmosphere as patients were finishing breakfast and staff were quietly attending to their needs. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were observed to be sitting either in the lounge, reception area or in their bedrooms, as was their personal preference. 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.

Patients spoken with were content and happy in their surroundings. We spoke with majority of the patients generally and individually with six patients. It was obvious from the interactions and non-verbal communications between staff and patients that there were good relations in the home and that patients were treated with dignity and respect.

We observed in one care record laminated pages which detailed how the patient communicated their needs, how best to communicate to the patient, how best to gain compliance with medications and their likes and dislikes. We discussed this information with the registered nurses who explained that, when this patient required hospitalisation this information was sent with them; the pages were laminated to allow them to be displayed at the patient's bedside. This initiative was commended as a person centred approach when sharing patient information.

We spoke with the visitor of one patient who commended the staff and the care their loved one was receiving. They commented that:
"If I had … at home with me they wouldn't get any better care and attention than they get here, it's first class."

We also sought relative's opinion via questionnaires; ten questionnaires were issue and two were returned in time for inclusion in this report. Both relatives were very satisfied that the care in the home was safe, effective and compassionate and that the service was well led. One relative commented that:
"…this is an excellent care home in all respects."

We spoke with one healthcare professional who visited the home regularly. They commented positively on the outcome of care for patients and the good communication which exists between the staff and the healthcare trust.

Staff spoken with were knowledgeable regarding patients' likes, dislikes and individual preferences. Staff stated they were satisfied that they were well supported in their role. Observation of interactions between staff evidenced that there was good team work and respect for the various roles within the home. Ten questionnaires were issued to staff; two were returned. The staff members were satisfied or very satisfied that the care in the home was safe, effective and compassionate and that the service was well led.

Areas for improvement

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

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

4.6 Is the service well led?

Staff commented positively regarding the registered manager and her role within the home. Staff reported that they were well supported in their role and that management were approachable. A visitor spoken with confirmed that they knew the registered manager and that she was approachable and regularly available in the home to speak with.

The registered manager confirmed that the responsible person visited the home regularly to provide support and assistance as required. In addition one of the responsible persons also regularly undertook shifts.

We reviewed the systems the registered manager had in place to monitor the quality of the services delivered. A programme of audits was completed. Due to the issues with care records it was recommended that the registered manager undertake more regular audits of care records to ensure that the required improvements are made and that care records are maintained in accordance with best practice.

The arrangements for the monthly monitoring visits required in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were reviewed. Reports of the visits undertaken were available in the home.

Areas for improvement

The registered manager should 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.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with deputy manager Isobel Johnston as part of the inspection process and with the registered manager Bernadette O'Neill on the day after the inspection. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The 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 provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. 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.

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 provider 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 provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements: There were no statutory requirements made as a result of this inspection.	
Recommendations	
Recommendation 1 **Ref**: Standard 4.1 **Stated:** Second time **To be completed by:** 21 February 2017	It is recommended that a detailed plan of care for all assessed needs should be drawn up from the completed assessments. **Ref section 4.2 & 4.4**
	Response by registered provider detailing the actions taken: All relevant careplans are undergoing a detailed review and a new sysyem in place for each care plan to be updated more efficently.
Recommendation 2 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 21 February 2017	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 4.2**
	Response by registered provider detailing the actions taken: All registered Nurses informed of recommendation and to complete all relevant reviews in detail as reflective of each assessed need in careplan.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 21 February 2017	It is recommended that care plans are updated to accurately reflect the needs of the patient. **Ref section 4.4**
	Response by registered provider detailing the actions taken: The relevant care plan has been updated accordingly with the information required.
Recommendation 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 21 February 2017	It is recommended that assessments are reviewed regularly to ensure they accurately reflect the patient's needs. **Ref section 4.4**
	Response by registered provider detailing the actions taken: New system of reviewing careplans and risk assessments has been commenced .

Recommendation 5 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 21 February 2017	It is recommended that care records are dated and signed by the registered nurse at the time of completion. **Ref section 4.4**
	Response by registered provider detailing the actions taken: All relevant staff have been informed of this recommendation, process of monthly auditing will ensure records are maintained continously.
Recommendation 6 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 28 March 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 4.6**
	Response by registered provider detailing the actions taken: A total review of all careplans is ongoing and will be audited monthly.

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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