Unannounced Care Inspection Report
2 June 2016

Clonlee

Address: 132 Belfast Road, Muckamore, Antrim, BT41 2ET
Tel No: 028 94461166
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Clonlee took place on 2 June 2016 from 09:30 hours to 16:00 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.

For the purposes of this report, the term 'patients' will be used to described those living in Clonlee which provides nursing and residential care for one named patient.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

Two areas of improvement were identified; to ensure that the registered nurse in charge of the home is clearly identified in the duty rota when the registered manager is off duty and that the date is recorded to evidence when the Access NI certificates are checked prior to the employee commencing employment. Two recommendations were made.

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. Patients, relatives and staff were of the opinion that the care delivered provided positive outcomes.

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

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 day to day issues affecting them. Patients and relatives spoken with commented positively in regard to the care.

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 Clonlee 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**	**3**

Details of the QIP within this report were discussed with Perpetua Latta, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 29 September 2015.

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

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

2.0 Service details

Registered organisation/registered person: Hutchinson Homes Ltd	**Registered manager:** Mrs Perpetua Latta
Person in charge of the home at the time of inspection: Mrs Perpetua Latta	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-LD, RC-PH(E), NH-PH	**Number of registered places:** 53 There may be a maximum of 8 patients in category NH-PH. Category NH-LD for 2 identified individuals only and category RC-PH(E) for 1 identified individual only. The home is also approved to provide care on a day basis to 4 persons.

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 10 patients, two registered nurses, three care staff, two housekeeping staff and three patients' visitors/ representatives.

Five questionnaires were issued to 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
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit

- records of staff meetings
- records of patient/relatives 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 29 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 29 September 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 25.12 **Stated:** Second time	It is recommended that the Regulation 29 report addresses the progress made in meeting the requirements and recommendations of RQIA inspections.	**Met**
	Action taken as confirmed during the inspection: Regulation 29 reports reviewed included the progress made in complying with any requirements and/or recommendations from RQIA inspections. This recommendation has been met.	

Recommendation 2 **Ref**: Standard 36.2 **Stated:** First time	It is recommended that the policies on breaking bad news, palliative and end of life care and death and dying are reviewed and updated to ensure that they are reflective of regional best practice guidance. When the relevant policies are updated staff should receive an induction/training on the content to ensure their knowledge and care delivery is reflective of best practice in palliative and end of life care.	**Met**
	Action taken as confirmed during the inspection: The policy entitled breaking bad news and palliative care referenced best practice guidance. The reviewed policy had been shared with staff who had signed to confirm that they had read and understood the content. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 20.2 **Stated:** First time	It is recommended that further opportunities, to discuss end of life care, are considered and created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that opportunities had been created to discuss end of life care and where wishes had been expressed a care plan was in place. This recommendation has been met.	

4.3 Is care safe?

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

A review of the staffing roster for week commencing 29 May 2016 evidenced that the planned staffing levels were adhered to. The staffing roster also evidenced a range of starting and finishing times; this was to ensure there were sufficient staff to meet the patients' needs at times when there was high demand for care; for example between 07:00 and 09:00 hours. The management of the staffing arrangements is commended as it was organised to best meet the health and welfare needs of the patients'. 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. Patients commented positively regarding the staff and care delivery.

A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. The record maintained of Access NI checks was reviewed. The home maintained a copy of the e mail received from Access NI which included the unique identification number of the certificate and the outcome. A record of the date the certificate was checked by the home should be maintained to evidence that the registered manager had checked the certificate prior to the candidate commencing employment. A recommendation has been made.

Discussion with the registered manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed. The registered manager was knowledgeable regarding the management of the Northern Ireland Social Care Council (NISCC) registration process for newly employed care staff.

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

The registered manager, registered nurses and staff 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 not identified on the staffing roster. This was discussed with the registered manager and a recommendation has been made.

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 registered 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. The importance of including the date on the completed assessment was discussed.

Mandatory training was provided by a clinical trainer employed by the registered providers to deliver mandatory training. Training opportunities were also provided by the local health and social care trust and external agencies such as The Royal College of Nursing (RCN).
The registered manager had systems in place to monitor staff attendance and compliance with training. These systems included a training matrix to facilitate an over view and e mails from the clinical trainer confirming which staff had attended. Copies of the signing in sheets were also provided to the registered manager to evidence staff attendance.

A review of the training matrix for 2015 evidenced good compliance. Mandatory training for 2016 was ongoing.

The registered manager explained the home was also a participant in the Northern Health and Social Care Trust (NHSCT) nursing home education and development initiative "In Reach"; a programme to deliver training to staff. One of the aims of the initiative was to provide training to the registered nurses in an attempt to reduce patients' attendance at local hospitals for routine procedures. The most recent training offered was on 15 March 2016 for PEG tube insertion and was attended by four registered nurses. Training had also been delivered in catherisation.

The registered manager confirmed that systems were in place for staff supervision. Records to evidence when supervisions were planned were available; the content of supervision records was not reviewed.

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

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of 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 nurse in charge of the home should be clearly identified on the staff duty rosters when the registered manager is off duty.

A record of the date Access NI certificates are checked by the home should be maintained to evidence that the registered manager has checked the certificate prior to the candidate commencing employment.

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

4.4 Is care effective?

We reviewed three patients' care records with regard to the admission process, management of wound care and the day to day maintenance of care records.

A review of one care record evidenced that a comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home. The holistic assessment contained good detail of the patient's individual needs. Initial plans of care were generated within 24 hours of admission. As previously discussed a range of validated risk assessments were also completed as part of the admission process.

Wound management in respect of one patient was reviewed. Details of the wounds and frequency with which they required to be re-dressed were recorded in patient's care plan. The care record contained an initial wound assessment and an assessment of the wound following each dressing renewal. Review of completed wound assessment records evidenced that prescribed dressing regimes were adhered to.

A review of one care record evidenced that care records were regularly reviewed and updated, as required. The delivery of care to minimise the risk of the patient acquiring pressure ulcers was reviewed. There was evidence of appropriate assessment to identify the risk of the development of pressure ulcers and care plans were in place to manage the level of risk identified. Repositioning charts evidenced that positional changes were carried out regularly. Care records were regularly reviewed and updated, as required, in response to patient need.

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

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

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

The registered manager confirmed that staff meetings were held regularly with all staff teams. Records of the issues discussed and agreed outcomes were maintained. The most recent meeting was a meeting with the catering staff and was held on 27 April 2016. Minutes of this meeting detailing the areas discussed were available. Meetings had also taken place with care staff on 2 March 2016 and with registered nurses on 3 January 2016. A number of meetings had been held with staff throughout 2015.

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 confirmed that if they had any concerns, they would raise these with the registered manager.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.5 Is care compassionate?

Throughout the inspection there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Patients were sitting in the lounges, or in their bedroom, 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. Staff spoken with were knowledgeable regarding patients' likes, dislikes and individual preferences.

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

Relatives spoken with confirmed that they were made to feel welcome into the home by all staff. They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. A quality assurance questionnaire was sent out annually to relatives of each patient. These were last issued in December 2015; the results had been analysed and displayed in the home. Joint relative and patient meetings were held quarterly; the most recent took place on 3 March 2016. The minutes of this meeting evidenced that feedback from the outcome of the questionnaires was shared.

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

"Thank you everyone for the lovely holiday. The company, good food and laughter" (from a patient in for a respite stay)

"…without a doubt your staff were exceptional and kept us notified promptly when circumstances changed."

"Thanks for making us feel very welcome at a difficult time and for the dignity shown to…".

Five patient questionnaires were issued; all were returned in time for inclusion in this report. Four of the respondents indicated that they were very satisfied with the care they were receiving. Despite providing a positive response one patient commented that at busy times there were not enough staff. The fifth respondent was of the opinion that service delivery could be better and included a number of comments; this questionnaire was returned

anonymously. All of the comments in the returned questionnaires were shared with the registered manager.

Ten questionnaires were issued to relatives; two were returned prior to the issue of this report. Both of the respondents were very satisfied or satisfied with the care delivery. There were no additional comments provided.

Ten questionnaires were issued to staff; four were returned in time for inclusion in this report. All of the respondents were positive regarding care delivery. There were no additional comments provided.

Areas for improvement

No areas for improvement were identified in the assessment 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 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 was good team work and the registered manager was responsive to any suggestions or concerns raised.

The registered manager explained that they had regular, daily contact with the patients and visitors and were available, throughout the day, to meet with both on a one to one basis if needed. It was obvious as the registered manager showed us around the home that the patients were familiar with her. One patient, who was enjoying the daily newspaper, light heartedly told us that the registered manager "makes sure I get first read." Patients and relatives spoken with confirmed that she was always approachable and regularly available in the home to speak with.

Patients and 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, good detail of the nature of the complaint, details of the investigation and the response provided to the complainant. The record also indicated how they concluded that the complaint was closed.

There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

The registered manager discussed the systems in place to monitor the quality of the services delivered. Programmes of audits were completed on a monthly basis by the deputy manager. Areas for audit included care records, infection prevention and control practices and falls. The following areas for improvement were noted:

- the date and signature of the person undertaking the audit should be recorded
- there should be traceability of which files have been audited
- where areas for improvement are identified there should be evidence of re audit to check compliance and drive improvement

The importance of the registered manager having oversight of the completed audits was discussed. A recommendation was made.

As previously discussed there were systems in place to ensure that notifiable events were investigated as appropriate and reported to the relevant bodies. The registered manager completed a monthly analysis of falls to identify any trends or patterns.

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.

Areas for improvement

A recommendation has been made in relation to information that should be recorded within records of audits undertaken.

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 registered manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS 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

Recommendations	
Recommendation 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 30 June 2016	It is recommended that the registered nurse in charge of the home is clearly identified on the staff duty roster in the nursing and residential units when the registered manager is off duty. **Ref: section 4.3**
	Response by registered person detailing the actions taken: Trained staff meeting held on the 15th June 2016, this recommendation discussed there will be a * at an individual's name to indicate that they are the nurse in charge in the absence of management.
Recommendation 2 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 30 June 2016	It is recommended that a record of the date the Access NI certificates are checked should be maintained to evidence that the registered manager had checked the certificate prior to the candidate commencing employment. **Ref: section 4.3**
	Response by registered person detailing the actions taken: The personel file has been updated to include the date as well as the serial number when the accessni certificate viewed
Recommendation 3 **Ref**: Standard 35.4 **Stated:** First time **To be completed by:** 30 June 2016	It is recommended that the record of audits undertaken should include**:** • the date and signature of the person undertaking the audit should be recorded • there should be traceability of which files have been audited • where areas for improvement are identified there should be evidence of re audit to check compliance and drive improvement **Ref section 4.6**
	Response by registered person detailing the actions taken: These recommendation have been dicussed with the Deputy Manager and have been implemented

Please ensure this document is completed in full and returned to 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