Inspection Report

24 January 2023

Clareview House

Type of service: Nursing Home
Address: 105 Doagh Road, Ballyclare, BT39 9ES
Telephone number: 028 9334 9694

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Hutchinson Homes Ltd **Responsible Individual:** Ms Naomi Carey	**Registered Manager:** Mrs Sharon Bell **Date registered:** 8 November 2010
Person in charge at the time of inspection: Sharon Bell	**Number of registered places:** 35 A maximum of 5 patients in category NH-DE.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 31
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 35 patients. The home is divided in two units over two floors. The ground floor and first floor provides general nursing care and there is a five bedroom unit on the ground floor which provides care for people with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 24 January 2023 from 9.30 am to 7.30 pm by a care inspector.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Patients told us that they were well looked after; they spoke highly about the care that they received and confirmed that staff attended to them in a timely manner. Patients who were less able to communicate their views were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report. The home environment was warm, clean and comfortable.

Areas requiring improvement were identified during this inspection and this is discussed within the main body of the report and Section 6.0.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in Clareview House. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

4.0 What people told us about the service

Patients expressed no concerns about the care they received and confirmed that all of the staff were 'good'. Patients also told us that the food was good. Patients told us, "I love it here it is home from home." and "I love it here I have no complaints."

Staff spoken with told us that they are mostly satisfied with the staffing levels and that team work was good. All comments from staff were passed to the manager for their information and action as required.

No responses to the questionnaires provided were received following the inspection.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 4 November 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (1) (a) **Stated:** First time	The registered person shall ensure that nursing staff follow the home's policy and Regional Guidance on the management and evaluation of care during and following a fall. This includes but is not limited to evidencing that clinical or neurological observations are carried out for all patients following a fall and that accidental falls care plans and risk assessments are reflective of the patients' needs.	**Partially met**
	Action taken as confirmed during the inspection: A review of records evidenced that this area for improvement was partially met and has been stated for a second time. This is discussed further in section 5.2.2.	
Area for Improvement 2 **Ref:** Regulation 16 (1) (2) (b) **Stated:** First time	The registered person shall ensure an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. The care plans should be further developed within five days of admission and kept under review to reflect the changes needs of the patients.	**Partially met**
	Action taken as confirmed during the inspection: A review of records evidenced this area for improvement was partially met and is stated for a second time. This is discussed further in section 5.2.2.	

Area for Improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the training for staff on IPC measures is embedded into practice. For example. staff can clearly describe the steps for hand hygiene; know when to take opportunities for hand hygiene, and the donning and doffing of PPE is carried out as per regional guidelines.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been met.	
Area for Improvement 4 **Ref:** Regulation 30 (1) (d) (f) **Stated:** First time	The registered person shall give notice to RQIA without delay of the occurrence of any notifiable incident. All relevant notifications should be submitted retrospectively.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that this area for improvement was met.	
Area for Improvement 5 **Ref:** Regulation 10 (1) **Stated:** First time	The registered person shall review the home's current audit processes to ensure they are effective. Consideration should also be given to the scope of the audits undertaken which should include auditing of restrictive practice, and/or care records or staff use of PPE.	**Partially met**
	Action taken as confirmed during the inspection: A review of records evidenced that this area for improvement was partially met and is stated for a second time. This is discussed further in section 5.2.5.	

Area for Improvement 6 **Ref:** Regulation 29 **Stated:** First time	The registered person shall review the process for carrying out the monthly monitoring visits to ensure it provides the responsible individual with the necessary assurances regarding the quality of services and care delivery to patients and that the home is adhering to legislative requirements and regionally agreed guidance. In addition, the report should not contain information that may identify an individual living or working in the home.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that this area for improvement was met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 4.9 **Stated:** Second time	The registered person shall ensure that supplementary care records, specifically, repositioning records are completed in a comprehensive, accurate and contemporaneous manner in accordance with legislative and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that this area for improvement was met.	
Area for Improvement 2 **Ref:** Standard 46 **Stated:** Second time	The registered person shall ensure that equipment is appropriately stored and that access to facilities in sluice rooms is not restricted to staff in order to minimise the risk of infection.	**Met**
	Action taken as confirmed during the inspection: Observations confirmed that this area for improvement was met.	

Area for Improvement 3 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure the following: • The patient dining experience is reviewed with regards to the availability of glassware • Variations to the planned menu are recorded.	**Partially met**
	Action taken as confirmed during the inspection: Glassware was available on the day of inspection however variations to menu records were not available therefore this area for improvement was partially met and is stated for a second time. This is discussed further in section 5.2.2.	
Area for improvement 4 **Ref:** Standard 21.1 **Stated:** First time	The registered person shall ensure that patients' wound care needs are managed in an effective manner at all times; this includes but is not limited to ensuring that: records are updated in a timely manner to reflect the assessed needs of patients; wound assessments and evaluations are completed after each dressing and daily progress notes include meaningful and patient centred entries regarding patients' skin condition.	**Not met**
	Action taken as confirmed during the inspection: A review of records evidenced that this area for improvement was not met and is stated for a second time. This is discussed further in section 5.2.2.	

Area for improvement 5 **Ref:** Standard 11 **Stated:** First time	The registered person shall ensure that the provision of activities in the home is reviewed to make sure that meaningful activities are provided to patients in the absence of the Personal Activity Lead. Activities must be integral part of the care process and care planned for. A contemporaneous record of activities delivered must be retained.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

A review of staff selection and recruitment records evidenced that staff members were recruited safely ensuring that pre-employment checks had been completed prior to the staff member commencing in post. Staff were provided with an induction programme to prepare them for their role.

Checks were made to ensure that staff maintained their registrations with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

The staff duty rota accurately reflected the staff working in the home on a daily basis. This rota identified the person in charge when the manager was not on duty.

There were systems in place to ensure that staff were trained and supported to do their job. The manager confirmed there was a balance in the training delivered between e-learning and face to face.

Staff consulted with confirmed that they received regular training in a range of topics such as adult safeguarding and infection prevention and control (IPC) however, not all staff had availed of manual handling and the second fire safety training. This was discussed with the manager who told us that further training dates had been arranged. This will be reviewed at the next inspection.

Staff told us that they were mostly happy with the staffing levels in the home and that team work was good. The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met and confirmed that efforts were ongoing in relation to the recruitment of care staff.

Patients spoke highly about the care that they received and confirmed that staff attended to them in a timely manner; patients also said that they would have no issue with raising any concerns to staff. It was observed that staff responded to patients' requests for assistance in a prompt, caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of patients. Staff were knowledgeable of patients' needs, their daily routine, likes and dislikes.

Staff were seen to provide a prompt response to patients' needs and demonstrated an awareness of individual patient preferences. It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly. Deficits were identified in the provision of oral care this was discussed with the manager and assurances were provided following the inspection as to how this was being addressed with staff.

Examination of accident records with regards to the management of falls evidenced that neurological observations had not been consistently recorded. This was discussed with the manager and an area for improvement was stated for a second time.

A review of two wound care records evidenced that there were no care plan in place to direct the care required for the wounds. An area for improvement was stated for a second time. Records of when patients were assisted to change their position were maintained.

A review of one recently admitted patient's care records evidenced that not all the required assessments or care plans had been developed in a timely manner. This was discussed with the manager and an area for improvement identified at the previous inspection was stated for a second time.

The personalisation of care plans was discussed with the manager who provided assurances following the inspection as to how this was being addressed. This will be reviewed in further detail at a subsequent care inspection. An area for improvement was identified to ensure that those patients receiving one to one care have detailed care plans developed to reflect their care needs.

The records for patients who required to have their fluid intake/output monitored were not fully completed and there was no evidence that these were reviewed daily by the registered nurses. This was discussed with the manager and an area for improvement was identified.

Records of food intake had not been completed in sufficient detail to identify the amount of the food consumed and the nature of the meal by the patients. This was discussed with the manager and identified as an area for improvement.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was seen to be a pleasant opportunity for patients to socialise and the atmosphere was calm and relaxed.

Staff had made an effort to ensure patients were comfortably seated and enjoyed their meal. There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, staff recognised that patients may need a range of support with meals and were seen to helpfully encourage and assist patients as required.

The menu was on display in the dining room however only one meal option was offered. A further review of the menu evidenced that this was the case for the lunch time meal most days. The cook advised us that alternatives would be offered. This was discussed with the menu and an area for improvement in regard to choice of meal was made.

There were no system in place to record any variation to the planned menu; this was discussed with the manager and an area for improvement was stated for a second time.

Patients who chose to have their lunch in their bedroom or lounge areas had trays delivered and the food was covered on transport. Meals were transported to the dementia unit in the home on a trolley and were covered however the trolley was not heated to maintain the temperature of the meal. The manager told us that generally there was no delay in the transportation of the meals but agreed to review this. This will be reviewed further at the next inspection.

There was a system in place to ensure that all staff were aware of individual patient's nutritional needs and any modified dietary recommendations made by the speech and language therapist (SALT).

Nutritional assessments had been conducted on a monthly basis by staff using the Malnutrition Universal Screening Tool (MUST), and there was evidence that patients' weights were checked at least monthly to monitor for weight loss or gain.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. The home was warm, clean and comfortable. There were no malodours detected in the home.

Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were suitably furnished. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. Review of records, observation of practice and discussion with staff confirmed that training on IPC measures and the use of PPE had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, some patients told us they liked the privacy of their bedrooms, but enjoyed going to the dining room for meals and choosing where to sit with their friends. Other patients preferred to enjoy their meals and socialise in the lounge.

Patients were observed listening to music, chatting with staff and watching TV. Some patients were observed enjoying a nature programme discussing the animals and different flowers that were shown throughout the programme.

The activity planner was displayed in the entrance hall and also a notice was displayed in regard to a planned movie evening. The provision of activities was not reviewed in depth and an area for improvement in regard to activities identified was carried forward for review at a subsequent inspection.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs. Sharon Bell has been the registered manager in this home since 8 November 2010**.**

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

A system of audits were in place in the home such as accident incident, care plan audits and infection prevention and control (IPC). It was positive to note that audits in regard to restrictive practice and SALT audit had been introduced since the last inspection. A review of the care records audit found that the deficits noted during the inspection had not been identified through the auditing process; the need for further development of this audit was discussed. An area for improvement identified at the previous inspection was stated for a second time.

A review of the accidents incidents evidenced these had been notified to RQIA appropriately. Messages of thanks including any thank you cards and emails received were kept and shared with staff.

There were systems in place and a designated person identified to oversee the appropriate safeguarding procedures and the safeguarding policy.

The home was visited each month by a representative of the responsible individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed and available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).**

	Regulations	Standards
Total number of Areas for Improvement	3*	7*

* the total number of areas for improvement includes three under regulation and two under standards that has been stated for a second time and one that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Sharon Bell, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(1) (a) (b) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that nursing staff follow the home's policy and Regional Guidance on the management and evaluation of care during and following a fall. This includes but is not limited to evidencing that clinical or neurological observations are carried out for all patients following a fall and that accidental falls care plans and risk assessments are reflective of the patients' needs. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: All trained staff have been reminded of the requirement to ensure that Neurological observations are being completed as per guidance and in the event that a resident refuses,/ it is being documented and health professionals informed for guidance on the best approach. Care plans and risk assessments are updated accordingly.

Area for improvement 2 **Ref:** Regulation 16 (1) (2) (b) **Stated:** Second time **To be completed by:** 31 March 2023	The registered person shall ensure an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. The care plans should be further developed within five days of admission and kept under review to reflect the changes needs of the patients. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Initial care plan check list in place using the pre admission assessment and referral information, care plans then further developed as staff get to know the patient and they have been reminded that they need to ensure this happens in a timely fashion over 5 days to ensure continuity of care and is relevant to the risk assessments
Area for improvement 3 **Ref:** Regulation 10 (1) **Stated:** Second time **To be completed by:** 30 April 2023	The registered person shall review the home's current audit processes to ensure they are effective. Consideration should also be given to the scope of the audits undertaken which should include auditing of restrictive practice, and/or care records or staff use of PPE. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: Audits in place as peer discussion on the day of the inspection including restrictive practice, care records and staff use of PPE
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 11 **Stated:** Second time **To be completed by:** Immediate action required	The registered person shall ensure that the provision of activities in the home is reviewed to make sure that meaningful activities are provided to patients in the absence of the Personal Activity Lead. Activities must be integral part of the care process and care planned for. A contemporaneous record of activities delivered must be retained. Ref: 5.1 and 5.2.4
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.

Area for improvement 2 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** 30 April 2023	The registered person shall ensure the following: • The patient dining experience is reviewed with regards to the availability of glassware • Variations to the planned menu are recorded. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Glassware continues to be available for those residents who request it so long as they are able to utilise it it is safe for them to do so. Both cooks are recording variations to the daily menu following the discussion with them.
Area for improvement 3 **Ref:** Standard 21.1 **Stated:** Second time **To be completed by:** Immediately and ongoing	The registered person shall ensure that patients' wound care needs are managed in an effective manner at all times; this includes but is not limited to ensuring that: records are updated in a timely manner to reflect the assessed needs of patients; wound assessments and evaluations are completed after each dressing and daily progress notes include meaningful and patient centred entries regarding patients' skin condition. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Records are being updated in a timely manner to reflect the present stage of the wound reflected in the daily notes and the care plan
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 30 April 2023	The registered person shall ensure detailed and patient centred care plans are in place for those availing of bespoke one to one care. Ref:5.2.2
	Response by registered person detailing the actions taken: All staff nurses re evaluating their care plans to ensure the care plans are person centred and reflect the care to be delivered in particular bespoke one to one. Company trainer is also involved in assisting staff with updating

Area for improvement 5 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 30 April 2023	The registered person shall ensure an accurate fluid balance is recorded for those patients who required to have their fluid intake/output monitored. These records should be reviewed and evaluated daily by a registered nurse. Ref:5.2.2
	Response by registered person detailing the actions taken: Fluid balance charts in place and recorded daily by care staff and overviewed by staff nurses. Care staff also document interactions including food and fluid on touch care part of the Epi care system so staff nurse can have an overview.
Area for improvement 6 **Ref:** Standard 12.7 **Stated:** First time **To be completed by:** 30 March 2023	The registered person shall ensure that food intake records are reflective of the actual food consumed by patients. Ref: 5.2.2
	Response by registered person detailing the actions taken: All staff reminded of the need for accurate recording on the food and fluid charts of what the residents have had at each meal, this is also reflected on touch care.
Area for improvement 7 **Ref:** Standard 12 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure menus are reviewed to evidence a choice of meals offered to patients and these choices are varied and recorded accurately. Ref: 5.2.2
	Response by registered person detailing the actions taken: Menus are reviewed 4 times a year by the senior cook taking into account seasonal produce and the likes and dislikes of the residents in the home. The cooks both ill also listen to requests by residents and provide to the best of their ability what has been requested. All variations to the menu recorded on the daily menu sheet

Please ensure this document is completed in full and returned via Web Portal

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