Unannounced Care Inspection Report
20 September 2016

Cairngrove

Type of Service: Nursing Home
Address: Balmoral Avenue, Rathfriland Road, Newry, BT34 1JS
Tel no: 028 3026 6442
Inspector: Donna Rogan

1.0 Summary

An unannounced inspection of Cairngrove Care Home took place on 20 September 2016 from 11.00 to 16.30 hours.

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

Is care safe?

Safe systems were in place for monitoring the registration status of current nursing and care staff. Relevant checks were conducted within the recruitment process prior to staff members commencing in post. RQIA were suitably informed of notifications under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A safe system for monitoring compliance with mandatory training was in place. Compliance with best practice in infection prevention and control was well maintained with one exception; a sluice room was being used as a store. A recommendation was made to ensure the designation of this area is decided and if necessary a minor variation should be submitted to RQIA for a change of use of the room. The room should be maintained as a sluice room until the variation if necessary is granted. A second recommendation was made in relation to ensuring the upgrade of the nurse call system is completed. Confirmation should be forwarded to RQIA upon completion of the upgrade.

Is care effective?

Staff were aware of the local arrangements for referral to health professionals. Communications between health professionals were recorded within the patients' care records and recommendations were adhered to. Patients and staff demonstrated confidence and awareness in raising any potential concerns to the relevant people. One issue raised was in relation to the quality of information provided in the evaluations of care. A recommendation is made that evaluations are more meaningful. Pain assessments should also be introduced and completed for those patients presenting with pain. A recommendation is made.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. 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.

Is the service well led?

Monthly monitoring visits were conducted consistently and reports were available for review. Many compliments had been received by the home in relation to the care and compassion provided to patients/relatives. Appropriate certificates of registration and public liability insurance were on display.

Whilst the registered manager regularly checks the quality of the care records and the environment in relation to infection control, audits were not being conducted. A recommendation is made in this regard. The registered manager also agreed to introduce a comments book to record views of relatives.

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**	**5**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Lisa Austin, 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 21 March 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered person: Carnhill Home 'A' Ltd Charles Anthony Digney	**Registered manager:** Lisa Austin
Person in charge of the home at the time of inspection: Lisa Austin	**Date manager registered:** 01 April 2005
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 23

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report and the returned QIP
- pre-inspection assessment audit.

During the inspection we met with approximately nine patients both individually and in small groups, the registered manager, three care staff, one registered nurse and two ancillary staff.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Six patient, seven staff and five patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- selection of available audit documentation
- two staff recruitment files
- competency and capability assessments for nurse in charge
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- duty rota for the period 12 September to 25 September 2016.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 March 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection 21 March 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard N10 **Stated:** First time	The registered persons should ensure that the plans for replacing/updating the nurse call system should are confirmed to RQIA in the returned QIP.	**Met**
	Action taken as confirmed during the inspection: Confirmation was made to RQIA detailing that the nurse call system would be upgraded. Work has commenced in upgrading the system. It is recommended that confirmation is provided to RQIA when this work is completed.	
Recommendation 2 **Ref**: Standard 11 **Stated:** First time **To be Completed by:** 30 April 2016	The registered persons should ensure that activities are organised on a formal basis and particular for those patients who do not attend day care. A formal programme should be implemented to include the preferences and choices of patients during the development of the programme. A record of the activity programme should be maintained and should evidence that the individual activities are evaluated regularly to ensure they are enjoyable, appropriate suitable. The record should include evidence of engagement with patients and those delivering the activity or event.	**Met**
	Action taken as confirmed during the inspection: A formal activity programme has been implemented.	

4.3 Is care safe?

The registered 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 rota from 12 to 25 September 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff and review of records confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. An induction booklet was completed and signed by the new employee and the staff member responsible for inducting the new employee.

Discussion with the registered manager and review of training records evidenced that a system was in place to monitor staff attendance at mandatory training. The records evidenced that mandatory training was fully compliant. Where there were shortfalls, for example, staff on leave, an action plan was in place to address the shortfall by the registered manager. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of current nursing and care staff with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC) were appropriately managed.

A review of the recruitment process evidenced best practice. Three records were reviewed; all records contained the required reference from the member of staff's most recent employer alongside all relevant information. There was evidence that interviews had been conducted prior to the staff members commencing their posts.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manger confirmed that any potential safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process.

Review of a random selection of records pertaining to accidents and incidents forwarded to RQIA since 1 March 2016 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, and dining room and storage areas. Rooms and communal areas were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction. An ongoing refurbishment programme was in progress. One of the sluice rooms was being used to store clothing. This is not in keeping with best practice. The registered manager stated that the room was not currently being used to sluice equipment. A recommendation is made to ensure the designation of this area is decided and if necessary a minor variation should be submitted to RQIA for a change of use of the room. The room should be maintained as a sluice room until the variation if necessary is granted. Work has commenced to upgrade the nurse call system; however, it is not yet completed. A recommendation is made to ensure the upgrade of the nurse call system is completed. Confirmation should be forwarded to RQIA upon completion of the work.

Areas for improvement

Two recommendations were made regarding the nurse call system the management of the identified sluice room.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

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 plans had been personalised to meet the individual needs of the patients and had been reviewed three monthly. The evaluations reviewed were repetitive and did not reflect any changes to patient care. A recommendation is made that evaluations should be more meaningful and reflective of outcomes of care delivered. A recommendation is also made to ensure pain assessments are introduced and completed for patients presenting with pain.

Registered nurses were aware of the local arrangements and referral process to access relevant healthcare professionals, for example General Practitioner's (GP), speech and language therapist (SALT), dietician and tissue viability nurse (TVN).

Discussion with the registered manager and a review of records confirmed that staff meetings had been conducted. The most recent staff meeting was held on 14 September 2016. Minutes of the meetings were available for review and included dates, attendees, topics discussed and decisions made.

The registered manager confirmed that they operate an 'open door policy' and are available to discuss any issues with staff, patients and/or relatives. The registered manager also confirmed that they would undertake a daily walk around the home and would avail of the opportunity to engage with patients and relatives at this time.

Staff consulted knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

There were no quality surveys completed with relatives/representatives of patients. The registered manager stated that there has been no response to quality surveys' completed in recent years. The registered manager confirmed that relatives have a very close relationship with staff and that they often communicate their views during conversations with staff. The registered manager agreed to introduce a comments book for relatives/representatives when they give a view on patient care or service.

A daily activity programme has recently been introduced for patients who do not attend day care.

Areas for improvement

Two recommendations are made in relation to the evaluations of care and the completion of pain assessments

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Seven staff questionnaires were left in the home to facilitate feedback from staff. Seven of the questionnaires were returned within the timescale for inclusion in the report. The seven returned questionnaires were very positive regarding all four domains. On inspection the inspector also spoke with, four care staff, one registered nurse and two ancillary staff.

Some staff comments were as follows:

- "This is a great place to work"
- "We are all one big happy family"
- "We are well trained and there is great support from the manager"
- "I think the care is excellent, the patients are spoilt and they rule the roost here"
- "I couldn't see myself working anywhere else"

Consultation with nine patients both individually and in smaller groups, confirmed that they felt safe and well looked after. Those who could not verbalised their view appeared content and comfortable.

Some patient comments were as follows:

- "I like it here"
- "I like the food"
- "I'm very happy here"
- "The staff are good"
- "I feel safe and well look after"

Six patient questionnaires were left in the home for completion. Six patient questionnaires were returned within the timeframe. There were no comments made, however, all responses to questions indicated that they felt all four domains were "very good".

There were no relatives or patient representatives visiting on the day of inspection. Five questionnaires were left for completion. There were no questionnaires returned within the timescale for comments to be included in the report.

The serving of lunch was observed in the main dining room. The mealtime was well supervised. Food was served in an organised manner when patients were ready to eat, or be assisted with their meals. Staff wore appropriate aprons when serving or assisting with meals and patients were provided with dignified clothing protectors. A selection of condiments was on the tables and a range of drinks was offered to the patients. The food appeared nutritious and appetising.

A menu was displayed in the dining room. They have recently been reviewed in consultation with patients. A review of the menu evidenced that there was good choice of meals available daily. All patients spoken with were complimentary of the food served in the home saying it was 'tasty and homely'.

Discussion with staff confirmed that the religious needs of patients were met as required. Staff also confirmed that members of the clergy come to the home to visit patients.

Areas for improvement

There were no areas for improvement identified under compassionate care.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The complaints procedure was included within the 'Patients Guide'. There were no recent complaints made. A compliments book was maintained to record and evidence compliments received.

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

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. Whilst the registered manager regularly checks the quality of the care records and the environment in relation to infection control, audits were not being conducted and records were not maintained. Following discussion with the registered manager it was agreed that a programme of auditing should be introduced to monitor the quality of care records and the environment in relation to infection control and infection control practices. A recommendation is made in to ensure the above audits are introduced and recorded. The outcome and action plans of audits should also be recorded alongside any action taken to address shortfalls.

Urgent communications, safety alerts and notices were reviewed by the registered manager on receipt and, where appropriate, were shared with staff. A system was in place to ensure that all relevant staff had read the communication or had been notified about it.

Discussion with the registered manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Areas for improvement

One recommendation has been stated in relation to the management of audits.

Compliance with the recommendations in the safe and effective domain will also assist in raising the standard within the well led domain.

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 Lisa Austin, registered manager, as part of the inspection process. 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

Recommendations	
Recommendation 1 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 30 October 2016	The registered provider should ensure the designation of the identified sluice room is decided and if necessary a minor variation should be submitted to RQIA for a change of use of the room. The room should be maintained as a sluice room until the variation if necessary is granted. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: No change ofuse being made to this room.
Recommendation 2 **Ref:** Standard N10 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure the upgrade of the nurse call system is completed. Confirmation should be forwarded to RQIA upon completion of the work. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Awaiting date for installation of system will inform you of date of same as soon we get it.
Recommendation 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 30 October 2016	The registered provider should ensure that evaluations are more meaningful and reflective of outcomes of care delivered. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: All nurses have been advised to ensure evaluations are meaningful and reflective of outcomes of care delivered.
Recommendation 4 **Ref**: Standard 21 **Stated:** First time **To be completed by:** 30 October 2016	The registered provider should ensure pain assessments are introduced and completed for patients presenting with pain. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Fully completed

Recommendation 5 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 30 October 2016	The registered provider should ensure the care record and infection control audits are introduced and recorded. The outcome and action plans of audits should also be recorded alongside any action taken to address shortfalls. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Audits are fully implemented.

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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