Cairngrove
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Unannounced Care Inspection of Cairngrove Nursing Home

21 March 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 21 March 2016 from 15.40 to 17.40.

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 06 January 2016.

1.2 Actions/Enforcement Resulting from this Inspection

Urgent actions or enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered nurse in charge, Carmel McVeigh, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Charles Anthony Digney	**Registered Manager:** Lisa Mary Austin
Person in Charge of the Home at the Time of Inspection: Carmel McVeigh, registered nurse in charge	**Date Manager Registered:** 01 April 2005
Categories of Care: NH-LD, NH-LD(E)	**Number of Registered Places:** 23
Number of Patients Accommodated on Day of Inspection: 22 1 in hospital	**Weekly Tariff at Time of Inspection:** £593 to £1063

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standard had been met:

- **Standard 11: Activities and events**

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to inspection the following records were analysed:

- 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 returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with approximately six patients and three care staff.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- two patient care records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Cairngrove Nursing Home was an unannounced care inspection dated 6 January 2016. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last care inspection on 6 January 2016

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 15 **Stated:** First time	The registered persons shall ensure that formal evaluations of care are more descriptive and meaningful. The registered persons shall ensure that the wording in one care record identified to the nurse in charge is reviewed to ensure that the description of their behaviour is factual and that it should be updated to reflect the patient's current needs. The registered persons shall ensure that the care record identified to the nurse in charge should be updated to describe changes in the patient's condition.	**Met**

	Action taken as confirmed during the inspection: A review of two care records evidenced that the evaluation of care had been reviewed. Evaluations recorded were observed to be meaningful and descriptive. The identified care record had been reviewed to include factual information regarding their behaviour in keeping with their current needs.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Standard:** N10 **Stated:** First time	The registered persons shall ensure that the nurse call system is continually reviewed as the needs of the patients change and in consultation with patients' representatives. Records should be retained for inspection of the review and confirmation should be retuned in the Quality Improvement Plan (QIP) that the nurse call system is fully operational should it be required to be switched on at any time.	**Met**
	Action taken as confirmed during the inspection: Confirmation has been received by RQIA that the nurse call system is operational. However it is continued to be disconnected. Confirmation has also been received that quotes are currently being received to replace/update the nurse call system. It is further recommended that the plans for replacing/updating the nurse call system should be confirmed to RQIA in the returned QIP.	
Recommendation 2 **Ref**: Standard 19 **Stated:** First time	The registered persons should ensure that palliative link nurse is appointed and that training is provided for staff. This training should include training in communication and the breaking of bad news.	**Met**
	Action taken as confirmed during the inspection: A palliative link nurse has been appointed and training has been provided on 5 February 2016.	

5.3 Standard 11: Activities and events

There were eleven patients in the home during the inspection. The remainder were attending day care services and there was one patient in hospital. The atmosphere in the home was observed as being jovial and relaxed. Staff were observed to engage with patients in a respectful and dignified manner. Staff recognised opportunities for interaction with patients and demonstrated an understanding in their approach to care. Staff were also very familiar with patients identified needs, life experiences and interests. There was evidence of appropriate equipment, aids and technology available in the home to provide purposeful, enjoyable and meaningful activities for patients. It was evident that the cultural, religious and spiritual needs of patients are being met throughout the range of activities provided in the home. The home incorporates important dates and festivals into the calendar of activities. Following discussion with staff on duty there are regular activities in place. However they are organised at an 'ad hoc' basis. It is recommended that activities are organised on a formal basis and in particular for those patients who do not attend day care. A formal programme should be implemented this should 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 and suitable. The record should include evidence of engagement with patients and those delivering the activity or event.

5.4 Other Areas Examined

5.4.1 Environment

A review of the environment evidenced that it was being well maintained in accordance with best practice in relation to the management of infection control. The environment was assessed as being bright, cheerful and welcoming. It is decorated to a high standard and patients who could communicated that they liked their bedroom and the environment of the home. Bedrooms were observed to be decorated and maintained in accordance with the individual interests and choices of patients. Relevant aids, equipment and support were available for patients to enable choices, independence.

5.4.2 Patient and staff views

Patients

Discussions with patients indicated that they were very happy in the home. Both verbal and non-verbal communication evidenced that patients were content and well looked after. Patients who could communicate verbally stated that they liked the staff in the home stating that they were well looked after and enjoyed staying there. There were no concerns raised by patients.

Staff

All staff on duty indicated that they were very happy working in the home. They stated that care services in the home were excellent and that it was the patients' home and where possible their choices, wishes and feeling were always prioritised. They stated that they were well trained and supported in their roles and responsibilities.

Areas for Improvement

There were two recommendations made, one in relation to the formalisation of an activity programme and one was in relation to the nurse call system.

Number of Requirements:	0	Number of Recommendations:	2

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with registered nurse in charge, Carmel McVeigh 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/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. 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 home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/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 provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard N10 **Stated:** First time **To be Completed by:** 30 April 2016	The registered persons should ensure that the plans for replacing/updating the nurse call system should are confirmed to RQIA in the returned QIP. **Ref Section 5.2, previous requirements**
	Response by Registered Person(s) Detailing the Actions Taken: Quotations obtained awaiting engineers report on viability of updating current system, we will keep you informed of progress on same.
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. **Ref Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: A formal programme of activities has been devised and included in residents care plan. A record of participation in activities are being documented in individual evaluation notes.

Registered Manager Completing QIP		**Date Completed**	
Registered Person Approving QIP		**Date Approved**	
RQIA Inspector Assessing Response	Donna Rogan	**Date Approved**	17/05/2016

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