Unannounced Care Inspection

Name of Establishment:	**Cairngrove**
RQIA Number:	**1465**
Date of Inspection:	**25 February 2015**
Inspector's Name:	**Lorraine Wilson**
Inspection ID:	**IN020999**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of Establishment:	Cairngrove
Address:	Balmoral Avenue Rathfriland Road Newry BT34 1JZ
Telephone Number:	(028) 3026 6442
Email Address:	cairnhillhomes@hotmail.co.uk
Registered Organisation/ Registered Provider:	Cairnhill Home 'A' Ltd Mr Charles Anthony Digney
Registered Manager:	Ms Lisa Mary Austin
Person in Charge of the Home at the Time of Inspection:	Staff Nurse Carmel McVeigh
Categories of Care:	NH-LD, NH-LD(E)
Number of Registered Places:	23
Number of Patients Accommodated on Day of Inspection:	22 + 1 patient in hospital
Date and Type of Previous Inspection:	25 October 2013 Unannounced Primary
Date and Time of Inspection:	25 February 2015 12.05 - 16.05 hours
Name of Inspector:	Lorraine Wilson

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the Provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process

4.0 Methods/Process

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

- Discussion with the registered provider
- discussion with the Staff Nurse in charge of the home
- discussion with staff
- discussion with patients individually and to others in groups
- consultation with one visiting relative
- review of a sample of policies and procedures pertaining to continence care
- review of a sample of staff training records
- review of a sample of staff duty rotas
- review of a sample of care plans
- review of the complaints
- observation during a tour of the premises
- evaluation and feedback.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients	All patients, speaking to five patients' individually.
Staff	One registered nurse, three care assistants and the cook.
Relatives	1 visiting relative.
Visiting Professionals	0

Questionnaires were provided, during the inspection, to staff to seek their views regarding the quality of the service.

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	0	0
Relatives/Representatives	0	0
Staff	8	8

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion. Specific elements reviewed are included in section 9.0.

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Cairngrove Private Nursing home is located centrally to Newry City.

The nursing home is owned and operated by Cairnhill 'A' Limited and the responsible individual for the company is Mr Charles Digney.

The current registered manager of Cairngrove is Mrs Lisa Austin.

Twenty three single bedrooms are located over two floors of the home, and access to the first floor is via a passenger lift or stairs.

A total of three communal lounges are available, with two lounges available on the ground floor and one on the first floor.

A separate dining area is provided on the ground floor of the home. The dining room is adjacent to the kitchen, and laundry services are available on the ground floor.

A number of communal sanitary facilities are available throughout the home.

The home is located in a cul-de-sac with suitable car parking available within the home grounds.

The home is registered to provide care for a maximum of twenty three persons under the following categories of care:

Nursing care

Nursing LD	Learning Disability
Nursing LD (E)	Learning Disability – over 65 years

The registration certificate issued by the Regulation and Quality Improvement Authority (RQIA) was reviewed and was appropriately displayed in the foyer of the home.

8.0 Executive Summary

The unannounced secondary inspection of Cairngrove Private Nursing Home was undertaken by Lorraine Wilson on 25 February 2015 between 12.05 and 16.05 hours.

Staff Nurse McVeigh who was the registered nurse in charge of the home facilitated the inspection and received verbal feedback at the conclusion of the inspection.

Mr Charles Digney, responsible individual arrived to the home at the conclusion of the inspection and met briefly with the inspector. Verbal feedback was provided to Mr Digney in respect of identified environmental issues.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous care inspection undertaken on 25 October 2013.

A number of documents were required to be submitted to RQIA pre inspection and the relevant documents were returned within the required timescale. Prior to the inspection, these documents were reviewed by the inspector and the required assurances were provided.

Compliance with standard 19 of the Nursing Home Minimum Standards (2005) regarding continence care was assessed. Two care records were reviewed.

The findings evidenced that elimination assessments had been completed as part of a comprehensive assessment of patients' needs on admission to the home which were updated as required and at least annually.

Bladder assessments were recorded in two records; however, information pertaining to bowel assessments referencing the Bristol stool chart was limited in assessments, care plans and daily records. This was identified as an area for improvement, and a recommendation was made.

The assessment of patients' needs informed the care planning process which reflected person centered information that was updated on a regular basis.

Policies on continence management were available for staff, and policies and procedures for the management of supra – pubic catheterisation was in place. The policies were in need of review and updating. The policies could be further enhanced by incorporating relevant evidence based guidance, which should also be made available to staff. A recommendation was made.

From a review of the available training records, and discussion with staff there was evidence that continence care training had been provided to 14 nursing and care staff.

Confirmation was provided that three registered nurses had been trained and assessed as competent in the management of catheterisation. However, as the training had taken place some years ago, a review of staff training needs in relation to catheter management should be undertaken to determine if a training update is necessary. A recommendation was made.

The staff nurse in charge confirmed that she had recently been appointed continence link nurse for the company, and had recently attended continence training. Confirmation was provided that the link nurse role has not been fully established. To support the continence link nurse for this role, further training should be provided. The registered manager provided confirmation post inspection that the link nurse was scheduled to receive further training on 23 March 2015.

Quality monitoring of continence care practices should also be undertaken. A recommendation was made.

From a review of the available evidence, discussion with relevant staff and observation, the inspector can confirm that the level of compliance with the standard inspected was substantially compliant.

Five recommendations have been made in respect of this standard. Further detail of the inspection findings can be found in section 10.0 of this report.

The inspector met all patients' living in the home on the day of inspection speaking with five individually. Several patients were unable to communicate verbally but had their own individual mode of communication which was understood by staff. Patients' demeanour indicated that overall they were content in their care environment.

The patients' able to communicate were positive about the care they received and no concerns were raised with the inspector.

Throughout the period of inspection, staff interactions with patients were observed to be positive, caring and respectful.

The relative of a patient who had been living in the home for several months discussed their experience with the inspector. The relative confirmed they visited the home regularly and conveyed satisfaction with the care and treatment provided, describing the registered persons, the staff and the home as "exceptional".

One registered nurse, three care assistants and the cook on duty met with the inspector, and eight staff completed and returned questionnaires to the inspector. Overall the comments were very positive comments regarding the home, the management, staff team and the care given to patients and no concerns were raised. Refer to section 11.6 of the report.

Confirmation was provided that communal bathroom areas had been upgraded in recent months. The home was maintained to a satisfactory standard of decorative order and a good standard of hygiene throughout. Areas for improvement with regard to redecoration, repair or replacement of furnishings were identified. These included specific bedrooms which were in need of repainting to address scuffed, damaged or stained walls. A few bedrooms had bedroom furnishings which were chipped or damaged and in need of repair or replacement.

An audit of the premises should be undertaken to ensure all areas which require redecoration, repair or replacements of furnishings are identified and an action plan and timeline devised to address identified works. A recommendation was made.

A small number of infection prevention and control issues were also identified. A recommendation was made.

A discussion was held with the responsible individual regarding the nurse call system which is not operational. Confirmation was provided that the majority of patients would be unable to summon staff assistance; however some patients may be assessed as able to use the call system. Therefore, to ensure patients' needs can be met, a review of the call system should be undertaken in consultation with, patients, nursing staff, trust representatives, and should include how assistance is summoned by patients in the event of an emergency. RQIA should also be informed of the review outcome. A requirement was made.

The progress in addressing one requirement and five recommendations made during the previous care inspection undertaken on 25 October 2013 was reviewed.

One requirement was validated as compliant.

Two of the five recommendations were compliant, one was moving towards compliance. Improvement was evidenced in specific areas, however, elements of the recommendation will be stated for a second time. Two recommendations were not compliant, one of which will be stated for a second time. One recommendation will not be stated again, and the recommendation made previously regarding a review of the action plan has been subsumed into a requirement which has been made in respect of regulation 29 visits.

Details of the findings can be viewed in section 9.00 immediately following this summary.

As a result of this inspection, two requirements and ten recommendations were made.

Details can be found in the quality improvement plan (QIP).

The inspector would like to thank the patients, one visiting relative, the registered provider, registered nurses and staff for their assistance and co-operation throughout the inspection process.

The inspector would also like to thank staff who completed questionnaires.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	16(1)	A care plan must be developed to clearly guide staff in the management of the identified patient's behaviour if they become physically aggressive. Any interventions prescribed must be discussed and agreed with the relevant healthcare professionals and family. Records must be retained of consultation.	The inspector reviewed a care plan of an identified patient. A care plan for the management of the patient's behaviour, and an additional care plan to reflect changes in the patient's behaviour had been implemented. This care plan provided specific information regarding behavioural changes. Clear guidance was provided for staff with regard to the nursing care to be delivered. The involvement of the multidisciplinary team and the patient's next of kin was clearly evidenced and the care plan reviewed was very person centered. **This requirement has been addressed.**	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	25.12	It is recommended that the action plan from the previous visit should be reviewed at the next visit and all areas commented on.	Copies of monthly regulation 29 reports which are completed on behalf of the responsible individual for the company were requested. The records provided indicated that the last recorded monthly visit was undertaken on 30 July 2014. The inspector was unable to validate this recommendation, which will not be restated**.** **This recommendation has not been addressed and will not be stated again.** **However, a requirement has been made in respect of regulation 29 visits, and recommendation 1 will be subsumed into this requirement.**	Not compliant
2.	16.1	It is recommended that further training is provided for registered nurses in the regional procedure for the protection of vulnerable adults. The training must be reflective of their role and responsibility as the nurse in charge of the home.	Confirmation was provided that the home's safeguarding policy had been updated to reflect RQIA's recommendation. Training records confirmed that safeguarding training was provided to staff during February and March 2014. The nurse on duty was aware of her role and responsibility in relation to safeguarding.	Compliant

			This recommendation has been addressed.	
3.	10.7	It is recommended that a policy to guide and direct staff in the implementation of behavioural support plans is developed.	The inspector can confirm that a policy on implementing behaviour support plans was implemented on 10 March 2014 and was ratified by a company director. **This recommendation has been addressed.**	Compliant
4.	11.1	It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated.	The inspector was unable to evidence that a baseline assessment had been completed for patients receiving analgesia including as and when required analgesia. The registered nurse also confirmed that no pain assessments were in place. **This recommendation has not been addressed and has been stated for the second time.**	Not compliant

5.	5.3	It is recommended that: • the frequency with which patients should be repositioned is specified in the care plan • a daily repositioning chart should be in place for any patient identified as requiring repositioning due to risk of pressure damage • repositioning charts should contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning.	The care plan for one patient at risk of pressure damage was reviewed. The care plan provided guidance to nursing staff regarding the frequency of repositioning. However, there were no repositioning charts to evidence daily repositioning in accordance with evidence based practice. Guidance and advice was provided by the inspector, emphasizing the importance of maintaining records to evidence repositioning as well as a traceable record of the condition of the patient's skin. **Parts of this recommendation will be stated again for a second time.**	Moving towards compliance

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigation

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

An announced finance inspection of the home was undertaken on 22 December 2014, and a range of matters which required to be addressed were identified. A further finance inspection will be undertaken within a short timescale to ensure that the identified issues have been effectively addressed.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of two patients' care records evidenced that elimination assessments were recorded. The outcome of these assessments referred mainly to urinary incontinence and included information on the type of continence products to be used, which was incorporated into the patients' care plans on continence care. There was limited information in respect of baseline bowel assessments referencing the Bristol Stool Chart, recorded in elimination assessments and care plans. A recommendation was made that this information is recorded for all patients. There was evidence in two patients care records that continence care plans were reviewed and updated at least three monthly or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. The care plans reviewed addressed the patients' assessed needs in regard to continence management, and detailed information in respect of one patient with no verbal communication, recorded how the patient made their continence needs known. Person centred information was also recorded in respect of one patient who had a catheter in place and reflected the patient's independence in managing some of their own catheter care. Daily nursing records provided details of continence care delivered, however, to enable traceable bowel function referencing the Bristol Stool Chart, recording improvements are needed. This was discussed with the staff nurse on duty. A recommendation was made.	Substantially compliant

There was no record of fluid intake and output being recorded, for a specific patient, and the continence link nurse agreed to seek advice from a specialist continence nurse regarding the necessity to measure and record urinary output. The inspector met a small number of patients living in Cairngrove who could discuss their contience and care needs. Confirmation was provided that discussions were held with representatives on admission and during patient care reviews for those patients unable to be involved in planning personal care. During inspection one patient was observed discussing their continence needs with the nurse in charge and prompt action was taken to address the patient's needs. One visiting relative advised the inspector that they were kept informed with regard to all aspects of their relative's care. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that a policy on continence management was in place. The policy was in need of updating and would be further enhanced with evidence based guidance as indicated in the NICE guidelines on the management of urinary incontinence, and NICE guidelines on the management of faecal incontinence. A recommendation was made. Guidance information available for staff when changing a supra pubic catheter. Discussion with staff confirmed that a number of patients living in the home required assistance with intimate care needs such as washing, dressing and continence management. It was positive to note that suitable guidance information had been devised for staff when providing intimate care for patients' with disabilities. The guidance which reflected the sensitivities of the task was based on evidence based practice. A recommendation was made that the following specified policies are reviewed and updated as appropriate and ratified by the responsible individual in accordance with nursing homes minimum standards. • Continence policy to include bowel care • Develop policies and procedures in respect of stoma care • Review the policy for catheter care Discussion with nursing and care staff on duty revealed that they had some awareness of the policies and guidelines in respect of continence management.	Substantially compliant

A recommendation was also made that a resource file containing the following guideline documents is developed for staff and available for staff reference. • RCN continence care guidelines • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence	

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not inspected.	Not inspected.
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with nursing and care staff confirmed that staff had recently received training in continence care and attendance sheets reviewed by the inspector confirmed that 14 staff from Cairngrove attended the training in January 2015. The training was provided by an external trainer. The training programme was not available for inspection. It was agreed that this information would be submitted to RQIA post inspection. The training course content received post inspection confirms that staff received training on a range of matters, examples include, the types and causes of incontinence, advice on toileting patients, information on product assessment. Discussion with the registered nurse on duty confirmed that one patient had a specific type of catheter and three registered nurses who work in the home had received training and were assessed as competent in catheter replacement. Confirmation was provided that the catheter training had been completed a number of years ago. Therefore, training needs of staff in all types of catheter management should be reviewed to determine if a training update is required. A recommendation was made. All nursing and care staff consulted were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns. As previously indicated, a policy in intimate care was in place and this information was also recorded in care records reviewed.	Substantially compliant

The registered nurse on duty confirmed that she had recently been appointed as link nurse for the company, confirming that the role was to be fully established. The link nurse anticipated that some responsibilities of the role would be involvement in the review of continence management and education programmes for staff. To assist the continence link nurse, enhanced training should be provided. RQIA was informed via electronic mail on 12 March 2015, and also during a telephone conversation with the inspector on 18 March 2015, that the continence link nurse is scheduled to attend training in bowel and bladder care on 23 March 2015. Currently there are no audits of continence management undertaken. A recommendation was made that continence audits should be undertaken regularly and the findings acted upon to enhance standards of care.	

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were very evident between patients and staff.

Patients were well presented with their clothing suitable for the season. The demeanour of patients indicated that they were relaxed in their surroundings.

There was evidence of good supervision of patients, and staff were observed responding to patients' requests promptly.

11.1.2 Activity Provision

Nine of the twenty two patients living in the home, attended day care until approximately 15.00 hours on the day of inspection. On return to the home, the patients discussed how they spent their day in day care with staff and with the inspector.

The remaining patients spent their day in the nursing home in the company of staff.

11.2 Complaints

It is not in the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The complaint record maintained in the home was reviewed and records evidenced that few complaints had been made.

In accordance with good practice in complaints management, a system to determine if the complainant is satisfied with the complaint outcome should also be recorded. A recommendation was made.

11.3 Patient Finance Questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

As indicated in 9.1, an announced finance inspection of the home was undertaken on 22 December 2014, and a range of matters which required to be addressed were identified. A further finance inspection will be undertaken within a short timescale to ensure that the identified issues have been effectively addressed.

11.4 NMC Declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC.

11.5 Patients and Relatives Comments

During the inspection the inspector spoke to five patients individually and to others in groups.

Overall patients expressed high levels of satisfaction with the standard of care, facilities and services provided in the home.

A number of patients were unable to express their views verbally. These patients indicated by positive gestures that they were content living in the home.

Examples of patients' verbal comments were as follows:

"I like it here and the staff are nice."
"Yes, I feel safe and enjoy going out with my family."
"I don't want to go to day care and like to stay here instead."
"I got new curtains and duvet for my room."

One visiting relative confirmed their relative had been in the home for a number of months. The relative confirmed they visited regularly and expressed the view that there had been an improvement in their relative's condition since admission to Cairngrove.

The relative confirmed that they were very satisfied with the care and treatment provided, describing the provider, the registered manager, staff and the home itself as "exceptional."

There were no issues or concerns raised by patients or a visiting relative.

11.6 Questionnaire Findings/Staff Comments

The inspector met with the registered nurse on duty, three care assistants and the cook. The inspector was able to speak to the staff individually and in private. Eight staff on duty were issued with questionnaires, and all were completed and returned to the inspector during the inspection.

Responses in returned questionnaires and in discussion with staff indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Staff provided positive comments in respect of the management of the home, confirming that that they were well supported by the manager, and no concerns or issues were raised with the inspector.

Examples of staff comments were as follows;

“I feel that Cairngrove is a very well managed home, where the residents are very well looked after. I would recommend Cairngrove to a family member.”
“Cairngrove is a unique nursing home. We are supplied with a great manager who always puts the needs of the residents first. The training is excellent and anything that staff need regarding equipment etc is reported and replaced/fixed if necessary. I enjoy working for this company and with the lovely residents.”
“Great place to work in, great residents, great group of people (staff) always a different day which is great.”

There were no issues or concerns raised by staff.

11.7 Governance and Staffing Arrangements

Confirmation was provided that a director undertakes monthly regulation 29 visits to the home on behalf of the responsible individual.

The registered nurse confirmed that visits were frequently undertaken, however, the record of the last monthly visit provided to the inspector was dated July 2014.

The responsible individual must ensure that unannounced regulation 29 visits are undertaken on a monthly basis, and records of visits are maintained in the home and available for inspection at all times.

In addition the action plan from the previous visit should be reviewed at the next visit and all areas commented on. This was recommended during the previous care inspection, but has now been incorporated into a requirement made regarding regulation 29 visits.

The staffing rota presented during the inspection was reviewed. The registered manager was on leave on the day of inspection and this was accurately reflected on the duty roster.

The rotas reflected sufficient staff were on duty to meet patients’ needs and staff rotas reflected that agency nursing staff worked in the home, mainly on night duty. The registered nurse confirmed that the agency staff regularly worked shifts in the nursing home and knew the needs of the patients well.

11.8 Environment

The inspector undertook an inspection of the premises and viewed a sample of patients’ bedrooms, bathroom, shower and toilet facilities and communal areas. The inspector was informed that replacement wall covering was recently installed in a number of communal bathrooms. Confirmation was also provided that repainting is undertaken annually.

Overall the home was comfortable and maintained to a good standard of hygiene.

A number of areas were identified in relation to the fitness of the premises and facilities and services.

These included:

- Bedrooms – in identified rooms, some walls were scuffed, stained and or damaged and were in need of repainting. Some melamine furniture was damaged, and to ensure these areas can be effectively cleaned, the furniture should be repaired or replaced.
- The woodwork and architraves of several doors was damaged and in need of repair and repainting.

A recommendation was made that an audit of the premises is undertaken and an action plan is implemented to address identified deficits.

The following infection prevention and control issues were also identified.

- pull cords in individual toilets, communal bathrooms and shower rooms should be fully covered with wipeable covering to ensure they can be effectively cleaned

- urinals and raised toilet seats should be appropriately stored on a suitable rack with a drip tray.

A recommendation was made in respect of these issues.

- The call system is not operational and the suitability of the system was discussed with the responsible individual. Confirmation was provided that not all patients are able to use the call system to summon assistance; however, currently some patients living in the home may be assessed as able. Therefore, a review of the call system should be undertaken and should incorporate how patients summon assistance in the event of an emergency. During the review, patients, nominated representatives, staff and commissioners of care should be included and consulted. RQIA should also be informed of the review outcome.

A requirement was made in respect of this issue.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Staff Nurse McVeigh, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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.

Enquiries relating to this report should be addressed to:

Lorraine Wilson
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nurse carries out initial assessment prior to admission using validated assessment tools. This allows an initial care plan to be constructed along with the information obtained from other relevant professionals. A comprehensive care plan is then devised within 11 days. Nutritional status is determined using MUST screening tool. A Braden score is recorded on all residents in Cairngrove.	Substantially compliant

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Each resident is appointed a named nurse who has responsibility for discussing, planning and agreeing nursing interventions. Referral arrangements are in place to contact TVN. A specific careplan is drawn up for any resident at risk of developing pressure ulcers. If a resident had lower limb or foot ulceration, advice would be sought from TVN and Podiatrist and other relevant disciplines. Arrangements to access other health professionals are in place and recommendations are forwarded to the GP to prescribe recommended Care.	Substantially compliant

Section C

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

Criterion 5.4

- **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Evaluation of careplan occurs at the end of each nurses shift. Review of careplan occurs every 3 months or sooner if changes occur. Manager audits careplans every 6 months.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All interventions and procedures are supported by research evidence and guidelines. Braden scale and the "open wound/ulcer assessment chart" are used to screen residents who have skin damage and a careplan devised accordingly. Staff take guidance from SLT, dietician and "Nutritional guidelines and menu checklist for residential and nursing homes 2014".	Substantially compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Accurately timed nursing records are kept of all nursing interventions and procedures in relation to each resident. A record of all meals taken by the residents are kept and when required an intake/output chart is completed. Recommendations from relevant professionals are documented and implemented.	Substantially compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Evaluation of care is documented at the end of each shift ior as it occurs. Careplans are reviewed every 3 months or sooner if required. Residents and their families are invited to take part in the care planning process.	Substantially compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Residents are invited to contribute to the care planning process and to attend their multidisciplinary review. Records of reviews are minuted by the trust. When received, records of reviews are kept in each residents file. Changes identified during multidisciplinary review is implemented as soon as possible and evaluated in notes. Families are informed of any changes.	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Residents are provided with nutritious and varied diet which rotates 3 weekly. If a resident does not want what is on the menu then alternatives are provided and this is documented. Guidance on devising menus is sought from dieticians, speech and language therapists and relevant guidance documents.	Substantially compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All care staff and cooks receive training in managing feeding techniques for residents who have swallowing difficulties. All instructions given by SLT are adhered to. All meals are provided at conventional times with snacks and drinks available between times. All staff are aware of each residents individual needs regarding mealtimes, i.e. positioning, consistencies, aids and level of assistance required. Nurses have received wound care training and are able to carry out wound assessments and apply wound care dressings as appropriate. There are no residents at present with wounds in Cairngrove.	Substantially compliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Substantially compliant

Quality Improvement Plan

Secondary Unannounced Care Inspection

Cairngrove

25 February 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Staff Nurse McVeigh either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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.

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 (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	29, (2), (3), (4) (c), 5 (a).	The registered person must ensure that regulation 29 visits are completed at least monthly and records of visits are maintained in the nursing home and available for inspection at all times. The action plan from the previous visit should be reviewed during each visit and all areas commented on. **Ref: Section 9, Follow up on previous issues and additional areas examined 11.7.**	One	Fully completed and available for inspection.	28 days from date of this inspection.
2.	18 (2)(a)	The registered person must undertake a review of the call system incorporating how patients summon assistance in the event of an emergency in consultation with staff, commissioners of care, patients and representatives. RQIA should also be informed of the review outcome. **Ref: Additional areas examined 11.8.**	One	The call system has been reviewed and it has been decided with the resident and their families and the home, that the measures which we have in place for many years have been found to work well and feel we have no grounds to change same.	When returning the Quality Improvement Plan. (QIP)

Recommendations

These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	11.1	It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated. **Ref: Section 9.0, Follow-up on previous issues**	Two	Baseline pain assessment is completed on admission and as indicated.	28 days from date of this inspection.
2.	5.3	It is recommended that: • a daily repositioning chart should be in place for any patient identified as requiring repositioning due to risk of pressure damage • repositioning charts should contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning. **Ref: Section 9.0, Follow-up on previous issues**	Two	Completed.	28 days from date of this inspection.

3.	19.1	The registered manager should ensure that a baseline bowel assessment is completed for all patients on admission, and bowel type referencing the Bristol stool chart is consistently recorded.in individual bowel assessments and care plans. To enable consistent monitoring of bowel function the information should also be recorded in patient's individual daily progress records. **Ref: Section 10.0,19.1**	One	Completed	28 days from date of this inspection.
4	26.6	The following policies and procedures are reviewed and updated as required and ratified by the responsible individual: • Continence care including bowel care • Develop policies and procedures in respect of stoma care • Review the policy in respect of catheter care **Ref: Section 10.0,19.2**	One	Completed and reviewed	18 May 2015
5	19.2	A resource file containing the following guideline documents is developed for staff and available for reference: • RCN continence care guidelines • British Geriatrics Society Continence • Care in Residential and Nursing	One	Same compiled	18 May 2015

		Homes • NICE guidelines on the management • of urinary incontinence • NICE guidelines on the management • of faecal incontinence **Ref: Section 10.0,19.2**			
6	19.4	The registered manager should review the training needs of each registered nurse working in the home to determine if updates in catheter training is required. **Ref: Section 10.0,19.4**	One	Reviewed and updated	30 April 2015
7	19.4	The registered provider should ensure that regular audits of continence care are undertaken and the findings acted upon to enhance standards of care for patients. **Ref: Section 10.0, 19.4**	One	The registered manager audits continence care on regular basis.	18 May 2015
8	17.1 17.6	The registered provider should ensure that a system is developed to determine if complainants are satisfied with the complaint outcome, and the information is recorded in complaints records. Complainants should also be advised who to contact should they remain dissatisfied. **Ref; Additional Areas Examined 11.2**	One	Completed	From date of next complaint

9	32.1 32.8	The registered provider should undertake an audit of the premises and implement an action plan which includes a timeline to address identified deficits. A copy of the action plan should be submitted to RQIA when returning the Quality Improvement Plan. **Ref; Additional Areas Examined 11.8**	One	The registered provider carries out a monthly audit and identifies any repairs or improvements required, some of which will have already been reported to office by nursing staff. these are recorded on repairs form, one of which I have attached with this form	When returning the Quality Improvement Plan. (QIP)

10	34.1	The registered provider should ensure there is a managed environment which minimises infection control risks to patients and staff at all times. • pull cords in individual toilets, communal bathrooms and shower rooms should be fully covered with wipeable covering to ensure they can be effectively cleaned • urinals and raised toilet seats should be appropriately stored on a suitable rack with a drip tray. **Ref; Additional Areas Examined 11.8**	One	No urinals or raised toilet seats in use at present.	30 April 2015

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Lisa Austin
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Charles Digney

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Lorraine Wilson	23/4/15
Further information requested from provider	No		