Unannounced Care Inspection

Name of Establishment:	**Cairnhill**
RQIA Number:	**1466**
Date of Inspection:	**27 November 2014**
Inspector's Name:	**Lorraine Wilson**
Inspection ID:	**17283**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Cairnhill
Address:	39 Rathfriland Road Newry BT34 1JZ
Telephone Number:	028 3026 8112
Email Address:	cairnhillhomes@hotmail.co.uk
Registered Organisation/ Registered Provider:	Cairnhill Home 'A' Limited Mr Charles Anthony Digney
Registered Manager:	Mr James Digney
Person in Charge of the Home at the Time of Inspection:	Mr James Digney
Categories of Care:	Nursing Care – LD and LD(E)
Number of Registered Places:	22
Number of Patients Accommodated on Day of Inspection:	20
Scale of Charges (per week):	£1217.00 - £581.00 per week
Date and Type of Previous Inspection:	29 January 2014, Primary Unannounced Care Inspection
Date and Time of Inspection:	27 November 2014 10.30 am – 4.50 pm
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: amend as relevant

- Discussion with the Registered Provider
- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Consultation with two visiting relatives
- Review of a sample of policies and procedures pertaining to continence management
- 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, accidents and incidents records
- 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	Initially met five patients, and met the remaining 15 patients on their return from day care
Staff	The manager, one registered nurse, three care assistants, the cook and domestic staff.
Relatives	Two
Visiting Professionals	0

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

Issued To	**Number Issued**	**Number Returned**
Patients	0	0
Relatives/Representatives	0	0
Staff	6	6

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.

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

Cairnhill 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 is Mr James Digney.

Accommodation for patients is provided on two floors, and access to the first floor is via a passenger lift and stairs.

A total of sixteen single bedrooms and three double bedrooms are located on both floors of the home.

Three communal lounges and one dining area are 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.

There is a lane leading to the home and a car parking is available within the home grounds.

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

Nursing care

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

8.0 Executive Summary

The unannounced secondary inspection of Cairnhill Private Nursing Home was undertaken by Lorraine Wilson on 27 November 2014 between 10.30 and 16.45 hours. The inspection was facilitated by James Digney, registered manager, who arrive shortly after the inspection commenced and was available throughout, and received verbal feedback at the conclusion of the inspection.

Mr Charles Digney, responsible individual was also in attendance during part of the inspection and also met with the inspector.

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.

The inspector spoke individually with five patients who were in the home throughout the inspection and met with the remaining fifteen patients who returned from day care during late afternoon.

Whilst not all patients are able to communicate verbally, they have their own individual mode of communication which staff understands. Patients' demeanour indicated that overall they were content in their environment.

The patients' able to comment were positive about the care they received and no concerns were raised. Staff interactions with patients were observed throughout the period of inspection and were found to be positive, caring and respectful.

Two visiting relatives also spoke with the inspector and confirmed they were very satisfied with the care and treatment provided to their relative.

This inspection focused on the level of compliance with standard 19 of the Nursing Home Minimum Standards (2005) concerning continence care and further detail can be found in section 10.0 of the report.

There was evidence that a continence assessment had been completed as part of a comprehensive assessment of patients' needs in the three care records examined. The risk assessments were updated on a regular basis as required and were evidenced to inform the care planning process.

A number of relevant policies on continence management were available for staff. However, the majority of policies were in need of review and updating and would be further enhanced by incorporating relevant evidence based guidance. A recommendation has been made that these are reviewed and updated.

There was no evidence of proactive quality monitoring of continence care practices within the home and a recommendation is made in this regard.

Discussion with the registered manager and nursing staff confirmed that not all nursing staff were trained and assessed as competent in continence management or male and female catheterisation and stoma care.

There were no patients receiving catheter or stoma care on the day of inspection, and an assurance was provided by the registered manager that should any patient require this treatment, the required training would be provided to nursing staff.

A requirement is made that continence training is provided to nursing and care staff, and as required catheter and stoma care training is also provided to nursing staff to meet patients' individual needs.

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.

The inspector spoke with all staff on duty and six completed questionnaires. Staff comments were very positive regarding the home, the staff team and the care given to patients and no concerns were raised. Refer to section 11.6 of the report.

The home was maintained to a suitable standard of decorative order and hygiene throughout. A number of areas throughout the home had been upgraded during the year and replacement furnishings had been provided.

The inspector also reviewed and validated the home's progress regarding the four requirements and four recommendation made during the previous care inspection undertaken on 29 January 2014.

The findings indicated that two requirements were compliant, one was substantially compliant, and one was not validated and has been stated again for review during the next inspection.

Three recommendations were compliant and one was not validated during this inspection and has been stated again for review during the next inspection.

As a result of this inspection, four requirements and eight recommendations were made.

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

The delivery of care to patients was evidenced to be of a satisfactory standard and patients were observed to be treated by staff with dignity and respect.

The inspector would like to thank the patients, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process and to those 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	12 (1) (b)	The registered person shall provide treatment, and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient reflect current best practice pertaining to the management of restraint by; • ensuring that staff are supported with policies / procedures which are reflective of legislative guidance • ensuring the availability of evidence based literature • providing training reflective of legislative guidance and evidence based literature • reviewing all methods of restraint currently in use in partnership with patients / patient's representative and relevant professionals.	The inspector validated that changes have been made to the restraint policy. The registered manager also advised that an evidenced based protocol had been developed in consultation with an occupational therapist from the commissioning trust, for seven patients who had lap belts in use. The registered manager confirmed that the protocol together with other information regarding the review of restraint, had not yet been received by the home, and was not validated during this inspection. There was available evidence that a number of staff had received MAPPA training and further training was scheduled in January 2015 for the remaining staff. The inspector observed a few patients with lap belts in use during this inspection. **Part of this requirement is stated again for a second time**.	Substantially compliant

			A separate requirement is made that evidence based practices are in place regarding the management of lap belts, and records of checks undertaken are available at all times.	
2	16 (2) (b)	The registered person shall ensure that – (b) the patient's plan is kept under review by ensuring that; • care plans reflect the partnership approach in determining interventions involving restraint and the specific monitoring / review arrangements in place • care plans are put in place for patients at risk of pressure damage to include pressure relieving / reducing equipment and daily repositioning and skin inspection processes • a care plan is put in place with regard to one identified patient's behaviour pattern.	The inspector validated that during care review meetings the care provided is discussed with patients' representatives. This was evidenced in minutes of care reviews which had been completed One visiting relative also advised that they were kept informed regarding the care and treatment in relation to their relative. As indicated in requirement 1 confirmation was also provided that there had also been liaison with the occupational therapist and care manager in respect of protocols for restrictive practices. On the day of inspection, there were no patients with pressure ulcers; however, repositioning charts were in place for patients at risk of pressure damage. The inspector was informed by the registered manager that a care plan had been implemented for the management of one patient's behaviour. **This requirement was addressed.**	Compliant

3	15 (2)	The registered person shall ensure that the assessment of the patient's needs is; (a) kept under review; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually, by ensuring that: • a falls risk assessment is completed for all patients and on admission. • body mapping charts are recorded on admission, re-admission or if the patient presents with any issues / changes which impact on or pertain to the condition of the skin. • a wound assessment chart is used in accordance with best practice	The inspector discussed admissions to the home since the previous inspection and was informed that whilst there had been two admissions, the patients were no longer in the home. The care records of the two patients were not presented during inspection. Therefore this requirement could not be validated in full. **This requirement will be stated for a second time and is brought forward for review during the next care inspection.**	Not validated

4	27 (4) (d) (1)	The registered person shall make adequate arrangements for detecting, containing and extinguishing fires by ensuring: • fire doors are not wedged open and that fire doors meet current fire safety regulations	There were no fire doors wedged open, and confirmation was provided by the registered manager that the bedroom door identified previously had been repaired by a contractor. **This requirement was addressed.**	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	25.11	It is recommended that the audit process evidences all stages of the audit cycle as discussed.	Audits of care records could not be provided during this inspection. The Inspector was advised they were locked in the manager's office. Therefore, the amended audit process in place for care records could not be verified during this inspection**.** The inspector did evidence that a hand washing at mealtimes audit had been undertaken on 27 August 2014. **This recommendation will be stated for a second time**	Not validated

2	25.12	It is recommended that with regard to Regulation 29 reports • the action plan from the previous visit by Mr C Digney, registered person should be reviewed at the next visit and all areas commented on • the report should evidence more robustly the registered person's opinion of the standard of nursing provided in the home. • that the nurse in charge at the time of the unannounced visit also signs the report.	The inspector reviewed regulation 29 reports which had been completed since the previous care inspection, and could verify that during the next visit, the actions required were commented on. There was also evidence that the report was signed by the nurse in charge at the time of inspection. The inspector would advise that the report template in use by the home should be reviewed in accordance with template guidance issued by RQIA**.** A recommendation is made.	Compliant

3	25.13	It is recommended that the annual quality report is further developed to include evidence of consultation with residents, relatives, staff and other stakeholders	The inspector reviewed the annual quality report which had been developed as recommended. However further suggestions were made by the inspector as to how the report could be further enhanced to evidence quality practice initiatives in the home. There was no evidence that the annual report was made available to patients and their representatives in a suitable format and this also must be addressed. **A recommendation will be made in this regard**	Compliant

4	5.5	It is recommended that: • all care assistants attend training in relation to pressure area care and the prevention of pressure ulcers • all registered nurses undertake wound care training • policies on the prevention and management of pressure ulcers and wound care are revised to include current evidence based references	The inspector reviewed training records which confirmed that nine care assistants had received training on wound care, and five registered nurses received wound care training during the period from September 2013 to April 2014. Four registered nurses are to receive wound care training by the end of January 2015. It should be noted that there are no patients in the home with wounds or pressure ulcers at the time of inspection. **This recommendation was addressed.**	Compliant

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

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.

There have been no complaints, safeguarding or whistleblowing information received by RQIA in respect of the home. Refer to 11.2 of the main report for further information.

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 three patients' care records evidenced that bladder and bowel continence assessments were undertaken. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' individual care plans. However, the inspector was unable to evidence that the patients' bowel type referencing the Bristol stool chart was consistently recorded. A recommendation was made. There was evidence in three patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a three monthly basis or more often as deemed appropriate. The care plans reviewed addressed the patients' assessed needs in regard to continence management. 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. There were no patients living in Cairnhill at the time of inspection who were able to advise the inspector that they were involved in discussions in agreeing and planning of nursing interventions. One visiting relative did advise 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.	Substantially compliant

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. The inspector reviewed guidance information available for staff when changing a supra pubic catheter, However, no policies were in place in respect of stoma care. During this inspection, there were no patients in the home with a stoma or 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. Policies and guidance information based on best practice and available evidence should be available for staff who are providing intimate continence care for patients with learning disabilities. A recommendation has been 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 and catheter care • Develop policies and guidance information for staff providing intimate care including continence • management Discussion with staff on duty revealed that they had some awareness of the policies and guidelines in respect of continence management.	Substantially compliant

A recommendation has been made that a resource file containing the following guideline documents is developed f staff and available for use on a daily basis. • 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 applicable.	Not applicable
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:	
There were no training records available to confirm that staff were trained and assessed as competent in continence care. All nursing and care staff must receive training in continence care and be deemed competent. Records should also be maintained. A requirement has been 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. Discussion with the registered manager and nursing staff confirmed that not all the registered nurses in the home were deemed competent in female/male catheterisation or the management of stoma appliances. There were no patients with catheters or stomas in the home on the day of the inspection. An assurance has been provided by the registered manager that should any patient require catheter or stoma care, the required training and competency assessments would be completed by nursing staff. Currently there is no continence link nurse working in the home, and as this is good practice, this role should be developed. A recommendation has been made. In addition a recommendation is made that regular audits of the management of incontinence are undertaken and the findings acted upon to enhance standards of care.	Substantially compliant

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. Patients were well presented with their clothing suitable for the season.

Good relationships were very evident between patients and staff. 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.

On the day of inspection one patient was observed in their bedroom sitting in specialist seating with a lap belt in use. In accordance with evidence based practice there were no records of checks undertaken by staff.

Discussion with the registered manager confirmed that the protocols being developed would provide this information. However, as these had not been received by the home, interim arrangements must be implemented.

An urgent action note was left in the home on the day of inspection confirming the immediate action required.

On the day of inspection, some patients assisted care staff to put up the Christmas tree in the home's main lounge.

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 no complaints were received in the preceding year.

The inspector reviewed the complaint record and discussed the management of complaints with the registered manager. This evidenced that few complaints had been made.

The registered manager discussed one complaint which had been forwarded to the commissioners of care and which had been sent to the home for local resolution.

There was evidence that the complaint was being managed in accordance with legislative requirements. The registered manager agreed to keep RQIA informed of the investigative outcome of the complaint. 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.

The returned questionnaire was not discussed during this inspection as notification provided confirmed an RQIA finance inspection was scheduled to take place on 10 December 2014.

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/Residents and Relatives Comments

During the inspection the inspector spoke with five patients individually and with others in smaller groups. Patients who were able confirmed they enjoyed living in the home and were looked after well.

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

Examples of patients' comments were as follows:

"I am alright and looked after well"
"I like the food"
"I feel safe and have no worries."
"The staff are nice"

There were no issues or concerns raised by patients during this inspection.

The inspector met privately with two relatives who were visiting a patient in the home. The relatives discussed their experience and confirmed that they were very satisfied with the care and treatment delivered and felt comfortable in addressing any queries or concerns with the registered manager and or nursing staff. The relative confirmed that they were regularly updated in respect of their relative's care.

11.6 Questionnaire Findings/Staff Comments

During the inspection the inspector spoke individually and in private with one registered nurse, and four care staff. Brief discussions were also held with ancillary and catering staff.

Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to meeting the patients' needs and were very satisfied that patients were afforded privacy, treated with dignity and respect and were provided with individual care based on need and wishes.

There were no issues or concerns raised by staff during private discussions or in the six returned questionnaires**.**

Examples of staff comments were as follows;

- "I am so pleased to work here, because all residents are getting high quality of care, treated with respect and dignity. Staff very friendly and supportive"
- "I think the quality of care and attention is unique to each resident as an individual. All the residents in Cairnhill appear very happy and content which is the main priority of my role"
- "the residents come first with care for them, promoting independence and listening to them"
- "Every resident in home is treated in high quality standards, with dignity and respect. Residents always come first and all their needs are respected"

11.7 Staffing Arrangements

The inspector reviewed the staffing rota presented during the inspection, and noted that the registered manager's hours had not been recorded. This was discussed with the manager post inspection and confirmation was provided that another record which details the actual hours worked is also maintained. This record was not viewed during the inspection.

As requested this information was submitted to RQIA post inspection and the record of hours worked by the registered manager were recorded. The records submitted indicated that the manager was off duty on the day of inspection. The registered manager confirmed they had arrived in the home for another purpose and remained to facilitate the inspection**.**

The staffing arrangements were in keeping with RQIA staffing guidance for the numbers of patients accommodated.

11.8 Activity Provision

Fifteen of the twenty patients who were living in the home, attended day care until 15.00 hours approximately on the day of inspection.

Some of the five remaining patients assisted staff to decorate the home's Christmas tree.

11.9 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a good standard of decoration and hygiene.

The inspector was informed of the areas which were upgraded throughout the year. This included annual painting of the home, and upgrading and redecoration of bedrooms with replacement furnishings and seating was also observed.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr James Digney, registered manager 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
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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 relevent professionals. A comprehensive care plan is then constructed within 11 days following admissioin. Nutritional status is determined using M.U.S.T screening tool. A braden score is recorded on all residents within Cairnhill	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. Referal arrangements are in place to contact TVN. A specific care plan 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. Arrangements to access dietician are in place and recommendations are forwarded onto the GP to prescribe any recommendations.	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 care plan occurs at end of each nurses shift. Review of care plan occurs every 3 months or sooner if needs change	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 activities 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 care plan constructed 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 for a particular residents. Any recommendations from relevent professionals are documented and and acted upon.	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 occurs at end of each duty or as it occurs. Care plans are reviewd every 3 months or sooner if felt necessary. 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 kept in each residents file and anything identifyed during multidisciplinary review is acted upon and the outcome documented. 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 menu then alternatives are provided and this documented. Guidance on menu construction is sought from mixture of SLT, dieticians 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 throughout the day. All staff are aware of each residents individual needs regarding mealtimes ie positioning, consistencies, aids and level of assistance required. Nurses have received wound care training and are able to carry out wound assessment and apply wound care dressings as appropriate.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Provider to complete

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic care: (BC) – basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.**
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	Examples include: Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) – communication which is disregarding of the residents' dignity and respect.**
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Secondary Unannounced Care Inspection

Cairnhill

27 November 2014

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 Mr James Digney, registered manager 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	12 (1) (b)	The registered person shall provide treatment, and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient reflect current best practice pertaining to the management of restraint by; • ensuring that staff are supported with policies / procedures which are reflective of legislative guidance • ensuring the availability of evidence based literature • reviewing all methods of restraint currently in use in partnership with patients / patient's representative and relevant professionals. **Ref: Follow up to previous inspection**	Two	There is a policy in place to support staff constructed around evidence based literature such as "Lets Talk About Restraint" and Patient + client council - Stand Up For Me. There has been a recent review of restraint currently in use involving OT, care manager, resident and ourselves	From date of inspection
2	15 (2)	The registered person shall ensure that the assessment of the patient's needs is; (a) kept under review; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually, by ensuring that:	Two	The residents key worker keeps the residents notes under review within an appointed time frame yet if needs suddenly change it is the nurse on duty who is responsible for carrying out necessary changes. A Falls Risk Assessment is	From date of inspection

		• a falls risk assessment is completed for all patients and on admission. • body mapping charts are recorded on admission, re-admission or if the patient presents with any issues / changes which impact on or pertain to the condition of the skin. • a wound assessment chart is used in accordance with best practice **Ref: Follow up to previous inspection**		completed on all residents at admission. Body map charts are completed on admission, re admission or if resident presents with any issues. The wound assessment chart that we use in Cairnhill is "The Open Wound Ulcer assessment Chart"	
3	14(5)(6)	The registered person must ensure that evidence based practices are in place in respect of the management of lap belts, and records of checks undertaken to minimise risks of harm and maintain the patients' safety are available at all times. On any occasion on which a patient is subject to restraint, the registered person shall record the circumstances, including the nature of the restraint. These details should also be reported to the Regulation and Improvement Authority as soon as is practicable. **Ref: Follow up to previous inspection and Section 11.1 of the report.**	One	From date of inspection interim arrangements have been in place to minimise risk of harm for specified resident using lap belt. Southern Trust have provided documentation with regard to use of lap belts for specific residents. Mechanical restrictive intervention risk assessment	From date of inspection
4	20(1)(c)(i)	The registered manager must ensure that all nursing and care staff receive training in continence care and are deemed competent.	One	Training has been arranged for 21st and 28th January 2015. As you mentioned in main body	Completed by 28 February 2015

		As required to meet patients' needs, all nursing staff must receive training in male and female catheterisation and stoma care, Records of the training provided and staff competency assessments must be maintained. **Ref: Section 10 of the report**		of report catheter care training will be provided to staff if a resident requires the use of a catheter. All training records and staff competencies are maintained in company office.	

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	25.11	It is recommended that the audit process evidences all stages of the audit cycle as discussed. **Ref: Follow up to previous inspection**	Two	Audit process has been reviewed	From date of inspection
2	25.12	It is recommended that the report template in use is reviewed in accordance with template guidance issued by the RQIA**.** **Ref: Follow up to previous inspection**	One	Amendments have been made	Completed by 31 January 2015
3	25.13	It is recommended that the annual quality report is enhanced further to evidence the quality initiatives in the home. The report should incorporate achievements for the reporting year as well as improvements planned for the forthcoming year. The report should be made available in a suitable format to patients and their representatives. A system to share this information should be developed.	One	When completing next quality report we shall address your recommendations	When completing 2014 annual report,

		Ref: Follow up to previous inspection			
4	19.1	It is recommended that the patients' bowel type referencing the Bristol stool chart is consistently recorded.in individual patients' bowel assessments, care plans and daily progress records. **Ref: Section 10 of report**	One	All staff have been instructed to metion stool type as per Bristol stool Chart when they refer to a residents bowel motion	From date of inspection
5	26.6	It is recommended that the following specified policies and procedures must be reviewed and updated as required and ratified by the responsible individual: • Continence Care including bowel care • Policies and procedures in respect of stoma and catheter care • Policies and guidance information for • staff providing intimate care including continence management **Ref: Section 10.0 of report**	One	Currently in process of updating continence care policy	Completed by 31 January 2015
6	19.2	It is recommended that a resource file containing the following guideline documents is developed for staff and available for use on a daily basis. • RCN continence care guidelines • British Geriatrics Society Continence • Care in Residential and Nursing Homes • NICE guidelines on the management • of urinary incontinence	One	Currently being developed	Completed by 31 January 2015

		• NICE guidelines on the management • of faecal incontinence **Ref: Section 10.0 of report**			
7	19.4	It is recommended that the role of a continence link nurse is developed for the company and regular audits of management of incontinence are undertaken and the findings acted upon to enhance standards of care for patients. **Ref: Section 10.0 of report**	One	Have appointed a staff member to develop role of continence link, responsible for audits and acting upon the findings	Completed by 28 February 2015
8	17.10	It is recommended that RQIA are informed of the investigative outcome of one complaint as discussed. **Ref: Section 11.2 of report**	One	Upon conclusion of the complaint RQIA shall be informed of outcome	Upon conclusion of the compliant investigation.

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	James Digney
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	✓	Lorraine Wilson	21/01/15
Further information requested from provider	No		