The Regulation and Quality Improvement Authority

Inspection Report

16 September 2021

Kilbroney House

Type of Service: Nursing Home
Address: 83 Kilbroney Road,
Rostrevor, BT34 3BL
Tel no: 028 4173 8600

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

1.0 Service information

Organisation/Registered Provider: Mrs Jacqueline Ann Campbell **Responsible Individual:** Mrs Jacqueline Ann Campbell	**Registered Manager:** Mrs Jacqueline Ann Campbell **Date registered:** 1 April 2005
Person in charge at the time of inspection: Ms Pauline Campbell	**Number of registered places:** 19 There shall be a maximum of 4 patients in Category NH-DE, a maximum of 10 patients in category NH-MP/MP(E) and a maximum of 2 patients in category NH-PH/PH(E). The home is also approved to provide care on a day basis to 1 person.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 16
Brief description of the accommodation/how the service operates: This home is a two storey registered nursing home which provides nursing care for up to 19 patients. Patients have access to a communal lounge, dining room and garden spaces.	

2.0 Inspection summary

An unannounced inspection took place on 16 September 2021 from 9.20am to 5.00pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Patients were well presented in their appearance and spoke positively on living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients, relatives and the staff are included in the main body of this report.

An area for improvement was identified in relation to the record keeping on the use of restrictive practice in the home.

RQIA was assured that the delivery of care and service provided in Kilbroney House was safe, effective and compassionate and that the home was well led. Staff were knowledgeable about the patients in their care and care was delivered in a caring and compassionate manner.

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

3.0 How we inspect

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

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

The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Pauline Campbell, Nurse Manager, at the conclusion of the inspection.

4.0 What people told us about the service

Seven patients, five staff and two care partners were consulted during the inspection. Patients spoke positively on the care that they received and with their interactions with staff describing staff as 'easy to talk to' and 'brilliant.' Staff were confident that they worked well together and enjoyed working in the home and interacting with the patients.

Two care partners consulted were positive in their feedback on the care provision in the home. One described the care as 'brilliant' and the second commented on 'how accommodating the home was with relatives.'

5.0 The inspection

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

Areas for improvement from the last inspection on 30 December 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 27 (4) (a) **Stated:** First time	The registered person shall submit a copy of a current valid fire risk assessment to RQIA.	**Met**
	Action taken as confirmed during the inspection: The requested fire risk assessment had been submitted following the premises inspection.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. All staff were provided with a comprehensive induction programme to prepare them for working with the patients. Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics such as infection prevention and control (IPC), patient moving and handling and fire safety. A system was in place to ensure that staff completed their training. Staff were complimentary on the training provision in the home.

A matrix was maintained to ensure that all staff received an annual appraisal and at minimum two supervisions per year.

Staff confirmed that the staffing arrangements in the home, including the number and skill mix of staff on duty, were sufficient in meeting the needs of the patients. The staff duty rotas accurately reflected all of the staff working in the home on a daily basis. Staff said there was good teamwork in the home and that they supported one another.

Patients spoke highly on the care that they received and confirmed that staff attended to them when they needed them and that they would have no issues on raising any concerns that they may have to staff. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through these interactions that the staff and patients knew one another well and were comfortable in each other's company.

5.2.2 Care Delivery and Record Keeping

Staff confirmed that they met at the beginning of each shift to discuss any changes in the needs of the patients and that additional information was provided at this handover when staff had been away from the home for a period of time. Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering; discussing patients' care in a confidential manner and by offering personal care to patients discreetly. This was good practice. Staff were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. A record of repositioning had been maintained. There were no patients with any wounds in the home.

Falls in the home were monitored monthly to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring. The number of falls in the home was low.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, alarm mats and/or bed rails. One patient's care records, where a restrictive practice had been implemented, did not contain sufficient detail of when and where the practice was to be applied and with whom this had been discussed with before/after the decision to implement this practice was made. This was discussed with the manager and identified as an area for improvement.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. Staff assisted patients throughout the day with food and fluids in an unhurried manner. Records of patients' intake and outputs were recorded where this was required. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST). Appropriate referrals had been made to dieticians and speech and language therapists where this had been deemed necessary.

Patients' individual likes and preferences were reflected throughout the records. Daily records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

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

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated and suitably furnished. A quiet area had been identified on a landing in the home where patients could enjoy comfortable seating and watch fish swimming in a fish tank if they wished. Externally the grounds had been well maintained.

Systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients and staff.

All visitors to the home had a temperature check and symptom checks when they arrived at the home. They were also required to wear personal protective equipment (PPE). Visits were by appointment only.

Review of records, observation of practice and discussion with staff confirmed that effective training on IPC measures and the use of PPE had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. Staff use of PPE and hand hygiene was regularly monitored by the manager and infection prevention and control audits were conducted monthly. In addition, mattress audits were conducted monthly to ensure that these were maintained clean and safe for use.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested.

Records were maintained of daily activity provision in the home. There were regular outings from the home to a variety of places such as shopping, out for ice cream or out for a drive. Patients told us that they had enjoyed lunch the previous day in a restaurant in a neighbouring town. The activity provision included group activities and one to one activity for those who did not wish to or could not engage in the group activities. Activities included arts and crafts, bingo, music, reading, manicure and massage. A therapeutic room was available where patients could cook their own meals and/or launder their own clothes.

Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

Since the last care inspection the management arrangements in the home had not changed. Mrs Jacqueline Campbell has been the registered manager and responsible person for the home from 1 April 2005. Staff commented positively about the manager and described her as always approachable; always available and they felt that she would listen to them if they had any concerns. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. It was established that the manager had a system in place to monitor accidents and incidents that happened in the home.

Review of staff training records confirmed that all staff were required to complete adult safeguarding training on an annual basis. Staff told us they were confident about reporting any concerns about patients' safety. Staff were aware of who to report their concerns to. The nurse manager was the adult safeguarding champion in the home. The adult safeguarding champion is the person nominated in the home who has responsibility for implementing the regional protocol and the home's safeguarding policy.

The manager confirmed that there were no recent or ongoing concerns relating to the home. We discussed that any area of dissatisfaction from a patient or relative should be documented as a complaint. A compliments book was maintained. The manager confirmed that any learning from complaints or any compliments received would be shared with staff.

6.0 Conclusion

Patients spoke positively on living in the home and were presented well in their appearance. The staffing arrangements in were sufficient in meeting the needs of patients accommodated in the home. Staff had been recruited safely and trained well. The environment was warm, clean and comfortable for patients to live in. Patients had choice in how to spend their day. The quality of the care and service provision in the home was monitored by the manager through internal audit to ensure effectiveness in the care delivery.

Based on the inspection findings and discussions held we are satisfied that this service is providing safe and effective care in a caring and compassionate manner and that the service is well led by the manager.

7.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	0	1

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

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that when a restrictive practice is implemented, care records give specific detail of how and when the practice will be used and confirm the persons involved in the decision making process. Ref: 5.2.2
	Response by registered person detailing the actions taken: This Resident's care plan for Restrictive Practice was updated and all the MDT had been informed and had input into this. The Resident now does not require this Restrictive Practice and so the Care Plan has been discontinued. Any future Restrictive care Plans will be detailed and time specific with evidence of MDT input and Resident input

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