Inspection Report

18 & 24 July 2023

Kilbroney House

Type of service: Nursing
Address: 83 Kilbroney Road, Rostrevor, BT34 3BL
Telephone number: 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: Ms Jacqueline Ann Campbell **Registered Person:** Ms Jacqueline Ann Campbell	**Registered Manager:** Ms Jacqueline Ann Campbell **Date registered:** 1 April 2005
Person in charge at the time of inspection: 18 July 2023 - Ms Pauline Campbell 24 July 2023 - Ms Jacqueline Ann Campbell	Number of registered places: 18 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:** 18 July 2023 – 15 24 July 2023 - 16
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 18 patients. Patients' bedrooms are located over two floors in the home. Patients have access to communal lounge and dining areas and there are additional communal treatment rooms external to the home. Patients also have access to a well maintained garden area.	

2.0 Inspection summary

An unannounced medicines management inspection took place on 18 July 2023 from 9.50 am to 12.55 pm. This was completed by a pharmacist inspector. An unannounced care inspection took place on 24 July 2023 from 9.35 am to 5.00 pm. This was completed by a care inspector.

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

Review of medicines management found that mostly satisfactory arrangements were in place for the safe management of medicines. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were generally administered their medicines as prescribed. However, improvements in several areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include maintaining a controlled drugs record book, maintaining prescribing and administration records for thickeners and maintaining pain management care plans. Whilst areas for improvement were identified, it was concluded that overall, with one exception, the patients were being administered their medicines as prescribe.

Review of the care provided found that patients were well presented in their appearance and felt well looked after by the staff who were seen to treat them with respect and kindness. The atmosphere throughout the home was warm, welcoming and friendly.

Patients spoke in positive terms about their experience of 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.

It was observed that there enough staff on duty to attend to the needs of patients in a timely manner.

An area for improvement was identified regarding wound care recording.

RQIA were assured that the delivery of care and service provided in Kilbroney House was safe, effective, compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services in the home.

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.

Questionnaires 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 and how staff went about their work was observed.

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 the management team at the conclusion of the inspection.

4.0 What people told us about the service

Patients said there were enough staff to help them, they felt well looked after and the food was good. Comments made by patients included that “the girls are brilliant”, “the staff would do anything for you”, “the food is lovely”, “it’s a very nice place” and “I am happy to stay here”.

Staff said that they were satisfied with staffing levels and teamwork, felt well supported and enjoyed their job. Comments made by staff included that “it’s a great team, most staff are here long term and know the patients so well”, “staffing levels are good and teamwork is brilliant” and “teamwork is great, we all work together”.

A relative said that her experience of the home and the care provided had been very positive. The relative commented that “I have never found any issues here” and “staff are just lovely and treat relatives very well”.

A record of compliments received about the home was kept and shared with the staff team, this is good practice.

Comments made by patients, staff and a relative were brought to the attention of the management team for information.

RQIA did not receive any completed questionnaires or responses to the staff survey.

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 26/27 October 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement **Ref:** Regulation 15 **Stated:** First time	The registered person shall ensure that a holistic set of patients' risk assessments are completed within five days of admission. Risk assessments should inform the patients' care plans in order to direct the care required for the patient.	**Met**
	Action taken as confirmed during the inspection: Review of care records provided evidence that risk assessments were completed in a timely manner following admission to the home. This area for improvement was met.	
Area for Improvement 2 **Ref:** Regulation 32 (h) **Stated:** First time	The registered person shall ensure that RQIA receives a variation application, prior to the commencement of any work, for newly planned building projects on the site of the home.	**Met**
	Action taken as confirmed during the inspection: The variation application had been submitted and was approved. This area for improvement was met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 18 **Stated:** Second time	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.	**Met**

	Action taken as confirmed during the inspection: Review of care records provided evidence that this area for improvement was met.	
Area for Improvement 2 **Ref:** Standard 18 **Stated:** First time	The registered person shall ensure that all staff members have knowledge on what constitutes a restrictive practice.	**Met**
	Action taken as confirmed during the inspection: Review of training records confirmed that all staff had completed relevant training in this area. Staff demonstrated their knowledge of what constitutes a restrictive practice. This area for improvement was met.	
Area for Improvement 3 **Ref:** Standard 12 Criteria (4) **Stated:** First time	The registered person shall ensure that nutritional screening is conducted on a monthly basis or more often if required.	**Met**
	Action taken as confirmed during the inspection: Review of care records provided evidence that nutritional screening was completed on at least a monthly basis. This area for improvement was met.	
Area for Improvement 4 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure that domestic cleaning records in the home are maintained accurately and contemporaneously.	**Met**
	Action taken as confirmed during the inspection: Review of relevant records evidenced that this area for improvement was met.	
Area for improvement 5 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure that staff members remain bare below the elbow in accordance with good practice in hand washing.	**Met**
	Action taken as confirmed during the inspection: Staff were observed to be bare below the elbow in accordance with good practice guidance. This are for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect patients.

There were systems in place to ensure staff were trained and supported to do their job.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty.

There was a system in place to ensure that registered nurses, who take charge in the home in the absence of the manager, had completed relevant competency and capability assessments.

There was a system in place to monitor that staff were appropriately registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC).

Staff supervisions and annual appraisals were completed as per the schedules in place and relevant records were maintained.

Staff said that teamwork was very good and that they felt well trained to carry out their roles and responsibilities.

5.2.2 Care Delivery and Record Keeping

Staff said they met for a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff demonstrated their knowledge of individual patient's needs, preferred daily routines, likes and dislikes.

It was observed that staff respected patients' privacy and dignity; they knocked on doors before entering bedrooms and bathrooms and offered personal care to patients discreetly. Staff were seen to be responsive to requests for assistance.

Patients' needs were assessed at the time of their admission to the home and there was evidence that relevant risk assessments were completed within five days of admission. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and these included any advice or recommendations made by other healthcare professionals. There was evidence of consultation with patients and their relatives in the care records. Patients' care records were held confidentially.

It was established that systems were in place to manage and monitor restrictive practices in use for patients, for example, sensor mats and bedrails. Relevant care plans had been developed where a restrictive practice was in use. Staff displayed their knowledge and understanding of what constitutes a restrictive practice.

Care records for patients with mobilising difficulties included recommendations regarding pressure relieving equipment in use and the frequency of repositioning. Records of repositioning were maintained.

Where a patient was at risk of falling, measures to reduce this risk were in place. Relevant risk assessments and care plans had been developed. Review of care records evidenced that staff took appropriate action in the event of a patient having a fall.

It was positive to note that only one patient had a wound and there was evidence that the wound was redressed on a regular basis. However, a relevant care plan had not been developed regarding the wound; an area for improvement was identified.

Review of care records evidenced that risk assessments and care plans were regularly reviewed by staff. Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

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 from simple encouragement through to full assistance from staff.

It was positive to note that a 'mealtime champion' role had been developed in the home. This involved a designated staff member having oversight of the mealtime to help ensure that the 'safety pause' was observed and that patients were served the correct consistency of diet and their preferred choice of meal. The serving of lunch was well organised and unhurried. Staff were seen to assist patients with the level of support they required throughout the meal time.

There was a choice of meals on offer, the food was attractively presented, smelled appetising and was served in appropriate portion sizes. Patients were offered a variety of drinks with their meal.

Records were kept of what patients had to eat and drink daily. Staff told us how they were made aware of patients' nutritional needs to ensure they were provided with the right consistency of diet.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. There was also evidence that nutritional screening was conducted on at least a monthly basis.

Patients said they enjoyed their lunch and described the food as "lovely", "delicious" and "very nice".

5.2.3 Management of the Environment and Infection Prevention and Control

The home was observed to be well decorated, warm, clean, tidy and fresh smelling. Communal areas were welcoming spaces for patients to relax and interact with other patients if they wished. Patients' bedrooms were attractively personalised with items that were important to them, such as, family photos, ornaments and pictures. Fire exits and corridors were clear of clutter and obstruction.

A retrospective application for a new laundry had been submitted to RQIA and had been approved. It was established that no other changes to the building, which would require a variation to the home's registration, were in progress or planned.

Domestic cleaning records were contemporaneously maintained.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of personal protective equipment (PPE) had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was being regularly monitored and records were kept.

Patients were satisfied that the home was kept clean and tidy. A relative commented that the home was "immaculately clean and very comfortable".

5.2.4 Quality of Life for Patients

The atmosphere throughout the home was warm, welcoming and friendly. Discussion with patients confirmed that they were able to choose how they spent their day.

Patients were aware of the activities on offer and said it was their decision to join in or not. Group activities on offer included singing, bingo and games. The planned activity for the day was recorded on a whiteboard in the dining room.

Staff said that it was very important that patients were involved in all aspects of their own care planning and were empowered, where possible, to make decisions about how they would prefer to spend their day. Staff aimed to ensure that activities were positive, meaningful and beneficial for patients' well-being.

Discussion with staff and patients provided evidence that patients' opinions and views were taken into account when individual and group activities were being planned but patients had not recently been offered the opportunity to participate in a patients' meeting. This was brought to the attention of the manager for information and appropriate action.

Patients who chose were involved in the running of the home by helping out with minor maintenance and gardening tasks. Some patients enjoyed activities such as baking and cooking in the home's rehabilitation room. The garden was accessible and had plenty of pleasant seating areas for patients' enjoyment and comfort.

Staff arranged regular bus outings for patients to go out for lunch, shopping trips or just for a drive and a change of scenery. Patients also visited their families and staff assisted with transport arrangements where necessary.

Patients spoke very positively about the staff and their experience of life in the home. They said they felt listened to and that any concerns they might have were sorted out. Comments made by patients included that "(staff) definitely help us out and if we need anything they get it for us", "we get out and about, go for runs, go to see the animals" and "I like to win the bingo and love the shower gel you get as a prize".

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection; Ms Jacqueline Campbell remains as the Registered Manager and the Registered Person. Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

There was a system in place to manage complaints. The management team confirmed that the outcome of complaints was disseminated to staff and used for learning. Patients and a relative said that they knew how to report any concerns and were confident that staff would help them sort things out.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately.

As the Registered Provider was in day to day charge of the home in her manager capacity a monthly visit to consult with patients, their relatives and staff and to examine all areas of the running of the home was not required. However, there was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients in order to help drive improvement.

Staff spoke in very positive terms about the support provided by the management team, comments included that "the managers are just brilliant here, really supportive" and "we are kept well up to date with any changes".

5.2.6 Management of Medicines

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, one audit discrepancy was observed in the administration of a medicine. The discrepancy was discussed with management, who agreed to investigate it and submit a notification to RQIA. This notification was submitted to RQIA on 19 July 2023.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments. The personal medication records reviewed at the inspection were generally accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to state that they were accurate.

The records inspected showed that medicines were available for administration when patients required them.

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment. A sample of the medicines administration records was reviewed. Most of the records were found to have been fully and accurately completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipts, administrations and disposals of controlled drugs should be recorded in the controlled drug record book. However, whilst controlled drug stock reconciliation checks were recorded up to four times a day, a controlled drug record book was not being maintained. An area for improvement was identified.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct nurses on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient. The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed for three patients. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware of the factors that may be responsible. Records included the reason for and outcome of administration.

The management of pain was discussed. The nurse advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Pain assessments were regularly completed and recorded. However, for two of the three patients whose records were reviewed, pain management care plans were not in place. Pain management care plans should be maintained for all relevant patients. An area for improvement was identified.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient. The management of thickening agents was reviewed. A speech and language assessment report and care plan was in place. However, records of prescribing and administration, which included the recommended consistency level, were not maintained. An area for improvement was identified.

The management of clozapine was reviewed. Clozapine is a high risk medicine and safe systems must be in place to ensure that patients are administered the correct dose and arrangements are in place for regular blood monitoring. Review of the administration records and audits completed at the inspection identified satisfactory arrangements were in place for the management of clozapine.

The medicines storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice. The need for management to more comprehensively record the medicines management audit outcomes was discussed.

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that they staff are competent in managing medicines and that they are supported. There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

6.0 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 the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	2	2

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** Immediate action required (18 July 2023)	The registered person shall ensure that a controlled drug record book is maintained. The receipts, administrations and disposals of controlled drugs should be recorded in the controlled drug record book; Ref: 5.2.5
	Response by registered person detailing the actions taken: A new Control Drug book with all required sections is now in use.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** Immediate action required (18 July 2023)	The registered person shall ensure that records are maintained of the prescribing and administration of thickeners. Ref: 5.2.5
	Response by registered person detailing the actions taken: Prescribed thickeners are now on the Drug Kardex and administration of these recorded.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that care plans are developed to direct staff where patients have a wound. Ref: 5.2.2
	Response by registered person detailing the actions taken: This Resident now has a wound care paln.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Immediate action required (18 July 2023)	The registered person shall ensure that care plans are in place to direct staff when patients are prescribed medicines for chronic pain. Ref: 5.2.5
	Response by registered person detailing the actions taken: All care plans for PRN pain relief are now in place

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