Unannounced Care Inspection Report
10 February 2020

Corriewood Private Clinic

Type of Service: Residential Care Home
Address: Corriewood Private Clinic, 3 Station Road, Castlewellan BT31 9NF
Tel no: 0284377 8230
Inspector: Marie-Claire Quinn

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for

2.0 Profile of service

This is a registered residential care home which provides care for up to four residents living with a learning disability. Three residents live permanently in the home, with one place to provide temporary short term care to individuals who usually live with their families in the community.

3.0 Service details

Organisation/Registered Provider: Corriewood Private Clinic **Responsible Individuals:** Anne Monica Byrne Imelda McGrady	**Registered Manager and date registered:** Teresa Josephine McClean 1 April 2005
Person in charge at the time of inspection: Mary Hardy, senior care assistant supported by Catherine Lenaghan, deputy manager of Corriewood Nursing Home due to unexpected absence of the home's registered manager.	**Number of registered places:** 4
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 5 (one service user arrived early for their short term stay).

4.0 Inspection summary

An unannounced care inspection took place on 10 February 2020 from 10.30 hours to 13.25 hours.

The inspection 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.

Evidence of good practice was found in relation to the friendly and homely atmosphere and the delivery of person centred care.

Areas requiring improvement were identified in relation to the duty rota and care records for those residents staying in the home on a temporary basis.

Residents were happy, friendly and content. Residents unable to voice their opinions were seen to be relaxed and comfortable in their surroundings and in their interactions with staff and other residents.

Comments received from residents and staff during the inspection are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	4

Details of the Quality Improvement Plan (QIP) were discussed with Catherine Lenaghan, deputy manager and Maria Therese McGrady, registered provider for the organisation, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 1 April 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 1 April 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the findings from the previous care inspection and any other written or verbal information received, for example serious adverse incidents.

During our inspection we:

- where possible, speak with residents, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. No responses were received within the agreed timescale of two weeks after the inspection.

During the inspection a sample of records was examined which included:

- staff duty rotas from 5 January to 23 February 2020
- audit of staff's professional registration with the Northern Ireland Social Care Council (NISCC)
- staff supervision and annual appraisal schedule
- care records of one permanent resident
- care records of two temporary/respite residents

- complaint records
- a sample of governance audits/records including care plans and environmental audits
- food temperature records for January 2020
- weekly management reports for January - February 2020
- minutes of residents meetings dated 3 October 2019 and 13 January 2020
- minutes of staff meetings dated 3 October 2019 and 13 January 2020
- fire drills records dated 2 June and 1 November 2019
- accident/incident records from 1 July 2019 to 31 December 2019
- monthly monitoring reports dated 24 October 2019, 15 November 2019, 16 December 2019 and 21-24 January 2020
- annual management review dated 7 January 2020

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 1 April 2019

There were no areas for improvement made as a result of the last care inspection.

6.2 Inspection findings

6.2.1 Environment

The home was clean, warm and tidy.

Some communal areas required repainting; one wardrobe needed to be repainted or replaced and the lock on the kitchen door needed to be repaired. Correspondence with the home following the inspection confirmed that these areas had been addressed therefore an area for improvement was not required on this occasion.

6.2.2 Staffing

Discussion with staff and observation of practice established that there were sufficient staff on duty to meet the needs of residents. Staff records confirmed that staff were registered with NISCC.

An area for improvement was made in relation to the staff duty rota as this did not identify the person in charge of the home, or the hours worked by the registered manager.

6.2.3 Care delivery

Residents were attending a group activity on the morning of the inspection. We spoke with residents when they returned to the home for their lunchtime meal. The residents looked well cared for, and were friendly, chatty and enthusiastic about their time in the home. There were lovely, relaxed interactions between residents and staff including a singalong and Irish dancing.

Residents told us how they enjoyed spending their time including visits from family, making Valentine's Day cards and helping staff set the tables for meals. Residents happily told us about their plans for celebrating their birthday and enjoyed dancing and singing in the lounge.

6.2.4 Dining experience

We observed part of the lunch time meal; the food had been freshly prepared and was served hot. The table was set with cutlery and condiments. The weekly menu was on display, and discussion with staff and review of records confirmed that residents were involved in menu planning. Alternative meals and snacks were readily available.

Residents told us the food was lovely and they always got enough to eat. They were looking forward to a Chinese takeaway as a treat that evening.

6.2.5 Care records

We reviewed the care record for one permanent resident; this was holistic, person centred and well maintained.

There were several deficits identified when we reviewed two care records of residents staying in the home on a temporary basis. These records were disorganised, and although they contained a range of need and risk assessments, it was difficult to determine which were relevant. Care plans also required review to ensure they were accurate and up-to-date. Although there was a summary review of each period of respite, we noted some of these records did not contain sufficient detail on any incidents which may have occurred. Evidence of communication with relatives was not fully recorded, or in the appropriate records.

We discussed this with management who highlighted how staff had attempted to seek updated information from health and social care trusts; management agreed that these arrangements would need to be immediately reviewed to ensure they were sufficiently robust. Management agreed that the home must ensure they have accurate and up-to-date information before admitting any resident to the home.

Management have subsequently submitted an action plan to RQIA outlining how these concerns will be addressed and three areas for improvement have been stated under standards.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the friendly and homely atmosphere and the delivery of person centred care.

Areas for improvement

Three new areas for improvement were identified in relation to care records, specifically for those residents staying in the home on a temporary basis.

	Regulations	Standards
Total number of areas for improvement	0	4

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Catherine Lenaghan, deputy manager and Maria Therese McGrady, registered provider, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 25.6 **Stated:** First time **To be completed by:** 10 February 2020	A record is kept of staff working over a 24-hour period and the capacity in which they worked. Ref: 6.2.2
	Response by registered person detailing the actions taken: We have one member of staff working in the gate lodge at any one time. We now have in charge beside their name. We have also included the managers and deputy managers hours and who is on call.
Area for improvement 2 **Ref**: Standard 5 **Stated:** First time **To be completed by:** 10 May 2020	Each resident, including those staying in the home on a temporary basis, must have an up-to-date needs assessment. Ref: 6.2.5
	Response by registered person detailing the actions taken: All respite have had their assessments brought up to date.
Area for improvement 3 **Ref**: Standard 6 **Stated:** First/Second/Third time **To be completed by:** 10 May 2020	Each resident, including those staying in the home on a temporary basis, must have an up-to-date comprehensive care plan. Ref: 6.2.5
	Response by registered person detailing the actions taken: All respite residents using the home have had their comprehensive care plan brought up to date.
Area for improvement 4 **Ref**: Standard 8.5 **Stated:** First time **To be completed by:** 10 May 2020	Residents' care records must be accurate and up-to-date. Ref: 6.2.5
	Response by registered person detailing the actions taken: Contact was made with the Trust to furnish the staff with the accurate information to enable them to complete the care plan and maintain it to an acceptable standard. Staff are instructed to record all communications with families and trust personnel .

Please ensure this document is completed in full and returned via Web Portal

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