The Regulation and Quality Improvement Authority

Inspection Report

29 August 2024

Castleview

Type of service: Nursing Home
Address: 761 Antrim Road, Belfast, BT15 4EN
Telephone number: 028 9077 7804

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: Tona Enterprises Ltd **Responsible Individual:** Mr Robert Maxwell Duncan	**Registered Manager:** Mrs Jacqueline Felicitas **Date registered:** 1 April 2005
Person in charge at the time of inspection: Mrs Jacqueline Felicitas	**Number of registered places:** 35 Category NH-MP(E) for one identified individual only.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment MP(E) - mental disorder excluding learning disability or dementia – over 65 years PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 31
Brief description of the accommodation/how the service operates: This is a registered nursing home which provides nursing care for up to 35 patients. Patients have access to communal lounges, a dining room and a garden space.	

2.0 Inspection summary

An unannounced inspection took place on 29 August 2024 from 9.30am to 5.30pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and determined 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 when describing their experiences of living in the home. Comments received from patients, relatives and staff are included in the main body of this report.

The inspection found that there was safe, effective and compassionate care delivered in the home and the home was well led by the manager/management team.

Two areas for improvement were identified and details can be found in the Quality Improvement Plan (QIP) at the end of this report.

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.

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 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 the manager at the conclusion of the inspection.

4.0 What people told us about the service

Patients told us that they were happy living in the home and were offered choice in how they spent their day. One patient said, "It is excellent here. The staff, carers and managers are excellent. I am very happy here".

Staff told us that there were enough staff on duty to provide good care and that there were good working relationships between staff and the home's management team.

Relatives consulted spoke positively in regards to the care provision and complimented the staff in the home.

There were five questionnaire responses received from patients and relatives. All responses indicated satisfaction with the care and support received from staff and management. Comments included, 'Feel safe because the staff are gentle and kind' and 'Excellent service and always attentive to needs'. We received no responses from 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 7th September 23		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall ensure that personal medication records are accurate and up to date with the most recent prescription.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met.	
Area for improvement 2 **Ref:** Regulation 20 (1) (c) (ii) **Stated:** First time	The registered person shall ensure that staff maintain their registration requirements with NISCC to remain live on the register.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met.	
Area for improvement 3 **Ref:** Regulation 27 (2) (m) **Stated:** First time	The registered person shall ensure that patients have a lockable space in their bedrooms to lock any items they wish away.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met.	

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		Validation of compliance
Area for improvement 1 **Ref**: Standard 11 Criteria (5) **Stated:** Second time	The registered person shall review the provision of activities in the home to ensure that meaningful one to one engagements are facilitated with patients who cannot or do not wish to engage in group activities.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Patients raised no concerns in regards to the staffing arrangements in the home. The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked. Staff consulted were satisfied that the staffing levels met the patients' needs. However, given the number of patients in receipt of one to one care and the planned staffing levels at night, an area for improvement was identified to review these levels to ensure that the care delivery and supervision of patients was in accordance with their care plans throughout the night. Staff felt that they worked well together and that the teamwork was good. They shared comments, such as, "It's good at present; everyone works well together".

A comprehensive pre-determined list of pre-employment checks had been completed and verified prior to any new employee commencing work in the home. All newly employed staff completed an induction to become more familiar with the homes policies and procedures. A booklet was completed to record the topics of induction completed. A list of training was identified for completion as part of the induction process.

Staff had a suite of mandatory training topics to complete annually to maintain their knowledge and skills in order to provide safe and effective care. Training topics included person centred care, equality and diversity, patient moving and handling, adult safeguarding, deprivation of liberty safeguards and fire safety training. Systems were in place to ensure staff completed their training and to ensure that staff received, at minimum, two recorded supervisions and an appraisal each year to review their performance and, where appropriate, identify any training needs.

Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC).

Staff were observed to work well and communicate well with one another during the inspection. Staff utilised communication books to aid in the sharing of information. Care was delivered in a caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

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.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles. Handover sheets were available to staff containing the pertinent patient details.

Supplementary care records were recorded to capture the care provided to patients. This included any assistance with personal care, food and fluid intake and any checks made on patients. Nursing staff completed daily progress notes to evaluate the daily care delivery.

All patients had a pressure management risk assessment completed monthly. Where a risk of skin breakdown was identified; a care plan was developed to guide staff on how to manage this risk. Where patients required to be repositioned, records of repositioning had been maintained well.

Incident forms were completed by staff to record any accidents or incidents which occurred in the home. Falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented. Accident records evidenced that the appropriate actions had been taken following a fall in the home and the appropriate persons notified.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Patients were safely positioned for their meals and the mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Charts were recorded daily to record patients' fluid intake and reviewed at 2.00pm and at the end of the shift to ensure that patients were drinking adequate amounts to remain hydrated.

Medication administration records reviewed evidenced gaps in recording where it was not clear if the medicine had been administered, refused or not given for some other reason. This was discussed with the manager and identified as an area for improvement.

5.2.3 Management of the Environment and Infection Prevention and Control

The home's environment including a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms were reviewed. Patients' bedrooms were personalised with items important to them. Appropriate doors leading to rooms which contained hazards to patients had been locked. The home was warm, clean and comfortable. There were no malodours detected in the home.

It was evident that fire safety was important in the home. Staff had received training in fire safety and the manager confirmed fire safety checks including fire door checks and fire alarm checks were conducted regularly. Corridors in the home were free from clutter and obstruction as were the fire exits should patients have to be evacuated. Fire extinguishers were easily accessible.

Infection prevention and control audits and environmental audits were conducted monthly and contained action plans to address any deficits found. Additional audits were conducted to monitor staffs' hand hygiene practice and a tracker was in place to ensure that all staff were observed.

5.2.4 Quality of Life for Patients

Patients appeared comfortable and settled in their environment. There was a pleasant atmosphere throughout the home. It was observed that staff provided care in a caring and compassionate manner. It was clear through patient and staff interactions that they knew one another well and were comfortable in each other's company.

Patients confirmed that activities took place in the home. An activities planner was available for review. Activities included board games, exercises, sing-a-longs, arts and crafts, sensory activities, bingo, pamper sessions and games. Activities were conducted on a group basis or one to one where this was the patient's preference. Daily activity logs were recorded to evidence the activity engaged in and who took part. Each patient had their own activity care plan identifying their likes and interests.

Patients spoken with told us they enjoyed living in the home and that staff were friendly. One patient told us, "I am very happy here. Staff are very good. I pick my lunch and dinner each morning. Activities go on in the room downstairs every day". Another patient told us, "I am very very happy here. Staff are lovely to me".

Relatives were equally satisfied with the care provision in the home. One told us, "The care is excellent. Xxx is very happy here. We are always made to feel welcome when we come in. We are very happy with the staff".

Visiting was open for relatives to attend when they wished and patients were free to leave the home with family members if they wished.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been no change to the management arrangements. Mrs Jacqueline Felicitas has been the registered manager of the home since 1 April 2005. Discussion with the manager and staff confirmed that there were good working relationships between staff and the manager. Staff told us that they found the manager to be 'approachable', and would 'listen to any concerns'.

In the absence of the manager, a nominated registered nurse would take charge of the home. Nurses first completed a competency and capability assessment on taking charge of the home prior to commencing this role.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff had a good understanding of the home's organisational structure should they need to escalate their concern and were aware of the departmental authorities that they could contact should they need to escalate further.

The manager confirmed their own internal governance practices in order to monitor the quality of care and other services provided to patients. Audits were conducted on, for example, patients' care records, restrictive practice, wound care, medicines management, staff training and the environment.

The home was visited each month by the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed and completed reports were available for review by patients, their representatives, the Trust and RQIA.

A complaint's file was maintained and records kept to include the nature of any complaint and any actions taken in response to the complaint. The number of complaints made to the home was low. Any compliment's received were also kept on file and shared with staff. Comments cards were left at reception and visitors to the home were encouraged to complete these to share their views on the service provision.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Jacqueline Felicitas, Registered 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 (December 2022)	
Area for improvement 1 **Ref:** Standard 41.1 **Stated:** First time **To be completed by:** 14 September 2024	The registered person shall review the staffing arrangements, especially night staffing, to ensure that at all times patients' assessed needs are met. Ref: 5.2.1
	Response by registered person detailing the actions taken: An additional member of staff has been provided by the agency to provide adequate cover during break times for agency staff providing one to one services, during the day and

	night shifts. This will ensure that the Homes staff are not required to provide cover for agency during agency break times. The home will continue to monitor this because as the number of one to one residents in the home fluctuates.
Area for improvement 2 **Ref:** Standard 29.2 **Stated:** First time **To be completed by:** With immediate effect (29 August 2024)	The registered person shall ensure that medicines' administration records are completed in full and contain no gaps in recording. Ref: 5.2.2
	Response by registered person detailing the actions taken: This improvement was highlighted with the Homes nurses with immediate effect during the hand over on the 29/8/24. Supervision with all nurses took place on the 5/9/2024 during which standards for medicines were discussed and reviewed and the importance of keeping accurate and up to date records was discussed, including documenting and signing any reason for refusal, with no gaps in recording. This is being monitored on a daily basis.

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The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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