Unannounced Care Inspection Report
28 November 2018

Cairnmartin

Type of Service: Nursing Home (NH)
Address: 250 Ballygomartin Road, Belfast, BT13 3NG
Tel No: 028 9072 2050
Inspector: Sharon McKnight

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 62 persons. At the time of this inspection 31 patients were accommodated.

3.0 Service details

Organisation/Registered Provider: Amore Elderly Care Limited **Responsible Individual** Mrs Nicola Cooper	**Registered Manager:** Mrs Fiona Archer
Person in charge at the time of inspection: Mrs Fiona Archer	**Date manager registered:** 10 August 2018
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 62 A maximum of 31 patients in categories NH-I and NH-PH(E) and a maximum of 31 patients in category NH-DE. Category NH-PH for 2 identified patients only.

4.0 Inspection summary

An unannounced inspection took place on 28 November 2018 from 10:00 to 16:15.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and 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.

Evidence of good practice was found in relation to staffing, risk management and the home's environment. There were examples of good practice found in relation to the assessment of patient need and care planning and the communication of patient need between staff. Good practice was evident in relation to supporting patient dignity and privacy and the provision of activities. There were examples of good practice found throughout the inspection in relation to governance arrangements and the management of complaints and incidents.

An area for improvement was identified in relation to the management of odours in two identified bedrooms.

Patients said they were happy in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	*2

*The total number of areas for improvement include one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Fiona Archer, registered manager, 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 14 June 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 14 June 2018. 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

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with four patients individually and with others in small groups, two patients' relatives and nine staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

A poster informing visitors to the home that an inspection was being conducted was displayed on the entrance door to the home.

The following records were examined during the inspection:

- duty rota for nursing and care staff from 29 October – 25 November 2018
- incident and accident records
- four patient care records
- two patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints records

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 14 June 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 14 June 2018

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref: Regulation 12(1) (b)

Stated: Second time</td><td>The registered person shall ensure that patients are monitored for signs of pressure ulcers.

Accurate records must be maintained of patients’ skin condition when being assisted to reposition.</td><td rowspan="2">Met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:
A review of two patients repositioning charts evidenced that this area for improvement has been met.</td></tr>
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Area for improvement 2 **Ref**: Regulation 14(2((c) **Stated:** First time	The registered person shall ensure that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated. Following near misses, accident and/or incidents individual risk assessments and care plans must be completed. The identified risk and actions taken to minimise the risk of a reoccurrence must communicated to staff.	**Met**
	Action taken as confirmed during the inspection: A review of two patients care records evidenced that this area for improvement has been met.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 38 **Stated:** First time	The registered person shall ensure that records are maintained to evidence that AccessNI checks are received and reviewed prior to staff commencing work.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that AccessNI checks were received and reviewed prior to staff commencing work. This area for improvement has been met.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that all care records contain the date they are completed.	**Met**
	Action taken as confirmed during the inspection: Records reviewed evidenced that significant improvements had been made with the completion of care records to include the date they were completed. This area for improvement has been met.	

Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that care plans are updated when dressing regimes change. Care plans should include the frequency with which wounds are required to be redressed.	**Met**
	Action taken as confirmed during the inspection: A review of two care records evidenced that this area for improvement has been met.	
Area for improvement 4 **Ref**: Standard 4.9 **Stated:** First time	The registered person shall ensure that body maps accurately reflect the patients' skin condition. When new body maps are completed previous documents should be discontinued.	**Not met**
	Action taken as confirmed during the inspection: We reviewed completed body maps for two patients; the records did not accurately reflect the patients' skin condition. This area for improvement has not been met and is stated for a second time.	
Area for improvement 5 **Ref**: Standard 35 **Stated:** First time	The registered person shall review the systems for communicating patient need to ensure they are effective.	**Met**
	Action taken as confirmed during the inspection: Staff spoken with confirmed that they receive a handover report at the commencement of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted. Staff spoken with were knowledgeable of patients' needs, likes and dislikes. This area for improvement has been met.	
Area for improvement 6 **Ref**: Standard 35.6 **Stated:** First time	The registered person shall ensure that systems previously in place to provide management with an overview of all of the wounds in the home, and compliance with care are reinstated.	**Met**

	Action taken as confirmed during the inspection: A review of audit records and discussion with the registered manager evidenced that this area for improvement has been met.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed the planned daily staffing levels for the home and explained that due to the proposed changes to the registration of the home staffing levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from the period 29 October – 25 November 2018 evidenced that the planned staffing levels were adhered to. Staff confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner. Staff spoken with were of the opinion that when the planned staffing was provided there were sufficient staff to meet the needs of the patients. These comments were with regard to short term absence. The registered manager confirmed that systems were in place to manage short term absence. These systems included return to work interviews and review meetings with management.

We spoke with the relatives of two patients, no issues were raised with regard to staffing. Questionnaires were provided for relatives; three were received within the timescale for inclusion in this report. All of the respondents were very satisfied with staffing.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

We reviewed accidents/incidents records completed in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example bed rails, alarm mats. There was also evidence of consultation with relevant persons. Care plans were in place for the management of bedrails and alarm mats.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Fire exits and corridors were observed to be clear of clutter and obstruction. The home was found to be warm, well decorated, clean and, with exception of two bedrooms, fresh smelling. We discussed the management of odours in two identified bedrooms and an area for improvement was made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, risk management and the home's environment.

Areas for improvement

An area for improvement was identified in relation to the management of odours in two identified bedrooms.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of four patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient. Care records contained details of the specific care requirements and a daily record was maintained to evidence the delivery of care. Interventions prescribed were individualised and care records were reviewed regularly.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), SALT and dieticians. Supplementary care charts such as food and fluid intake records evidenced that contemporaneous records were maintained. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), the speech and language therapist (SALT) or the dietician changed.

A review of accidents/incidents records evidenced that patients were appropriately monitored following falls and that medical advice was sought as required.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. As previously discussed staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and that this handover provided information regarding each patient's condition and any changes noted.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to assessment of patient need and care planning and the communication of patient needs between staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home 10:00 and were greeted by staff who were helpful and attentive. Patients were enjoying breakfast in the dining room, in the lounge or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Staff provided a detailed knowledge of patients' wishes, preferences and assessed needs.

We reviewed the provision of activities in the home and were informed that the activity co-ordinator had been temporarily redeployed to another role within the home. We talked at length with the activity co-ordinator who explained the measures in place to ensure the patients continue to avail of meaningful activities. The activity co-ordinator explained that she continued to plan the weekly activity programme and that an identified care assistant had been rostered to undertake the role of the activity co-ordinator on a number of shifts throughout the week. Numerous activities were arranged for the Christmas period, including visits from local schools and choirs, Christmas dinner and a Christmas fair. Arrangements were also in place to meet patients' social, religious and spiritual needs within the home.

We spoke with four patients individually, and with others in smaller groups. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

We spoke with the relatives of two patients who commented positively regarding the care their loved one was receiving.

As previously discussed questionnaires were provided for relatives; three completed questionnaires were received from relatives. All of the relatives replied that they were very satisfied with the care delivered across the four domains.

We spoke with nine member of staff. Staff were generally happy working in the home and were satisfied with the standard of care delivery. Staff were asked to complete an on line survey, we had no responses within the timescale specified.

Any comments from relatives and staff in returned questionnaires received after this report is issued will be shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the dignity and privacy of patients and the provision of activities. ,

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff and relatives evidenced that the registered manager's working patterns provided opportunities to meet with them, if required. Staff confirmed that the registered manager worked a variety of hours and was often in the home for the morning handover report from night staff to day staff.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the registered manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, wound care, infection prevention and control practices (ICP) and handwashing.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and the management of complaints and accidents.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Fiona Archer, registered manager, 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 nursing 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 Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 4.9 **Stated:** Second time **To be completed by:** 26 December 2018	The registered person shall ensure that body maps accurately reflect the patients' skin condition. When new body maps are completed previous documents should be discontinued. Ref: Section 6.2
	Response by registered person detailing the actions taken: The use of body mapping processes has been reviewed and all Nursing staff updated. All resident records have been reviewed and files updated in line with Priory documentation procedures. Procedures are on display in the nurses station and a monitoring tool is in place. Monthly auditing of each care record including residents body map documentation and assess that records are reflective of resident asessments, care needs, events/incidents and follow up care and assessment. The home manager continues to review compliance with completion of body maps.
Area for improvement 2 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 26 December 2018	The registered person shall ensure that the management of odours in the identified bedrooms is reviewed and necessary action taken to eliminate the malodour. Ref: Section 6.3
	Response by registered person detailing the actions taken: Addressed on the day of inspection. Any lingering issue of smell is reported to the house keeping team and appropriate action taken in a timely manner. All concerns of cleanliness or odours are also highlighted by the team at daily staff/ flash meetings with the home manager. Environmental audits are completed on a regular basis using the Priory Environment Quality tools. Evidence of same is retained and is reviewed by Management Daily walkarounds by the home manager/ or designate also check the environemnt, including sampling residents rooms. These checks are not time specific and occurred randomly through the day. Cleaning schedules exist, and timetables are adaptable to meet residents needs. A resident of the day process incorporate a full deep clean as a minimum standard each month (or when needed), in addition to daily cleaning activities. Records are reviewed by Head House Keeper and checked by Home Manager.

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

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