Announced Care Inspection Report
30 April 2020

Glenabbey Manor

Type of Service: Residential Home
Address: 93-97 Church Road, Glengormley, Newtownabbey BT36 6HG
Tel No: 028 9084 3602
Inspector: Gillian Dowds

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 residential home registered to provide residential care for up to 76 persons.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Gavin O'Hare-Connolly	**Registered Manager and date registered:** Carol Shields Registration Pending
Person in charge at the time of inspection: Liza Lorimer - Deputy Manager	**Number of registered places:** 76
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia	**Number of patients accommodated in the nursing home on the day of this inspection:** 50

4.0 Inspection summary

An inspection took place on 30 April 2020 from 13.40 to 18.30 hours. Short notice of the inspection was provided to the management on the day in order to ensure that arrangements could be made to safely facilitate the visit during the ongoing outbreak of coronavirus (Covid-19) within the home.

During the coronavirus (Covid-19) pandemic the Department of Health (DoH) directed RQIA to continue to respond to ongoing areas of risk identified in care homes. Due to the ongoing concerns identified as a result of daily data returns to RQIA, discussions with management, the protracted nature of the outbreak and the level of support required from the local Trust to the service, RQIA decided to undertake and inspection to this home.

Prior to the inspection we had been in regular contact with the home's management to provide support and advice. We were aware that a number of residents and staff had tested positive for Covid-19. Representatives from the Northern Health and Social Care Trust (NHSCT) had visited the home to assess how staff were managing the outbreak and to determine if additional support or resources were required. The NHSCT had provided additional support with staffing, supplies of personal protective equipment (PPE) and input from district nursing and the acute care at home team.

During the inspection we spoke to the deputy manager to determine how the outbreak was being managed with emphasis on the following areas:

- staffing
- care provided
- infection prevention and control measures
- the home's environment

4.0 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2*

This inspection resulted in no new areas for improvement being identified. Two areas for improvement from the previous care inspection were not reviewed as part of this inspection and are carried forward to the next care inspection.

Findings of the inspection were discussed with Liza Lorimer, Deputy Manager and Gavin O'Hare Connolly, Responsible Individual, as part of the inspection process and can be found in the main body of the report.

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
- the registration status of the home
- written and verbal communication received regarding the Covid-19 related concerns
- the previous care inspection report

The following records were examined during the service support visit:

- a selection of food and fluid intake charts
- a selection of weight monitoring charts
- the staff duty rota from 19 April 2020 to 2 May 2020

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

Areas for improvement identified at the last care inspection were not reviewed as part of this inspection and are carried forward to the next care inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 28 October 2019.

Two areas for improvement from the previous inspection were not reviewed and were carried forward to the next care inspection.

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 28.7 **Stated:** First time	The registered person shall ensure that there is a system in place to provide staff with gloves, aprons and hand sanitiser to prevent risk of harm, injury or infection to themselves or others.	**Met**
	Action taken as confirmed during the inspection: Supply of gloves, aprons and hand sanitiser was provided and available for staff.	
Area for improvement 2 **Ref**: Standard 17.1 **Stated:** First time	The registered person shall ensure that all complaints are fully documented in line with the company's policies and procedures and best practice.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	
Area for improvement 3 **Ref**: Standard 25.8 **Stated:** First time	The registered person shall ensure that an agenda is prepared for each staff meeting and a system is put in place for the minutes of staff meetings to be shared with those staff who are not present.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	

6.2 Inspection findings

Staffing

During our inspection we discussed staffing levels and were informed that a substantial number of staff employed by the home was off due to Covid-19, but every effort was made to cover shifts to ensure the assessed needs of residents were met. The deputy manager told us that the home's own staff had been extremely helpful and were prepared to work additional shifts, when able. NHSCT continued to provide staff and agency staff were also used. The acute care at home team provided nursing support in the evenings and additional support was provided at

nights by Marie Curie nurses. The district nursing team was also assisting the home to ensure residents' increased needs and palliative care needs were met effectively.

We observed that staffing levels consisted of a mix of the home's own staff, NHSCT staff and agency staff. The staff we spoke with told us how Trust staff had supported them to meet the changing needs of the residents. Staff spoken with were knowledgeable about the current needs of the residents.

During our inspection staff were observed to be responsive to the needs of residents. The deputy manager and staff all commented positively about team work within the home, wanting to do their best for the residents and the support from the staff from the NHSCT.

Staff told us that they felt well supported by the manager and deputy manager. Staff discussed the increased dependency needs of the residents; they were of the opinion that the staffing levels had not been increased proportionately to meet this need. This was discussed with Gavin O'Hare Connolly, Responsible Individual, who was present at the inspection.

Following the inspection a meeting was held between Gavin O'Hare-Connolly, Responsible Individual and RQIA senior management on 1 May 2020. The purpose of the meeting was to provide high level feedback to Mr O'Hare-Connolly on the outcome of the inspection and seek assurances that the care needs of residents were being appropriately met during the outbreak.

Mr O'Hare-Connolly confirmed governance arrangements for the home which included interim management arrangements to support the home and the Trust staff working there to ensure continuity of care. Issues in relation to the dependency of residents were discussed and again advice was given in the context of the coronavirus outbreak and medical and nursing support being provided by the local Trust.

Care delivery

Residents were supported by staff to attend to their personal appearance and they looked well cared for. They were content and settled in their surroundings and in their interactions with staff. Those residents who were able to have a chat with us told us that they were well looked after and had plenty to eat and drink.

We observed that residents who were being cared for in bed also appeared to be comfortable and settled. Staff were observed assisting these residents with drinks, chatting with them and ensuring their comfort. Staff were observed reassuring residents and tending to their needs as required.

The deputy manager told us that in order to ensure residents' nutritional needs were met effectively and safely, a member of staff was allocated to encourage fluids with the residents. Staff from the NHSCT were supporting the home with this; records were maintained of residents' daily food and fluid intakes as required. Staff recognised the importance of ensuring that residents had adequate daily food and fluid intake.

We reviewed the management of weights in the home; there was a system in place for the weights to be monitored. The weights had not been consistently recorded during the period of the outbreak. Staff explained that weights were usually monitored more regularly. Staff were knowledgeable of what to do if a resident had lost weight. For one resident who had weight loss, arrangements had been made for appropriate dietary supplements to be provided.

The deputy manager told us that visits from families had been suspended prior to the outbreak but maintaining effective communication remained paramount. Through support from social workers from the NHSCT, families were provided with regular updates via telephone calls and video calls.

Personal Protective Equipment (PPE)

We observed that there was a ready supply of PPE at the entrance to the home. Signage had been placed at the entrance which provided advice and information about Covid-19. PPE stations were well stocked throughout the home; the deputy manager told us that there was no issue with stock. There were sufficient handwashing facilities and hand sanitisers throughout the home.

We ensured that we donned and doffed PPE appropriately during the visit to the home and carried out hand hygiene at appropriate times.

Staff were observed to use PPE appropriately during our visit and told us that they had received training in the correct method of donning and doffing of PPE and infection prevention and control (IPC) measures.

The deputy manager told us that the NHSCT was providing the home with adequate supplies of PPE and that observations of staff confirmed that they were being compliant with the required usage of PPE, hand hygiene and IPC measures.

Residents appeared to be accepting of the need for staff to wear masks and were not alarmed by the usage. Staff advised they explained the need for the use of PPE to those residents who might not understand this.

The environment

During our visit we looked at a variety of areas including bedrooms, lounges and bathrooms; we observed that the home was clean and tidy throughout. The deputy manager told us that additional domestic staff had been provided by the NHSCT and that a full schedule of cleaning and deep cleaning was maintained within the home.

Residents who had Covid-19 were being cared for as far as possible in isolation within their own rooms. Residents' bedrooms were observed to be personalised, clean and tidy.

Enhanced measures had been put in place to minimise the risk of the spread of infection. This included additional cleaning, and isolating residents in their rooms as far as possible. The home cares for residents within a variety of categories of care, including dementia, and this can make effective isolation more difficult as residents might not understand the need for isolation. Some residents were up and about in one of the lounges, but staff monitored these residents and encouraged social distancing as far as possible.

The atmosphere in the home was calm. Residents who were in their rooms had music playing or televisions on. We observed one member of the NHSCT staff who came to the home to play music for a resident.

Areas of good practice

We noted good practice in relation to the supply of PPE, availability of handwashing facilities and the positive interactions between staff and residents.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.3 Conclusion

On the day of the inspection we observed that staffing levels were being maintained by staff from the home and staff supplied by the NHSCT. The deputy manager acknowledged that staffing issues had been a major issue as a result of the Covid-19 outbreak; she had alerted all relevant bodies to this issue immediately and had worked with the NHSCT to ensure shifts were covered.

We observed that residents were well looked after, staff treated them with kindness, care and compassion. Staff took time to ensure residents' needs were met.

The current guidelines on the use of PPE and IPC measures to be employed during an outbreak of Covid-19 were being followed within the home.

The findings of the inspection were provided to Gavin O'Hare-Connolly during the visit and Liza Lorimer, Deputy Manager, at the conclusion of the visit.

Following the visit a teleconference meeting was held with Gavin O'Hare Connolly, Responsible Individual, and senior management within RQIA to discuss the outcome of the visit in greater detail.

7.0 Quality improvement plan

No new areas for improvement were identified during this inspection. Two areas for improvement from the previous care inspection have been carried forward to the next inspection.

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 17.1 **Stated:** First time	The registered person shall ensure that all complaints are fully documented in line with the company's policies and procedures and best practice. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**	**Carried forward to the next care inspection**
Area for improvement 2 **Ref**: Standard 25.8 **Stated:** First time	The registered person shall ensure that an agenda is prepared for each staff meeting and a system is put in place for the minutes of staff meetings to be shared with those staff who are not present. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**	**Carried forward to the next care inspection**

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