Unannounced Care Inspection Report
16 February 2017

The Graan Abbey

Type of Service: Nursing Home
Address: Derrygonnelly Road, Enniskillen, Bt74 5PB
Tel no: 028 6632 7000
Inspector: Bridget Dougan

1.0 Summary

An unannounced inspection of The Graan Abbey took place on 16 February 2017 from 11.30 to15.30 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The focus of the inspection was meals, mealtimes and nutrition.

Is care safe?

There was evidence of competent and safe delivery of care on the day of inspection. Patients, relatives and staff expressed no concerns regarding staffing levels. Staff were required to attend mandatory and other training relevant to their roles and responsibilities. One recommendation has been made in respect of staff training.

Is care effective?

Care records reflected the assessed needs of patients' were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate.

Each staff member understood their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager.

There were no requirements or recommendations made.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients were given a choice in regards to food and fluid choices and the level of help and support requested.

Patients and relatives were complimentary regarding the care they received and life in the home.

There were no requirements or recommendations made.

Is the service well led?

Systems were in place to monitor and report on the quality of nursing and other services provided. Complaints were managed in accordance with legislation. One recommendation has been made in respect of the management of incidents and accidents.

Throughout the report the term “patients” is used to describe those living in The Graan Abbey Nursing Home which also provides residential care.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Pamela Fee, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 13 February 2017. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI’s), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Carewell Homes Ltd/Mrs Carol Kelly	**Registered manager:** Ms Pamela Fee
Person in charge of the home at the time of inspection: Ms. Pamela Fee	**Date manager registered:** 21 September 2016
Categories of care: RC-DE, RC-A, NH-PH, NH-MP, NH-MP(E), NH-LD, NH-I, RC-I, RC-PH, NH-DE, RC-MP, RC-MP(E)	**Number of registered places:** 86

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection we met with 30 patients, three registered nurses, six care staff, two catering and one domestic staff.

Six questionnaires were also issued to patients, staff, and relatives. Refer to section 4.5.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- accident and incident records
- notifiable events records
- complaints and compliments records
- sample of audits
- policy on meals and mealtimes.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 13 February 2017

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector. This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

4.2 Review of recommendations from the last care inspection dated 23 May 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 6.14 **Stated:** First time **To be completed by:** 23 June 2016	The registered person should ensure that patients personal care needs are regularly assessed and met to include (but is not limited to) grooming needs. Records should be completed to evidence care delivered or not delivered. **Ref: Section 4.5**	**Met**
	Action taken as confirmed during the inspection: Review of three patients care records evidenced that patients' personal care needs had been assessed and met. There were no concerns raised by patients or their representatives regarding the personal care afforded to patients by staff.	
Recommendation 2 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 23 June 2016	The registered person should ensure that details of information obtained from Access NI Disclosure applications should be handled as per Access NI guidelines. **Ref: Section 4.3**	**Met**
	Action taken as confirmed during the inspection: Review of three personnel files evidenced that enhanced criminal records checks were completed with Access NI and the reference number and date received had been recorded.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing roster for weeks commencing 30 January and 06 February 2017 evidenced that the planned staffing levels were adhered to. Feedback from questionnaires and discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing levels.

Review of the training records evidenced that food hygiene training had been provided for all relevant staff in 2016. Training in the management of patients with swallowing difficulties had also been provided in September 2016. This training had been attended by five nursing and

care staff. It is recommended that training in the management of swallowing difficulties is provided for all relevant staff.

Staff consulted with and observation of care delivery and interactions with patients, clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice.

A nutritional policy was in place and there was a system to ensure all relevant staff had read and understood the policy. Up to date nutritional guidelines were available and used by staff on a daily basis.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, fresh smelling and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction and equipment was appropriately stored.

Areas for improvement

One recommendation has been made in respect of staff training.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required.

There was evidence that care had been assessed, planned, evaluated and reviewed in accordance with NMC guidelines. Risk assessments informed the care planning process.

Care records reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

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 their line manager and /or the registered manager.

Patients and their representatives expressed their confidence in raising concerns with the home's staff/management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Observation of the lunch time meal confirmed that patients were given a choice in regards to, food and fluid choices and the level of help and support requested. The majority of patients chose to come to the dining rooms where the tables were nicely presented with cutlery, crockery and a choice of condiments. Those patients who choose to remain in their bedroom were served their meals on trays set with condiments; the meals were covered prior to leaving the kitchen. A record was maintained for all patients to reflect their food and fluid intake at each mealtime. A discussion with catering staff demonstrated that they were knowledgeable regarding the patients dietary needs. This included; patients who required modified diets; diabetic diets and food fortification. The daily menu was displayed in the dining rooms and offered patients a choice of two meals for lunch and dinner. All the meals looked and smelt attractive and appealing and patients appeared to enjoy their lunch.

Where patients required assistance with meals, staff were observed to offer patients reassurance and assistance in a discreet, unhurried and sensitive manner.

Patients spoken with were complimentary regarding the care they received and life in the home. Those patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process, we issued questionnaires to staff, patients and patients' representatives. Five staff, five patients and three relatives completed and returned questionnaires within the required time frame. Some comments are detailed below.

Staff

- "I have been here a long time. I enjoy working here"
- "I love it here. I have no concerns. Our residents are very well cared for"
- "we get plenty of training"

Relatives

- "excellent care"
- "we are kept up to date with all changes in medications and any issues are dealt with compassion"

- "we are made to feel welcome when we arrive. Tea is offered on arrival"
- "Dad is very well cared for. Spotlessly clean"

Patients indicated that they were either "very satisfied" and/or "satisfied" that the care was safe, effective and compassionate and the home was well led. No additional written comments were received.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities.

The registration certificate was displayed in the entrance lobby. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager and review of the home's complaints record evidenced 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. Representatives spoken with and who responded by questionnaire, confirmed that they were aware of the home's complaints procedure. Staff and representatives confirmed that they were confident that staff and management would manage any concern raised by them appropriately.

Discussion with the registered manager and review of records evidenced that generally systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. A number of accidents requiring medical intervention had not been notified to RQIA. A recommendation has been made accordingly.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Areas for improvement

One recommendation has been made in respect of the management of notifiable events.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Pamela Fee, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 12.9 **Stated:** First time **To be completed by:** 30 April 2017	The registered provider should ensure that all relevant staff receives updated training in the management of feeding techniques for patients who have swallowing difficulties. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Training has now taken place in the Management of Feeding techniques for patients who have swallowing difficulties. Speech and Language Therapist with the Trust provided training on 27/3/17. Diana Dihmus from Fresenius Kabi, is due to provide training re: safe use of thickening agents. (Date to be confirmed) Notices are up within the Home to advise staff of Dysphagia Awareness training on Monday 8/5/17 in Lecture Theatre SWAH.
Recommendation 2 **Ref:** Standard 35.9 **Stated:** First time **To be completed by:** 17 February 2017	The registered provider should ensure that all accidents and incidents occurring in the home are reported to RQIA and other relevant organisations in accordance with legislation and procedures and a record is maintained. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Management is now clear that all accidents requiring medical intervention should be notified to RQIA and other relevant orgaqnisations. Registered nurses have been adviced to keep manager informed. Registered manager will keep accident and incident books uner review to ensure that RQIA are notified as appropriate.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address*

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