



The Regulation and  
Quality Improvement  
Authority

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**Unannounced Care Inspection  
of  
The Graan Abbey**

**29 September 2015**

The Regulation and Quality Improvement Authority  
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## 1. Summary of Inspection

An unannounced care inspection took place on 29 September 2015 from 09.45 to 16.30 hours. The focus of this inspection was to determine what progress had been made in addressing the requirements and recommendations made during the previous care inspection on 04 June 2015, to re-assess the homes level of compliance with legislative requirements and the DHSSPS Minimum Standards for Nursing Homes and to determine if the safety of patients could be assured. The areas for improvement and compliance with regulation were in relation to:

- clinical leadership and the robustness of governance arrangements
- the care needs of patients
- issues pertaining to infection prevention and control
- the management of staff records
- staff training
- staff induction, supervision and appraisal.

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to section 5.3.

For the purposes of this report, the term 'patients' will be used to describe those living in The Graan Abbey which provides both nursing and residential care.

### 1.1 Actions/Enforcement Taken Following the Last Care Inspection

Following an unannounced care inspection on 04 June 2015, RQIA senior management held a serious concerns meeting with the responsible person and the manager of The Graan Abbey Nursing Home on 16 June 2015 with the intention of issuing a Failure to Comply Notice. Mrs Carol Kelly, responsible person and Mrs Martina McGuinness, manager attended the meeting and one Failure to Comply Notice was issued under Regulation 14 (5) of The Nursing Homes Regulations (Northern Ireland) 2005 (in respect of restrictive practices).

An enforcement compliance inspection took place on 18 August 2015. Evidence was available to validate full compliance with the Failure to Comply Notice.

### 1.2 Actions/Enforcement Resulting from this Inspection

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

One previously stated recommendation has been stated for a second time and two recommendations have been stated for a third and final time. The recommendations that were

stated for a third time were discussed with the responsible person and the manager who were advised that continued non-compliance will result in a requirement being made. One requirement was not examined and has been carried forward to a future care inspection.

### 1.3 Inspection Outcome

	Requirements	Recommendations
<b>Total number of requirements and recommendations made at this inspection</b>	1	3

The details of the QIP within this report were discussed with the manager and the responsible person as part of the inspection process. The timescales for completion commence from the date of inspection.

### Service Details

<b>Registered Organisation/Registered Person:</b> Carewell Homes Ltd Mrs Carol Kelly	<b>Registered Manager:</b>
<b>Person in Charge of the Home at the Time of Inspection:</b> Mrs Martina McGuinness (applicant manager)	<b>Date Registered:</b> Registration pending
<b>Categories of Care:</b> NH-I, NH-PH, NH-DE, NH-MP, NH-MP(E), NH-LD, RC-I, RC-PH, RC-MP, RC-MP(E)	<b>Number of Registered Places:</b> 86
<b>Number of patients accommodated on day of inspection:</b> 75	<b>Weekly Tariff at Time of Inspection:</b> Nursing - £581.00 Residential - £461.00

### 2. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous care inspection and to determine if the safety of patients could be assured.

### 3. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the responsible person
- discussion with the manager
- discussion with staff (three registered nurses and 12 care staff)
- discussion with patients (20 individually and the majority of others in small groups)
- observation during an inspection of the premises
- evaluation and feedback.

The following records were examined during the inspection:

- three patients care records
- accidents/incidents records
- complaints records
- a sampling of staff duty rotas
- regulation 29 reports
- staff training records
- staff induction records
- supervision and appraisal records
- a sample of audits.

#### 4. The Inspection

##### 4.1 Review of Requirements and Recommendations From the Last Care Inspection

Previous Inspection Statutory Requirements		Validation of Compliance
<p><b>Requirement 1</b></p> <p><b>Ref:</b> Regulation 13 (1) (a)</p> <p><b>Stated:</b> Second time</p>	<p>The registered person must ensure the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients.</p> <p>The registered person must ensure that the treatment provided to each patient –</p> <ul style="list-style-type: none"> <li>• meets their individual needs</li> <li>• reflects current best practice, and</li> <li>• is (where necessary) provided by means of appropriate aids or equipment.</li> </ul> <p><b>Action taken as confirmed during the inspection:</b> Staffing levels had been reviewed and increased since the previous inspection. Twenty patients were spoken with individually and the majority of others in small groups. Patients advised that they were happy living in the home and that staff were kind to them. No concerns were raised. No complaints had been recorded since the previous care inspection. Staff were observed to respond to patients needs in a timely and respectful manner. No inappropriate moving and handling practices were observed.</p> <p>The daily routine and the management of meals and mealtimes was observed and found to be managed effectively.</p>	<p><b>Met</b></p>

<p><b>Requirement 2</b></p> <p><b>Ref:</b> Regulation 13 (7)</p> <p><b>Stated:</b> Second time</p>	<p>The registered person must make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. Ensure the following issues are addressed:</p> <ul style="list-style-type: none"> <li>a number of chairs throughout the home had upholstery damage and were torn with foam exposed.</li> </ul> <hr/> <p><b>Action taken as confirmed during the inspection:</b> All chairs identified with upholstery damage had been re-upholstered.</p>	<p><b>Met</b></p>
<p><b>Requirement 3</b></p> <p><b>Ref:</b> Regulation 15 (1) (a)</p> <p><b>Stated:</b> First time</p>	<p>The registered person must not provide accommodation to a patient unless the needs of the patient have been fully assessed by a suitably qualified or suitably trained person and the home can meet the patients assessed needs.</p> <p>The registered person must ensure that required aids or specialist assessed equipment to meet patient's needs are in place before admission.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> As no admissions took place since the previous inspection, inspectors were unable to validate this requirement. It has therefore been carried forward for review at a future care inspection.</p>	<p><b>Not inspected</b></p>
<p><b>Requirement 4</b></p> <p><b>Ref:</b> Regulation 19 (2)</p> <p><b>Stated:</b> Second time</p>	<p>The registered person shall maintain in the nursing home the records specified in Schedule 4. These should include the following:</p> <ul style="list-style-type: none"> <li>a record of all staff employed at the home including the dates employment commences and ceases</li> <li>staff training records.</li> </ul> <hr/> <p><b>Action taken as confirmed during the inspection:</b> A record of all staff employed in the home and staff training records were reviewed and found to be maintained appropriately.</p>	<p><b>Met</b></p>

<p><b>Requirement 5</b></p> <p><b>Ref:</b> Regulation 20 (1) (a)</p> <p><b>Stated:</b> Second time</p> <p><b>To be Completed by:</b> 28 days from date of this inspection</p>	<p>The registered person must review staff allocation, taking into consideration the structure and layout of the home, the categories of care and the dependency levels of patients.</p> <p>Consideration should be given to the development of a deputy manager role and/or clinical leads in each unit to enable the manager to develop and implement robust governance systems within the home.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> Two clinical lead nurses had been appointed since the previous care inspection. One clinical lead for Cloisters and Primrose units (30 hours with 24 hours supernumerary). The second clinical lead (36 hours with 12 hours supernumerary in Innisview unit). Part of the clinical lead nurses' role was to undertake and complete audits relating to care practice and to support and carry out staff supervisions. Two senior care assistants had also been appointed and were supernumerary within Primrose and Cloisters units to provide support and supervision for staff.</p> <p>A sample of duty rotas for weeks commencing 21 and 28 September 2015 were reviewed and confirmed that additional staff were on duty as advised by the responsible person.</p>	<p><b>Met</b></p>
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Recommendations		
<p><b>Recommendation 1</b></p> <p><b>Ref:</b> Standard 4.7</p> <p><b>Stated:</b> Second time</p>	<p>The registered person should ensure that, with regard to care records –</p> <ul style="list-style-type: none"> <li>• the assessment of the patient’s needs is kept under review, and</li> <li>• revised at any time when it is necessary to do so having regard to any change of circumstances</li> <li>• the patient’s care plan is kept under review and reflects the current assessment of needs and care delivery.</li> </ul> <p><b>Action taken as confirmed during the inspection:</b>  A review of three care records evidenced that in relation to some aspects of identified care needs, risk assessments and care plans were either not in place, or not sufficiently reviewed in response to the changing needs of patients or contained conflicting information. Therefore, this recommendation has not been fully met and has been stated for a third and final time.</p> <p>Management representatives have been advised that should this recommendation be assessed as not fully met at the next care inspection it will be stated as a requirement.</p>	<p><b>Partially met</b></p>

<p><b>Recommendation 2</b></p> <p><b>Ref:</b> Standard 36.5</p> <p><b>Stated:</b> Second time</p>	<p>The registered person should ensure the organisation has robust systems in place to monitor, audit and review the quality of nursing and other services provided within the home. This includes regular audits of:</p> <ul style="list-style-type: none"> <li>• accidents/incidents</li> <li>• care records</li> <li>• infection prevention and control</li> <li>• management of pressure areas.</li> </ul> <hr/> <p><b>Action taken as confirmed during the inspection:</b>  Since the last care inspection there was evidence that systems had been developed to monitor, audit and review the quality of nursing and service provision. A review of audits undertaken in relation to the areas outlined above was reviewed and evidenced that further development is needed to further enhance outcomes so as to change or make improvements. For example;</p> <p>Infection control audits are carried out weekly within the home. The audits examined did not include adequate details in relation to areas examined. The selection criteria for particular areas examined needs to be reviewed to ensure it includes all units and areas of the home. The actions identified as a result of audit activity needs to have a follow-up report to evidence the actions taken and the level of compliance achieved.</p> <p>An audit tool for care records has been drawn up. A selected number of care records will be audited each calendar month. This is the responsibility of the Senior Nurse and compliance will be monitored by the Home Manager.</p> <p>Accident/incident audits have commenced and will be improved upon to ensure that patterns emerging/time of accidents/environmental issues are teased out and action taken where appropriate.</p> <p>An audit tool to review the incidence and management of pressure/wounds has been developed. A review of audits undertaken for July and September 2015 evidenced that the tool makes no provision for auditing documentation pertaining to pressure/ wound care management for example wound observation charts, care plans and</p>	<p><b>Partially met</b></p>
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	<p>repositioning records. These findings were discussed with management at feedback who agreed to develop the tool in this regard.</p> <p>This recommendation has been stated for a third time.</p>	
<p><b>Recommendation 3</b></p> <p>Ref: Standard 40.1</p> <p>Stated: First time</p>	<p>The registered person should ensure that all staff who are newly appointed, including agency staff and students, complete a structured orientation and induction; and records are retained.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> The induction records of five recently recruited staff were reviewed and confirmed that a structured orientation and induction had been completed upon appointment. While induction records had been signed and dated by the inductee and the mentor, it is recommended that the manager also signs and dates all induction records. The manager agreed to address this following the inspection.</p>	<p><b>Met</b></p>
<p><b>Recommendation 4</b></p> <p>Ref: Standard 40.2</p> <p>Stated: First time</p>	<p>The registered person should ensure that all staff have recorded individual, formal supervision according to the home's procedures and no less than every six months for staff who are performing satisfactorily. More frequent supervision should be held for new staff and those who are not performing satisfactorily.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> A sample of four staff supervision records were reviewed and found to be completed appropriately. A 12 monthly supervision planner was in place with dates for forthcoming supervision for all staff.</p>	<p><b>Met</b></p>
<p><b>Recommendation 5</b></p> <p>Ref: Standard 40</p> <p>Stated: First time</p>	<p>The registered person should ensure that all staff have recorded annual appraisal meetings with line managers to review their performance against their job descriptions, and to agree personal development plans.</p> <p>A timetable should be developed with dates for appraisal for all staff working in the home.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> A sample of two staff appraisal records were reviewed and found to be completed appropriately. A planner was in place with dates for all staff appraisals for 2015/16.</p>	<p><b>Met</b></p>

<p><b>Recommendation 6</b></p> <p><b>Ref:</b> Standard 44.4</p> <p><b>Stated:</b> Second time</p>	<p>The registered person should ensure that the home environment is safe for patients. Risk assessments should be completed with regard to the free standing electric heaters in use in patients' bedrooms.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> All free standing electric heaters in use in patients bedrooms were attached to the wall with a cover over the heater. Risk assessments were in place.</p>	<p><b>Met</b></p>
<p><b>Recommendation 7</b></p> <p><b>Ref:</b> Standard 36.5</p> <p><b>Stated:</b> First time</p>	<p>It is recommended that audits are undertaken of patients and residents who are incontinent and the findings acted upon to enhance continence care in the home.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b> A sample of audits pertaining to continence care management was reviewed; however, there was no evidence of any evaluation of the outcomes or actions taken as a result of the audit findings. The criteria for completing audits in this area of practice were discussed with the manager in reference to the key indicators for why and how to complete same. The manager agreed to consider the guidance given going forward. This recommendation has been stated for a third time.</p>	<p><b>Partially met</b></p>
<p><b>Recommendation 8</b></p> <p><b>Ref:</b> Standard 40.4</p> <p><b>Stated:</b> Second time</p>	<p>The registered person should ensure that records are maintained to evidence that all staff working in the home have received the following update training appropriate to their roles and responsibilities:</p> <ul style="list-style-type: none"> <li>• the management of challenging behaviour</li> <li>• moving and handling</li> <li>• infection prevention and control</li> <li>• the management of restraint</li> <li>• safeguarding of vulnerable adults.</li> </ul> <hr/> <p><b>Action taken as confirmed during the inspection:</b> Staff training records evidenced that the above training had been completed by all staff. Training was delivered by a combination of e-learning modules and face to face training provided externally and in-house.</p>	<p><b>Met</b></p>

## 4.2 Care records

A review of three care records evidenced that in relation to some identified care needs, risk assessments and care plans were either not in place, or not sufficiently reviewed in response to the changing needs of patients or contained conflicting information.

For example, one patient's care plan reviewed advised the patient required the assistance of two care staff and a hoist. However, daily progress notes recorded that the patient walked with the assistance of one staff member and this was also observed during the inspection. In the same care record there was conflicting information in regards to the patients need for oxygen therapy. A care plan was available however; the evaluation records would have indicated that this intervention was no longer required. A review of the daily progress notes evidenced that this intervention had been recently implemented.

A review of another care record for a patient who had been confirmed with an infection status, did not have a care plan in place. This patient had a care plan in place for pain management to administer PRN pain relief however; daily progress notes reviewed advised that the patient was experiencing pain during postural changes. The risk assessment and care plan should both be reviewed to determine the effectiveness of the current interventions for the patient's pain management.

Care records reviewed also evidenced that in some instances there were two care plans for the same problem. This should be reviewed to avoid duplication and the potential for conflicting interventions.

A review of the bed rail assessment currently being used to assess the safe use of bedrails was discussed. The bed rail assessment made no provision to calculate the degree of risk for the use of bedrails or not to use. Management representatives agreed to review the tool for suitability and action accordingly.

The previously stated recommendation has been stated for a third and final time. It is acknowledged that since the last care inspection, progress has been made in relation to care records. However, management representatives were advised that should this recommendation not be fully met at the next care inspection, the recommendation will be stated as a requirement. This was acknowledged by those at feedback who agreed to follow up the findings as a result of this inspection and action accordingly.

## 4.3 Consultation with patients and staff

Twenty patients were spoken with individually and the majority of others in small groups. Some patients were unable to communicate verbally due to the frailty of their condition. Patients advised that they were happy with the standard of care in the home and that staff were good to them. No concerns were raised by any of the patients consulted.

Staff members stated that they were satisfied that the care provided to patients was of a high standard.

#### 4.4 Incidents/accidents records

The review of a sample of incident/accident records evidenced that incidents had been notified to RQIA in accordance with legislative requirements. As stated in section 4.1, there was no evidence of the analysis of accidents/incidents or any trends identified. A recommendation has been stated for the third time.

#### 4.5 Complaints records

No complaints had been recorded since the previous inspection on 18 August 2015.

### 5. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Carol Kelly (responsible person) and Martina McGuinness (manager) as part of the inspection process. The timescales commence from the date of inspection.

The registered person 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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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 person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

#### 5.2 Recommendations

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

#### 5.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to [nursing.team@rqia.org.uk](mailto:nursing.team@rqia.org.uk) and assessed by the inspector.

***\*Please complete in full and returned to RQIA from the authorised email address\****

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

## Quality Improvement Plan

### Statutory Requirements

#### Requirement 1

**Ref:** Regulation 15 (1)  
(a)

**Stated:** First time

**To be Completed by:**  
28 days from date of  
this inspection

**Not inspected at this inspection - Carried forward for review at the next inspection:**

The registered person must not provide accommodation to a patient unless the needs of the patient have been fully assessed by a suitably qualified or suitably trained person and the home can meet the patients assessed needs.

The registered person must ensure that required aids or specialist assessed equipment to meet patient's needs are in place before admission.

**Ref: Section 4.1**

**Response by Registered Manager Detailing the Actions Taken:**

This requirement was made specifically in relation to one identified patient who was transferred to hospital from the home on 25 April, and officially discharged from the home on 28 April 2015 . The appropriate equipment will be made available to all patients on admission to the home, in accordance with their assessed needs. Information in this regard has been included in the revised preadmission assessment tool.

### Recommendations

#### Recommendation 1

**Ref:** Standard 4.7

**Stated:** Third time

**To be Completed by:**  
28 days from date of  
this inspection

The registered person should ensure that, with regard to care records –

- the assessment of the patient's needs is kept under review, and
- revised at any time when it is necessary to do so having regard to any change of circumstances
- the patient's care plan is kept under review and reflects the current assessment of needs and care delivery.

**Ref: Section 4.1 & 4.2**

**Response by Registered Manager Detailing the Actions Taken:**

The importance of ensuring that the patient's assessment of need and care plans are kept under review and reflect the current care needs for the patient has been reiterated to all nursing staff.

<p><b>Recommendation 2</b></p> <p><b>Ref:</b> Standard 36.5</p> <p><b>Stated:</b> Third time</p> <p><b>To be Completed by:</b> 28 days from date of this inspection</p>	<p>The registered person should ensure the organisation has robust systems in place to monitor, audit and review the quality of nursing and other services provided within the home. This includes regular audits of:</p> <ul style="list-style-type: none"> <li>• accidents/incidents</li> <li>• care records</li> <li>• infection prevention and control</li> <li>• the management of pressure areas.</li> </ul> <p><b>Ref: Section 4.1</b></p> <hr/> <p><b>Response by Registered Manager Detailing the Actions Taken:</b> Auditing systems were already in place in relation to each of the above areas. Following the inspection we revised the audit tools for accident/incidents, infection prevention and control and the management of pressure areas. The new improved tools are now in use.</p>		
<p><b>Recommendation 3</b></p> <p><b>Ref:</b> Standard 36.5</p> <p><b>Stated:</b> Second time</p> <p><b>To be Completed by:</b> 28 days from date of this inspection</p>	<p>It is recommended that audits are undertaken of patients and residents who are incontinent and the findings acted upon to enhance continence care in the home.</p> <p><b>Ref: Section 4.1</b></p> <hr/> <p><b>Response by Registered Manager Detailing the Actions Taken:</b> Continence audits had already been completed. At feedback it was recommended that we focus on patients with specific care needs. With a clear goal identified we are due to commence the new auditing programme shortly. The audit tool has been revised.</p>		
<p><b>Registered Manager Completing QIP</b></p>	<p>Martina McGuinness</p>	<p><b>Date Completed</b></p>	<p>11/11/15</p>
<p><b>Registered Person Approving QIP</b></p>	<p>Carol Kelly</p>	<p><b>Date Approved</b></p>	<p>11/11/15</p>
<p><b>RQIA Inspector Assessing Response</b></p>	<p>Bridget Dougan</p>	<p><b>Date Approved</b></p>	<p>24/11/15</p>