The Regulation and Quality Improvement Authority

Inspection Report

9 and 10 October 2023

Greerville Manor Care Home

Type of service: Nursing Home
Address: 192 Newtownbreda Road, Belfast, BT6 6QB
Telephone number: 028 9064 4244

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Beaumont Care Homes Limited **Responsible Individual:** Mrs Ruth Burrows	**Registered Manager:** Mrs Jocelyn Cruz Cristobal **Date Registered:** 20 November 2020
Person in charge at the time of inspection: Mrs Jocelyn Cruz Cristobal	**Number of registered places:** 60 A maximum of 28 patients in category NH-DE accommodated in the Dixon Unit, a maximum of 15 patients in category NH-A accommodated in the Belvoir Unit and a maximum of 16 patients in categories NH-MP/MP(E) accommodated and 1 named resident in category RC-MP accommodated in Millbrook Unit.
Categories of care: Nursing Home (NH) A – Past or present alcohol dependence. MP – Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 58
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 60 patients. The home is divided in three units; the Dixon Unit provides care for patients with dementia, the Belvoir Unit provides care for patients with alcohol related brain injury and the Millbrook Unit provides care for patients with a mental health disorder. Within each unit patients have access to communal lounges, dining rooms and a courtyard garden.	

2.0 Inspection summary

An unannounced inspection took place on 9 October 2023 from 9.00am to 4.15pm and on 10 October 2023 from 9.20am to 2.10pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home 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.

Patients were well presented in their appearance and spoke positively when describing their experiences of living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report.

Staff promoted the dignity and well-being of patients and were knowledgeable and well trained to deliver safe and effective care. There was a good working relationship between staff and management.

Areas for improvement were identified in relation to record keeping and the environment. Addressing the areas for improvement will further enhance the quality of care and services in Greerville Manor Care Home.

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 and the regional manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with patients and staff. Patients spoke positively on the care that they received and on their interactions with staff. One told us, "You can't get any better; I am happy here". Staff were confident that they worked well together and enjoyed working in the home and interacting with the patients.

There were two questionnaire responses received indicating satisfaction with the service provision and management of the home. We received no feedback from the staff online 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 9 January 2023		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time	The responsible person shall ensure that with regard to supplemental care booklets: • all relevant front page patient details, for example, date of birth, recommended level of diet and fluids, frequency of repositioning and skin checks, are consistently completed • if a skin check has been carried out this should be clearly recorded.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met.	
Area for improvement 2 **Ref:** Standard 12 **Stated:** First time	The responsible person shall ensure that: • menus on display are up to date and reflective of the current week of the menu cycle in the home • menus are on display in each dining room of the home in a suitable format for patients.	**Partially met**

	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been partially met and this will be discussed further in Section 5.2.2. This area for improvement has not been fully met and has been stated for the second time.	
Area for improvement 3 **Ref:** Standard 46.2 **Stated:** First time	The responsible person shall ensure that equipment is effectively cleaned, as and when required, in addition to scheduled cleaning. There should be a system in place to monitor compliance in this area.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. All staff were provided with a comprehensive induction programme to prepare them for working with the patients. An induction booklet was completed to capture the topics covered during the induction. Agency staff also had an induction to the home prior to commencing their first shift.

There were systems in place to ensure staff were trained and supported to do their job. A system was in place to ensure staff completed their training and evidenced that the majority of staff had achieved compliance with this. Training was completed online and face to face. Staff were trained on a range of topics including dementia awareness, mental health awareness and training for de-escalation and management of behavioural challenges. Additional training was arranged on alcohol related brain damage.

Staff confirmed that they were further supported through staff supervisions and appraisals. A system was in place to ensure that staff received, at minimum, two supervisions and an appraisal conducted annually.

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

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff raised no concerns regarding the staffing levels and confirmed that patients' needs were met with the number and skill mix of staff on duty. Staff said there was good teamwork in the home. One told us, "We all work very well together", and another commented, "We have good support from each other".

The staff duty rota accurately reflected all of the staff working in the home on a daily basis. However, the duty rota did not identify the nurse in charge of the home in the absence of the manager. There were no records maintained of who was in charge of the home in the absence of the manager. This was identified as an area for improvement. An on-call manager rota was available to staff to offer support when required.

It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through these interactions that the staff and patients knew one another well and were comfortable in each other's company.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

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. Assessments and care plans were reviewed regularly to ensure that they were reflective of patients' needs. However, following a period of time in hospital, a patient's care records were not reviewed on return to the home. This was discussed with the manager and identified as an area for improvement. Patients care records were held confidentially.

Patients' care records evidenced involvement from the patient and/or the patients' next of kins when developing the care plans.

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 in how to manage this risk. Some patients require staff to assist them in repositioning to maintain their skin integrity. Where this was required, records of repositioning had been well maintained. Moving and handling risk assessments and mobility care plans had been completed to ensure safe practice in this aspect of care.

Care plans took into consideration the patients' rights and capacity to make complex or simple decisions. They identified the need for consent and the right to refuse care.

An accident book was completed by staff to record any accidents or incidents which occurred in the home. A review of accident records following a fall in the home confirmed that the correct actions were taken following the accident and the appropriate persons notified of the fall.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. Staff assisted patients throughout the day with food and fluids in an unhurried manner. Staff were knowledgeable in regards to patients' nutritional requirements. Records of patients' intake and outputs were recorded where this was required. However, deficits were found in relation to the management of hydration. This was discussed with the manager and identified as an area for improvement.

There was good availability of food and fluids observed during the inspection. The meal timings were adequately spaced out. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST).

The majority of patients dined together in the dining room during lunch. The mealtime was well supervised. There were meal options on the menu for patients to choose from. Although, the menu had not been displayed in a suitable format; especially for those patients with a dementia. This was discussed with the manager and an area for improvement previously stated in this regard was stated for a second time.

Staff wore the appropriate personal protective equipment (PPE) and patients, who required, wore clothing protectors to maintain their dignity. The food served appeared nutritious and appetising. A range of drinks was served with the meal. Staff sat alongside patients when providing assistance with their meals. There was a calm atmosphere in the dining room and patients spoke positively on the mealtime experience.

Patients' individual likes and preferences were reflected throughout the records. Daily records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were decorated and suitably furnished. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

The home was warm, clean and comfortable. Two rooms were found where the floor in each was wet. There was no signage in place warning any persons entering the rooms of the wet floors. This was discussed with the manager and identified as an area for improvement. There were no malodours in the home.

Fire safety measures were in place to ensure the safety of patients, visitors and staff. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible.

Areas in the home were identified in which unattended chemicals were found accessible to patients. Thickening agents, which could be harmful to patients if ingested inappropriately, were also observed accessible to patients. An area for improvement was identified to ensure compliance with Control of Substances Hazardous to Health (COSHH) legislation.

Training on infection prevention and control (IPC) measures and the use of PPE had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. However, an area for improvement was made to ensure that all staff wore PPE at the appropriate times and remained bare below the elbow. There were good stocks and supplies of PPE and hand hygiene products. Daily cleaning and decontamination charts had been maintained. Infection control audits had been conducted monthly.

5.2.4 Quality of Life for Patients

Three activities therapists were employed to oversee activity provision in the home. A monthly programme of activities was available for review. Activities included games, massage, painting, reminiscence, walks, massage, quiz and pampering. Activities were conducted each morning and afternoon on a group and/or on a one to one basis. Plans were in place for a Halloween party. Each unit in the home had been well decorated for Halloween. Records of activity engagements were maintained. A patient told us," The staff here are really nice; I enjoy the bingo. Looking forward to going out for lunch with my daughter today".

Patients confirmed that they were offered choice and assistance on how they spent their day. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested. One patient told us, "I do get asked if I want to go out or join in with the activities; it's your choice whether you do or not".

Staff provided care in a dignified manner. Personal care was delivered discreetly behind closed doors.

Visiting had returned to pre-covid arrangements. Visits could take place in the patients' preferred visiting areas including their bedrooms. Patients were free to leave the home with relatives if they wished.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been no change in the management arrangements. Mrs Jocelyn Cruz Cristobal has been the Registered Manager of the home since 20 November 2020. Discussion with staff confirmed that there were good working relationships between staff and the home's management team. Staff described the manager as 'very approachable' and 'would always listen to any concerns'.

Staff told us that they were aware of their own roles in the home and how to raise any concerns or worries about patients' safety, care practices or the environment. Staff members were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required. Staff demonstrated good knowledge of the organisational structure in the home.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Areas audited included patients' care records, complaints, pressure damage, infections, restrictive practice, staff training and the environment.

Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA. Falls in the home were reviewed monthly for patterns or trends to see if any further falls could be prevented.

The home was visited each month by a representative of 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 the reports were available for review by patients, their representatives, the Trust and RQIA. Where improvement actions were required, an action plan was included within the report. The action plan would be reviewed at the subsequent monthly monitoring visit to ensure completion.

A complaint's book was maintained and records included the nature of the complaint and any actions taken in response to the complaint. Cards and letters of compliments were maintained on file and shared with staff.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	4	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Jocelyn Cruz Cristobal, Registered Manager and Judy Derby, Regional 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 15 (2) (b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that patients' risk assessments and care plans are reviewed on return to the home following a period of time in hospital to ensure that these remain current. Ref: 5.2.2
	Response by registered person detailing the actions taken: The area of improvement required was discussed with staff in the Heads of Department meeting held on 7th November 2023. The discussion emphasised that residents' risk assessments and care plans are to be reviewed and updated promptly when a resident returns to Greerville Manor following a period of time in hospital. The documentation for residents returning from a stay in hospital will be audited by the Manager using the Company audit form and any areas of deficit found will be discussed with nurses and actioned. Care records will be spot checked during Reg 29 visits.
Area for improvement 2 **Ref:** Regulation 14 (2) (a) and (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that chemicals are not accessible to patients, in any part of the home, when not in use in keeping with COSHH legislation. Thickening agents must be stored securely when not in use. Ref: 5.2.3
	Response by registered person detailing the actions taken: The nurse in charge is to ensure and evidence on a daily basis that thickening agents are secured and in a plastic thumb lock container for individual residents and stored securely in the treatment room when not in use. Supervision was held with domestic staff on 12th October to discuss COSHH. Training compliance check completed on e-learning platform for completion of Health, Safety & Welfare (inc COSHH & RIDDOR) modules. This was found to be up to date with the exception of two staff. The Manager is following up this training requirement with staff involved to ensure its completed. The Home Manager and Deputy Manager to spot check during walkabout that chemicals are secured and locked

	away when not in use and not left unattended. Any omissions to be addressed with staff involved. Security of thickening agents and chemicals will be reviewed during Reg 29 visits
Area for improvement 3 **Ref:** Regulation 14 (2) (a) and (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the appropriate signage is displayed when floors are wet to warn patients, visitors and staff of slip hazards. Ref: 5.2.3
	Response by registered person detailing the actions taken: Supervision, coaching and developmental sessions held with domestic staff on 12th October 2023 to discuss health and safety protocols and compliance in minimising risk of accidents due to wet flooring. The Manager's Daily Walkabout Report has been revised to include spot checking for appropriate signage in place, to ensure effective governance of Health and Safety compliance and minimise risk of accidents. Use of signage will be checked during Reg 29 visits.
Area for improvement 4 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that training on infection prevention and control is embedded into practice. This is in relation to staff remaining bare below the elbow in areas where care is delivered and the appropriate use of PPE. Ref: 5.2.3
	Response by registered person detailing the actions taken: An initial flash meeting was held with staff on 12th October to reiterate infection control training, best practice to facilitate good hand hygiene and IPC guidelines when delivering direct care to service users is '' Bare Below Elbow'' . Compliance is being monitored daily and evidenced in shift reporting. Spot checks are being completed by management and recorded on the Daily Walkabout. Compliance with uniform policy will be checked during Reg 29 visits
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 12 **Stated:** Second time	The responsible person shall ensure that: • menus on display are up to date and reflective of the current week of the menu cycle in the home • menus are on display in each dining room of the home in a suitable format for patients.

To be completed by: 1 January 2024	Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Menus on display are up to date for autumn and winter menus, reflecting current week of the menu cycle in the Home. The Cook Manager has been advised to inform staff through the pre order sheet of any last-minute changes, as required. Menus on display have been changed to pictorial illustrations suitable for residents in each unit. Displaying of menus will be reviewed during Reg 29 visits.
Area for improvement 2 **Ref:** Standard 41 Criteria (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the nominated nurse in charge of the home in the absence of the manager is identified on a duty rota. Ref: 5.2.1
	Response by registered person detailing the actions taken: The nominated Nurse in Charge of the Home in the absence of the Manager is identified and highlighted on the rota. The information is also displayed in the reception area. Compliance will be monitored by the Operations Manager during the Reg 29 visits.
Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 October 2023	The registered person shall ensure that the management of hydration in the home is reviewed to make sure that patients deemed at risk of dehydration have: • A realistic daily fluid target • Accurate recording of fluid intake records to include supplements taken • Actions to take, recorded within the patient's care plan, of what to do when the fluid targets are not being met. Ref: 5.2.2
	Response by registered person detailing the actions taken: Effective management of resident hydration was discussed with staff during Head of Department meeting on 7th November 2023. The system in place to ensure that service users who are identified at risk of dehydration are managed effectively has been reviewed. This involved monitoring and discussing with the GP individual resident fluid targets which have not been attained over three consecutive days. It was also discussed that staff are to accurately record fluid intake,

	including supplements and promptly take action when target fluid is not met. Staff are to evidence intake in plan of care and ensure that risk assessments and care plans are reviewed and updated to reflect changes and actions taken. The Nurse in charge is to review fluid intake charts, follow up any actions identified and update care documentation. Charts to be initialled and signed by the nurse in charge. The Manager is to discuss changes in residents' fluid during daily flash meeting. The Manager and/or deputy is to review care documentation for residents not meeting fluid intake targets to ensure follow up actions have been initiated, progressed and recorded. Compliance will be monitored by the Operations Manager during reg 29 visit.

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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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