Unannounced Care Inspection Report
6 June 2016

Glenkeen House

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Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Glenkeen House took place on 6 June 2016 from 09.30 to 14.30 hours. The inspection sought to assess progress with any 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.

For the purposes of this report, the term 'patients' will be used to described those living in Glenkeen House which provides both nursing and residential care.

Is care safe?

The staffing levels for the home were subject to regular review to ensure the assessed needs of the patients were met. New staff completed an induction programme and all staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals. Compliance with mandatory training was overseen by the registered manager. The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adults safeguarding. A range of risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process. There were safe systems in place for the recruitment and selection of staff. Registration checks were undertaken on a regular basis to validate the staffs' registration status with the appropriate professional body; and staff did not commence employment until enhanced criminal records checks had been completed with AccessNI. A recommendation has been made to ensure that a system is developed to record the AccessNI reference numbers, the date received and whether or not the AccessNI checks were clear. The home was found to be clean; and infection prevention and control measures were adhered to. Fire exits and corridors were maintained clear from clutter and obstruction.

Is care effective?

Patients' needs were assessed on admission and thereafter, on a regular basis, as required. These risk assessments informed the care planning process. The care records accurately 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, if appropriate and there was evidence of regular communication with patient representatives within the care records. A review of supplementary care records evidenced that patients' personal care needs were met, in line with their care plans. Staff, patients and their representatives confirmed that if they had any concerns, they could raise these with the management.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with patients confirmed that they were afforded choice, privacy, dignity and respect. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Consultation with staff confirmed that they felt they had the necessary skills to communicate effectively with patients. The mid-day meal was served in the dining room which was quiet and tranquil and patients were encouraged to eat their meals.

Staff supported patients to maintain friendships and socialise within the home. There was also a range of activities available for patients to choose from. There was evidence that patients' end of life care needs were considered and compliments had been recorded in relation to how well the staff delivered compassionate care during this period. There were systems in place to ascertain the views of patients and their representatives and there was evidence that this information had been acted upon. All comments received from patients and their representatives were positive and a number of the comments have been included in the report.

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. The home was operating within its registered categories of care. The policies and procedures for the home were systematically reviewed on a three yearly basis. Any complaints received had been managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. There were systems in place to monitor and report on the quality of nursing and other services provided. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified. All incidents had been managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and actioned, as required. Monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

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	1

Details of the QIP within this report were discussed with the 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 care inspection

The most recent inspection of Glenkeen House was an unannounced care inspection undertaken on 14 March 2016. Other than those actions detailed in the previous QIP there were no further actions required. 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. There were no areas that required to be followed up in this inspection.

2.0 Service details

Registered organisation/registered person: Hutchinson Homes Ltd	**Registered manager:** Jacqueline Elizabeth McShane
Person in charge of the home at the time of inspection: Jacqueline Elizabeth McShane	**Date manager registered:** 1 April 2005
Categories of care: NH-LD, NH-I, NH-PH, RC-I, RC-MP(E), RC-PH(E)	**Number of registered places:** 40

3.0 Methods/processes

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

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, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with four patients, five care staff, two ancillary staff, one registered nurse and four patient's representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- accident and incident records
- notifiable incidents
- audits
- records relating to adults safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 March 2016

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

4.2 Review of requirements and recommendations from the last care inspection dated 14 March 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 16 (1) (b) **Stated:** First time **To be Completed by:** 11 May 2016	Risk assessments and care plans must be reviewed in a timely manner. This refers specifically to patients who return to the home, following a period of hospitalisation. **Carried forward from previous inspection** **Ref: Section 5.2**	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of care records confirmed that there was a system in place to re-assess patients, following a period of hospitalisation.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39.9 **Stated:** First time	The registered manager must ensure that all relevant staff have training in the management of dysphagia and are deemed competent in this. **Ref: Section 5.3.1**	**Met**
	Action taken as confirmed during the inspection: There was evidence that training had been scheduled for all staff to attend.	
Recommendation 2 **Ref**: Standard 4 **Stated:** First time	Patients' care plans should reflect the assessed needs of the patients. **Ref: Section 5.3.2**	**Met**
	Action taken as confirmed during the inspection: A review of the care records evidenced that care plans reflected the assessed needs of the patients. Falls risk assessments and care plans had been completed in relation to patients' falls and abbey pain scales had also been completed for patients who required transdermal opioid patches.	
Recommendation 3 **Ref**: Standard 35.3 **Stated:** First time	The process for carrying out audits of care records should be developed, to ensure that there is traceability of audit and evidence of follow up action taken to address identified deficits. **Ref: Section 5.3.2**	**Met**
	Action taken as confirmed during the inspection: The system for auditing care records had been further developed and there was evidence of traceability in terms of the assessments reviewed and follow-up action taken, to address identified deficits.	

4.3 Is care safe?

There were systems in place for the recruitment and selection of staff. A review of two personnel files evidenced that these were reviewed by the registered manager and checked for possible issues.

Where nurses and carers were employed, their pin numbers were checked with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), on a regular basis to validate their registration status. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with AccessNI. However, a recommendation has been made to ensure that a system is developed to record the AccessNI reference number, the date received and whether or not the checks were clear.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. This ensured that they had the basic knowledge needed to begin work. A training matrix had been developed which provided clear information to enable the registered manager to review staff training and see when updates/refresher training were due. This confirmed that the majority of staff had received training in all mandatory areas.

A review of staff training records confirmed that staff completed training modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adults safeguarding, as appropriate. Observation of the delivery of care evidenced that training had been embedded into practice.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota commencing 29 May 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adults safeguarding. Discussion with the registered manager confirmed that a system was in place to record and report any potential safeguarding concerns, in accordance with the regional safeguarding protocols and the home's policies and procedures.

A range of risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails and restraint, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate; assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. These risk assessments informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans had been completed following each incident, care management and patients' representatives were notified appropriately. RQIA had been notified appropriately.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

A system should be developed to ensure that a record is maintained of the AccessNI reference numbers, the date received and whether or not the AccessNI checks were clear. A recommendation has been made in this regard.

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

4.4 Is care effective?

The home used an electronic system for assessing, planning and recording patients' care needs and a review of five patient care records evidenced that risks to patients were assessed on admission and thereafter, as required. Examples included, where patients may require the he use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails and restraint, if appropriate; regular repositioning due to the risk of developing pressure damage and wound assessment, if appropriate; and assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. There was also evidence that risk assessments informed the care planning process.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

A review of five patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. For example, where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound. A review of the daily progress notes, evidenced that the dressing had been changed according to the care plan.

The care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

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

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to discussing patients' details in front of other relatives.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and it provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. 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.

Discussion with the registered manager and review of records evidenced that patients and/or relatives meetings were held on a regular basis and records were maintained. Patient and representatives spoken with 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. Consultation with five patients individually and with others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were consulted with regarding meal choices and their feedback had been listened to and acted on. Patients were offered a choice of meals, snacks and drinks throughout the day. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Consultation with staff confirmed that they felt they had the necessary skills to communicate effectively with patients and confirmed that should patients require specialist communication tools, these would be provided by the registered manager.

Menus were displayed clearly and were correct on the day of inspection. The mid-day meal was observed. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with tablecloths and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. There was a list of activities displayed on a notice board on the ground floor. The hairdresser visited regularly. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

A review of patient care records confirmed information about patient's background. However, a number of patients did not have their life histories undertaken. This was discussed with the registered manager who advised that the completion of the life histories was ongoing and that this would be completed on admission in the future.

The care plan detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included: 'My mother has flourished since she came here, she could not have been in better hands'.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

'It's very good. The team works well together'.
'Absolutely perfect. The girls are very good with the patients'.
'I love it here. Everyone is really lovely'.
'I have no concerns. All the patients are treated the same'.

Patients

'I have nothing bad to say'.
'I have no complaints whatsoever'.
'It's as good as being at home'.

Patients' representatives

'Absolutely fantastic. I praise the staff up so much'.
'It is very homely and my (relative) is happy and content'.
'The patients are always very well cared for'.
'No issues at all'.
'The staff are very good. I have had no problems'.

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 consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis and stated that plans were in place to ensure that all the policies within the Hutchinson group would be the same. Staff confirmed that they had access to the home's policies and procedures.

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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- care records
- infection prevention and control
- environment audits

- NMC registration audits
- dining experience audits

The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. For example, an audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. Action had been taken to address any identified deficits. A review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection, confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts and alerts regarding staff who had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, monitoring visits were completed in accordance with the regulations and/or care standards and copies of the reports were available for patients, their representatives, staff and trust representatives.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

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

The registered person/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 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 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 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 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the 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 by the registered manager. Once fully completed, the QIP will be returned to Nursing.Team@rqia.org.uk and assessed 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Statutory requirements	
No requirements were made during this inspection.	
Recommendations	
Recommendation 1 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 06 August 2016	The registered persons should ensure that the recruitment process is further developed, to ensure that a record is maintained of the AccessNI reference numbers, the date received and whether or not the checks were clear. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: Whenever an access certificate is received for an employee, the date it was received, the reference number and whether it was clear is recorded in the staff reference register

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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