

Inspection Report 8 and 14 February 2023



Glenkeen House

Type of service: Nursing Home

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Hutchinson Homes Limited Responsible Individuals: Ms Naomi Carey Mrs Janet Montgomery	Registered Manager: Mrs Jacqueline Elizabeth McShane Date registered: 1 April 2005
Person in charge at the time of inspection: Mrs Jacqueline McShane	Number of registered places: 40 The home is approved to provide care on a day basis to 5 persons.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment.	Number of patients accommodated in the nursing home on the day of this inspection: 37
Brief description of the accommodation/how the service operates: This is a registered nursing home registered to care for up to 40 patients. Patients' bedrooms are located over two floors and patients have access to communal dayrooms and dining rooms.	

2.0 Inspection summary

An unannounced inspection took place on 8 February 2023, from 9.30am to 6.00pm by a care inspector and 14 February 2023 from 11.00am to 1.30pm by a finance inspector.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

With regards to finance, adequate controls surrounding patients' finances were in place. Two areas identified within Section 5.2.6 of this report will be reviewed at the next RQIA inspection.

Patients were well presented in their appearance and spoke positively when describing their experiences on 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 members are included in the main body of this report.

Observation showed that staff promoted the dignity and well-being of patients and were knowledgeable of patients' care needs to enable them to deliver safe and effective care. There was a good working relationship between staff and management.

Areas for improvement were identified and can be found in the Quality Improvement Plan (QIP) (Section 6.0).

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.

In relation to finance a sample of patients' financial records was reviewed which included; records of transactions, records of patients' financial arrangements and personal property. Controls surrounding the management of patients' monies and property were also reviewed.

The findings of the inspection were discussed with the manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection patients, staff and patients' relatives were consulted with regarding the services provided in the home. Patients were mostly positively in regard to the care that they received and on their interactions with staff describing staff as being 'very nice' and 'very helpful' to them.

Patients relatives told us they were happy with the service provided in the home, all comments were passed to the manager to address as required. Staff members enjoyed interacting with the patients. One staff member shared their concerns in relation to staffing arrangements in the home.

There were no questionnaire responses received and 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 18 May 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for Improvement 1 Ref: Regulation 13 (4) Stated: First time	The registered person shall ensure that robust arrangements are in place for the disposal of medicines. Records must be dated, recorded in chronological order and verified by a second member of staff. The destruction of controlled drugs prior to disposal must be recorded.	Partially met
	Action taken as confirmed during the inspection: A review of records evidenced that this area for improvement was partially met and was stated for a second time. This is discussed further in section 5.2.2.	

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		Validation of compliance
Area for Improvement 1	The registered person shall ensure that MUST assessments are accurately scored.	Met
Ref: Standard 12	Action taken as confirmed during the inspection:	
Stated: Second time	A review of records evidenced that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at recruitment, a review of records evidenced that pre-employment checks had been completed prior to the staff member commencing in post. However, deficits were identified in one record viewed whereby only one reference had been received. This was discussed with the manager and an area for improvement was identified.

Checks were made to ensure that staff maintained their registrations with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

A system was in place to monitor staffs' compliance with mandatory training. Training was completed on a range of topics such as adult safeguarding, infection prevention and control (IPC), patient moving and handling and fire safety.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked. The duty rota identified the nurse in charge of the home when the manager was not on duty.

Staff told us that they understood their own roles in the home and that teamwork was good. Staff spoken with told us they were generally happy with the staffing levels, however, one staff spoken with told us that the staffing levels at times were not adequate due to shifts not being covered. The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. However, on the day of inspection it was observed that the planned staffing levels for the home were not met due to short notice absence. Whilst no impact to patients was identified, this was discussed with the manager and the ongoing recruitment for the home was discussed. The manager provided an update to RQIA following the inspection that the staffing levels were being addressed.

Most of the patients consulted spoke highly on the care that they received and one patient told us the "Staff are very good and helpful." Two patients spoken with told us that they experienced delays in being attended to. All comments received from patients', staff and patient's visitors were shared with the manager to review and address as needed.

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. All staff received this handover and they confirmed that there were sufficient details shared at this meeting. Staff members were knowledgeable of patients' needs, their daily routine, wishes and preferences.

It was observed that staff provided care in a caring and compassionate manner. Patients told us that they were generally happy living in the home. One said, "I love it here." Another patient told us, "It's very nice, I feel safe".

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 and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Falls risk assessments were completed for patients when they were admitted to the home and reviewed on a monthly basis. When a risk of falls was identified, a dedicated falls care plan was developed to identify measures in minimising the risk as much as possible. Falls in the home were reviewed on a monthly basis to identify if any patterns or trends were emerging which could be counteracted.

A review of a sample of wound care records evidenced that relevant documentation was in place and wound care was provided. However, gaps in the recording of the ongoing assessment and evaluation was identified, this was discussed with manager who agreed to address this and will be further reviewed at the next inspection.

Records of when patients were assisted to change their position were recorded when the patients were in bed. However, the repositioning charts were not completed to reflect the pressure care provided during the day and one patient who had a repositioning record in place, did not have a care plan in place to direct the care required. This was discussed with the manager and an area for improvement was identified.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails and/or alarm mats. It was established that safe systems were in place to manage this aspect of care.

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. Nutritional risk assessments were carried out regularly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST).

The records for patients who required to have their fluid intake/output monitored were not fully completed and there was no evidence that these were reviewed daily by the registered nurses. This was discussed with the manager and an area for improvement was identified.

Patients dined in their preferred dining area; the dining room, lounge or their own bedrooms. Food was prepared freshly in the kitchen. The food served was not fully reflective of what was displayed on the menu. For those patients who required their diets to be modified the combination of foods on offer did not appear appetising. This was discussed with the cook and the manager and an area for improvement was identified.

Staff wore the appropriate personal protective equipment (PPE) when serving and/or assisting with meals and patients, who required, wore clothing protectors to maintain their dignity. Staff sat alongside patients when providing assistance. There was a calm atmosphere in the dining room and patients spoke positively on the mealtime experience.

During the lunchtime meal service, the treatment room was observed to be left unlocked. Various medications were accessible in this room. This was addressed by the nurse and discussed with the manager and an area for improvement was identified.

During the afternoon, patients were offered a choice of drinks from the tea trolley and snacks were provided to the patients. It was observed one patient was offered a snack not in keeping with her dietary requirements. This was discussed with the manager who addressed this with staff. Written assurances were provided to RQIA as to how this was to be monitored going forward.

The arrangements in place for the disposal of medicines were examined. Records were dated and recorded in chronological order and verified by a second member of staff. Evidence of the destruction of controlled drugs before disposal was not always recorded. An area for improvement in this regard was stated for a second time.

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. The home was warm, clean and comfortable. There were no malodours detected in the home. It was observed that various wardrobes were not appropriately secured to the wall. The manager confirmed following the inspection that this had been addressed.

Observation on the day of inspection evidenced that manual handling equipment had not been effectively cleaned between patient use. This was discussed with the manager and an area for improvement was identified.

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

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were suitably furnished. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

Review of records, observation of practice and discussion with staff confirmed that effective training on 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. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept. However, some staff were observed to be wearing nail varnish. This was discussed with the manager who agreed to address this.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, some patients told us they liked the privacy of their bedrooms, but enjoyed going to the dining room for meals and choosing where to sit with their friends. Other patients preferred to enjoy their meals and socialise in the lounge.

The activity planner was displayed in the entrance hall and a notice was displayed and photographs of previous activities as well as some of the patients' arts and crafts. The provision of activities was not reviewed in depth during this inspection and will be further reviewed at a subsequent inspection.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Jacqueline McShane has been the Registered Manager in this home since 1 April 2005.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

A system of audits were in place in the home such as accidents/incidents, care plans and infection prevention and control.

A review of the accidents incidents evidenced these had been notified to RQIA appropriately.

Messages of thanks including any thank you cards and emails received were kept and shared with staff.

There were systems in place and a designated person identified to oversee the appropriate safeguarding procedures and the safeguarding policy.

The home was visited each month by a representative of the responsible individual 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 available for review by patients, their representatives, the Trust and RQIA.

5.2.6 What arrangements are in place to ensure that patients' monies, valuables and personal property are appropriately managed and safeguarded?

It is the policy of the home for patients to manage their own monies. However, in line with The Nursing Homes Regulations (NI) 2005, a safe place was available for patients to deposit items for safekeeping when required. A review of records confirmed that monies and valuables were held for safekeeping for a small number of patients when admitted to the home. The records were up to date at the time of the inspection on 14 February 2023.

It was noticed that an amount was held for a patient admitted in 2015. The manager was advised to contact the patient's care manager at the Health and Social Care Trust to discuss the current arrangements for holding the patient's monies. This will be reviewed at the next RQIA inspection.

A sample of records evidenced that reconciliations (checks) of monies and valuables held on behalf of patients were undertaken on a monthly basis. The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

Discussion with staff confirmed that no bank accounts were used to retain patients' monies and no member of staff was the appointee for any patient, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

Three patients' finance files were reviewed. Written agreements were retained in all three files. The agreements included the details of the current weekly fee paid by, or on behalf of, the patients and a list of services provided to patients as part of their weekly fee. A list of services available to patients at an additional cost, such as hairdressing, was also included within the agreements. The agreements were signed by the patient, or their representative, and a representative from the home.

Review of records and discussion with staff confirmed that all patients' weekly fees, including third party payments, were paid to the home by the health and social care trusts. Discussion with staff confirmed that patients were not paying an additional amount towards their fee over and above the amount agreed with the health and social care trusts.

It was noticed that although the agreements showed the patients' current fees they did not show details of the third party payment which was included within the fee. The manager was advised to show the breakdown of the fee when the agreements are next updated with the new fee. The agreements will be reviewed at the next RQIA inspection.

Discussion with the manager confirmed that it was policy for the home to pay for services, such as hairdressing and podiatry, in advance and subsequently invoice patients or their representatives for the services provided.

A review of a sample of invoices issued to five patients showed that the amounts on the invoices reflected the amounts detailed in the records provided by the hairdresser and podiatrist. These records listed the names of the patients availing of the services and the amount charged to each patient. The records were signed by the hairdresser and podiatrist along with a member of staff to confirm that the services took place.

A sample of two patients' files evidenced that property records were in place for both patients. The records were updated with additional items brought into patients' rooms and when items were disposed of. The records were checked and signed by two members of staff at least quarterly.

Financial policies and procedures were available for inspection. The policies were readily available for staff use. A review of the policies evidenced that they reflected the operational areas for managing patients' finances. The policies were up to date and reviewed at least every three years.

Discussion with staff confirmed that no transport scheme was in place at the time of the inspection.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	2*	5

* 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 Jacqueline McShane, Registered 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 13 (4) Stated: Second time To be completed by: With immediate effect	The registered person shall ensure that robust arrangements are in place for the disposal of medicines. Records must be dated, recorded in chronological order and verified by a second member of staff. The destruction of controlled drugs prior to disposal must be recorded. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Robust arrangements are in place within the home to ensure the correct disposal of all medications, records are maintained, ensuring they are dated, in chronological order and verified by 2 members of staff. The destruction of any controlled drugs are disposed of by denaturing via Denkit and this will be recorded on the disposal record that this process has occurred
Area for improvement 2 Ref: Regulation 14 (2) (a) (b) (c) Stated: First time To be completed by: Immediately and ongoing	The registered person shall ensure as far as reasonably practicable unnecessary risks to health and safety of the patients is identified and so far as possible eliminated. This is stated in reference to the access to medications in the unlocked treatment room Ref: 5.2.2
	Response by registered person detailing the actions taken: Measures have been put in place and all qualified staff informed that all cupboards containing drugs remained locked and the Treatment door is locked at all times

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 Ref: Standard 38 Stated: First time To be completed by: Immediately and ongoing	The registered person shall ensure that each new employee has two references in place prior to commencing employment. Ref: 5.2.1
	Response by registered person detailing the actions taken: Pre-employment checks within the home are robust and are completed prior to any potential new employee commencing employment, unfortunately on 1 occasions the 2 nd reference was not returned despite several attempts to obtain this Measures will be put in place to ensure that the pre-employment checks are more robust to ensure that this does not reoccur and both references are received before commencement of employment
Area for improvement 2 Ref: Standard 23 Stated: First time To be completed by: 1 May 2023	The registered person shall ensure that patients at risk of developing pressure damage have a care plan in place to prescribe the care required. Repositioning records should be accurately maintained to evidence the care delivery. Ref:5.2.2
	Response by registered person detailing the actions taken: All residents that are identified as at risk of developing any pressure damage have a care plan in place to ensure that the identified care is delivered, repositioning charts are recorded when residents are nursed in bed and skin integrity is checked and recorded at each reposition. Repositioning records will continue to record repositioning to reflect the pressure care provided during the day
Area for improvement 3 Ref: Standard 12 Stated: First time To be completed by: 1 May 2023	The registered person shall ensure an accurate fluid balance is recorded for those patients who required to have their fluid intake/output monitored. These records should be reviewed and evaluated daily by a registered nurse. Ref:5.2.2
	Response by registered person detailing the actions taken: Any resident that is identified who requires to have their fluid intake/output monitored, that is any residents who have a long term catheter insitu , will have their fluid intake/output recorded and this will be reviewed daily by registered nurses

<p>Area for improvement 4</p> <p>Ref: Standard 12</p> <p>Stated: First time</p> <p>To be completed by: 31 May 2023</p>	<p>The registered person shall ensure that all staff have adequate training in regard to the provision of modified meals and meals are provided in accordance with the individual patient's requirements.</p> <p>Ref:5.2.2</p> <p>Response by registered person detailing the actions taken: All staff have adequate training in regard to consistencies of different food and fluid stages recommended by SALT and all Levels of diets and fluids are displayed on the nurse's noticeboard and in the dining room and will also be displayed on the tea trolley to ensure if any staff is not sure they have documentation readily available to check against</p>
<p>Area for improvement 5</p> <p>Ref: Standard 46</p> <p>Stated: First time</p> <p>To be completed by: Immediately and ongoing</p>	<p>The registered person shall ensure a robust system is in place for the cleaning of manual handling equipment between patient use.</p> <p>Ref:5.2.3</p> <p>Response by registered person detailing the actions taken: A record has been devised to ensure that the manual handling equipment is cleaned regularly and will be signed by member responsible for the cleaning of the equipment, and the equipment will be checked regularly to ensure that this is being maintained</p>

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