Glenkeen House
RQIA ID: 1414
100 Glenkeen Church Road
Randalstown
BT41 3JX

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Unannounced Care Inspection
of
Glenkeen House

14 March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 14 March from 09.30 to 17.30.

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

The purpose of this inspection was to seek assurances that the care and welfare of patients was in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes, July 2015.

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.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 3 August 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	*1	4

*The requirement made refers to one requirement that was not examined and has been carried forward for future inspection.

The details of the Quality Improvement Plan (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.

2. Service Details

Registered Organisation/Registered Person: Hutchinson Homes Ltd Mrs Janet Montgomery Ms Naomi Carey	**Registered Manager:** Ms Jacqueline Elizabeth McShane
Person in Charge of the Home at the Time of Inspection: Ms 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
Number of Patients Accommodated on Day of Inspection: 3 residents 36 patients	**Weekly Tariff at Time of Inspection:** £520 - £623

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/Process

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

Prior to inspection the following records were analysed:

- 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, four care staff, one registered nurse and two patients' representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- complaints records
- regulation 29 monthly monitoring reports
- cleaning records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 3 August 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care inspection on 3 August 2015.

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 12 (4) (a) (b) **Stated:** First time	The registered person must review the serving of meals to ensure that: • meals are served at a temperature which is in accordance with the nutritional guidelines • staff provide appropriate supervision to patients during mealtimes The deployment of staff at mealtimes and issues in relation to respect and dignity, when assisting patients to eat, must be included in this review. **An audit of the mealtime experience must be submitted to RQIA with the returned QIP.**	**Met**
	Action taken as confirmed during the inspection: A comprehensive audit of the mealtime experience was submitted to RQIA with the returned QIP. During the inspection, meals were observed to be served to patients in a dignified manner and assistance was provided to patients as required. Advice was given to the registered manager regarding the frequency of completing subsequent audits.	

Requirement 2 **Ref**: Regulation 16 (1) (b) **Stated:** First time	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.	**Not Examined**
	Action taken as confirmed during the inspection: Given that there was no patient identified currently residing in the home, who had recently been hospitalised, this requirement has been carried forward for review at future inspection.	
Requirement 3 **Ref**: Regulation 29 (5) (a) **Stated:** First time	A copy of the regulation 29 monitoring reports must be retained in the home and available for inspection.	**Met**
	Action taken as confirmed during the inspection: The regulation 29 monthly monitoring reports were available for inspection.	
Requirement 4 **Ref**: Regulation 27 (2) (c) **Stated:** First time	Seating provided in the home for use by patients must be in good working order, properly maintained in accordance with the manufacturer's instructions and fit for purpose. **An audit of specialist seating and action plan for replacement of identified chairs must be submitted to RQIA with the returned QIP.**	**Met**
	Action taken as confirmed during the inspection: All chairs observed appeared to be intact, properly maintained and in good working order.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 12.5 **Stated:** First time	It is recommended that the registered person must ensure that a variety of hot and cold drinks and snacks are offered to the patients/residents midmorning. **Carried forward from last inspection.**	**Met**
	Action taken as confirmed during the inspection: Observation of the serving mid-morning refreshments confirmed that there was a variety of snacks available for patients to choose from.	
Recommendation 2 **Ref**: Standard 36.2 and 36.4 **Stated:** First time	All policies and procedures should be reviewed to ensure that they are subject to a three yearly review. • A policy on palliative and end of life care should be further developed in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines* and should include the out of hours procedure for accessing specialist equipment and medication. • A policy on death and dying should be developed in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters.* The policies and guidance documents listed above, should be made readily available to staff.	**Met**
	Action taken as confirmed during the inspection: A review of the palliative and end of life care policies confirmed that they had been reviewed in line with this recommendation.	

Recommendation 3 **Ref**: Standard 11.4 **Stated:** First time	The activities programme should be formalised in order for patients to be aware of what activities are planned.	**Met**
	Action taken as confirmed during the inspection: The activities for the home were displayed on an activity board on the ground floor. Inspector confirmed that records relating to activity provision were maintained in the patients' electronic records system.	
Recommendation 4 **Ref**: Standard 4.1 **Stated:** First time	The registered manager must ensure that patients DNR decisions are recorded in keeping with good practice guidelines and there should be evidence of effective communication of DNR decisions between staff involved in the patients care	**Met**
	Action taken as confirmed during the inspection: A review of two patient's care plans confirmed that DNR decisions were recorded appropriately and care plans were in place to address this.	
Recommendation 5 **Ref**: Standard 41.4 **Stated:** First time	The staffing levels on the nursing unit should be reviewed to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home. This refers specifically to days when the registered manager is not on duty and to the shortfall of the twilight shift.	**Met**
	Action taken as confirmed during the inspection: A review of the staff duty roster confirmed that staffing levels were in line with the planned staffing levels discussed with the inspector.	

Recommendation 6 **Ref**: Standard 41 **Stated:** First time	The registered managers hours worked should be included on the duty rota and identify either management duty or working as lead nurse. The duty rota should also record the surname and first name of each member of staff.	**Met**
	Action taken as confirmed during the inspection: A review of the staff duty roster confirmed that records were maintained appropriately.	
Recommendation 7 **Ref**: Standard 33.1 **Stated:** First time	It is recommended that, in addition to the emergency equipment already provided, the following equipment readily available and records maintained of regular checks: • Emergency patient airways (both floors) • Emergency 'ambu' bag (both floors) • Suction equipment (ground floor)	**Met**
	Action taken as confirmed during the inspection: Records were available to evidence regular checks of emergency equipment on both floors. However, the emergency boxes only contained one size patient airway. The manager was advised to obtain advised to provide additional airways in various sizes.	

5.3 Additional Areas Examined

5.3.1. Care Practices

The interactions between patients, and staff were appropriate, and good relationships were evident. Through discussions with staff and the observation of care practice in the home, it was evident that some staff were unclear regarding the prescribed consistency of fluids some patients required. The staff consulted with, were not knowledgeable regarding the different consistencies and the descriptions of fluid consistency varied between staff. Discussion with the registered manager confirmed that training had been provided on dysphagia and thickening fluids. A review of the staff induction record also confirmed that the use of thickening agents was included. However, there was no evidence that competency and capability assessments had been completed in this regard. This was discussed with the registered manager who agreed to further develop the induction programme to ensure that competency and capability assessments are completed as part of the induction programme. A recommendation has been made in this regard.

5.3.2. Care Records

A review of five patient care records evidenced that patients' risk assessments and care plans were generally reviewed on a regular basis. However, a number of deficits were identified and were discussed with the registered manager during feedback. One patient, who was receiving diazepam in response to distressed reactions, did not have a care plan in place in this regard. Another patient, who had been treated with antibiotics for cellulitis and a urinary tract infection similarly did not have a specific care plan in place. Although assessments were generally completed on a regular basis, the outcomes of the assessments were not always reflected in the patients' care plans. For example, two patient care records identified that the patients malnutrition universal screening tool identified high risk levels of weight loss; however, there was no reference to this included in the patient's care plan. Despite care plans being in place for two patients who had been prescribed transdermal pain relief, there was no evidence that a validated pain assessment had been completed. One patient, who had sustained a fall did not have a falls risk assessment or care plan reviewed, following the incident. A recommendation has been made in this regard.

The above deficits and the processes for auditing care records were discussed with the registered manager. Although there was evidence that the care records had been audited on a regular basis, the auditing records did not provide traceability of audit, in terms of the assessments and care plans that were audited and there was no evidence of the follow up action taken to ensure that the identified deficits had been addressed. A recommendation has been made in this regard.

5.3.3. Staff, Patients and Patients' Comments

All comments received were in general positive. Some comments received are detailed below:

Staff

'I have no concerns'
'There is a good atmosphere here, I like it'
'Morale is very good and we all work as a team'
'More activities would be nice'
'It's a nice place to work – I love it here'

Patients

'I have no complaints. They are very good to me here'
'I have no complaints'
'It is very good'
'I have no problems. It is very good'

Patients' representatives

'I couldn't have asked for better'
'I am happy enough. We have no complaints'

5.3.4. Environment

A general tour of the home was undertaken which included review of 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 generally clean, reasonably tidy, well decorated and warm throughout.

However, the cleaner's store on the first floor was found to be disorganised with items stored on the floor, wet cloths were observed in buckets and there was debris on the floor. There were also broken tiles on the wall which required replacement. There were also some areas identified which required cleaning. For example, the undersides of toilet risers and shower chairs were not clean. These matters were conveyed to the registered manager and appropriate action was taken on the day of the inspection.

A review of the cleaning records identified that records were not completed contemporaneously. For example, the records for the first floor did not evidence that bedrooms had been cleaned from 23 February 2016 to the date of the inspection. The cleaning records also did not provide traceability of audit. For example, the records relating to the cleaning of toilets and bedrooms, did not indicate which rooms had been cleaned. There was also no evidence that records were completed on a daily basis and the records did not clearly evidence when weekly/deep cleaning had been completed. A recommendation has been stated in this regard.

These matters were discussed with the registered manager and a recommendation has been made to ensure that the cleaning records are further developed to ensure that there is traceability of audit. Included in this recommendation is the need for training to be provided to cleaning staff on the completion of cleaning records. Records of this training, in whatever form this may be, should be retained in the home.

5.3.5. Areas for Improvement

The registered manager should ensure that all relevant staff have training in the management of dysphagia and are deemed competent in this.

Patients' care plans should reflect the assessed needs of the patients.

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.

The cleaning records should be further developed to ensure that there is traceability of audit. Training should be provided to cleaning staff on the completion of cleaning records.

Number of Requirements:	**0**	**Number of Recommendations:**	**5**

6. Quality Improvement Plan

The issues identified during this inspection are 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 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.

6.1 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.

6.2 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.

6.3 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 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 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 in this report do not absolve the registered provider/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 provider/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 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**
	Response by Registered Person(s) Detailing the Actions Taken: Risk assessments and care plans are updated immediately whenever a resident returns to the home after a period of hospitalisation, unfortunately this could not be verified on the day of the inspection as there had been no recent admissions to hospital
Recommendations	
Recommendation 1 **Ref**: Standard 39.9 **Stated:** First time **To be Completed by:** 11 May 2016	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**
	Response by Registered Person(s) Detailing the Actions Taken: Training on dysphagia has been arranged for all staff within the home and an assessment of staff's competency on dysphagia will be assessed by qualified staff and signed on a relevant form
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be Completed by:** 11 May 2016	Patients' care plans should reflect the assessed needs of the patients. **Ref: Section 5.3.2**
	Response by Registered Person(s) Detailing the Actions Taken: Any resident within the home who has been prescribed diazepam has a care plan in place, if there is a change in any of the resident's condition i.e. UTI, chest infection etc a care plan is immediately put into place and review and evaluated as the need arises
Recommendation 3 **Ref**: Standard 35.3 **Stated:** First time **To be Completed by:** 11 May 2016	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**
	Response by Registered Person(s) Detailing the Actions Taken: The existing care plan audit has been further developed, so the assessments being audited are all individually listed and there is a clear follow action detailed if required

Recommendation 4 **Ref**: Standard 46.2 **Stated:** First time **To be Completed by:** 11 May 2016	The cleaning records should be further developed to ensure that there is traceability of audit. **Ref: Section 5.3.4**
	Response by Registered Person(s) Detailing the Actions Taken: New cleaning records have been developed in accordance with NHS, The national specifications for cleanliness, and staff have had training on record keeping and the head housekeeper will be responsible for auditing these records

Registered Manager Completing QIP	Jacqueline Mc Shane	**Date Completed**	2/6/16
Registered Person Approving QIP	Janet Montgomery	**Date Approved**	2/6/16
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	10/06/2016

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