Unannounced Care Inspection Report
8 November 2018

Glenkeen

Type of Service: Nursing Home
Address: 100 Glenkeen Church Road, Randalstown, BT41 3JX
Tel no: 02894479794
Inspector: Dermot Walsh

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 40 persons.

3.0 Service details

Organisation/Registered Provider: Hutchinson Homes Ltd **Responsible Individual(s):** Janet Montgomery Naomi Carey	**Registered Manager:** Jacqueline Elizabeth McShane
Person in charge at the time of inspection: Jacqueline Elizabeth McShane	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment	**Number of registered places:** 40 The home is approved to provide care on a day basis to 5 persons. There shall be a maximum of 1 named resident receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 8 November 2018 from 10.00 to 17.30 hours.

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 Care Standards for Nursing Homes 2015.

The term 'patient' is used to describe those living in Glenkeen House which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified during and 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.

Evidence of good practice was found in relation to staffing arrangements, staff training and development, monitoring registration status of staff, communication, quality improvement and the home's general environment. Further good practice was found in relation to teamwork, maintaining good working relationships and with the delivery of compassionate care.

Areas requiring improvement were identified under standards in relation to safe storage of equipment and with recommendations from another healthcare professional.

Patients described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. Some patients' comments can be found in section 6.6. There was evidence that the management team listened to and valued patients and their representatives and took account of the views of patients.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Jacqueline McShane, 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.

4.2 Action/enforcement taken following the most recent inspection dated 13 September 2018

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 13 September 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with nine patients, four patients' representatives and nine staff. A poster was displayed at a staffing area in the home inviting staff to respond to an online questionnaire. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten questionnaires for patients and 10 for patients' representatives were left for distribution.

A poster indicating that the inspection was taking place was displayed at the entrance to the home and invited visitors/relatives to speak with the inspector. The inspector provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients, relatives and families, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

The following records were examined during the inspection:

- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff duty rota for week commencing 5 November 2018
- staff training records
- incident and accident records
- three patient care records
- three patients' daily care charts including bowel management, personal care, food and fluid intake charts and reposition charts
- a selection of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, not met or partially met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 13 September 2018

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector and will be validated at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 1 May 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (1) (a) and (b) **Stated:** Second time	The registered persons shall ensure that patient care records accurately reflect the assessed needs of any patient and evidence that assessed need has been reviewed and that care plans have been developed and reviewed to reflect the current assessed need of an individual. Wound care records should also be supported by wound photography, in keeping with the National Institute of Clinical Excellence (NICE) guidelines.	**Met**
	Action taken as confirmed during the inspection: A review of two patient care records evidenced that this area for improvement is now met.	
Area for improvement 2 **Ref:** Regulation 12 (1) (a)(b) **Stated:** First time	The registered person shall ensure that post falls management is conducted in accordance with best practice guidance.	**Met**
	Action taken as confirmed during the inspection: A review of one patient's care and accident records following a fall evidenced that the appropriate actions had been taken and documented following the fall.	
Area for improvement 3 **Ref:** Regulation 19 (2)	The registered person shall ensure that a record is maintained of all visitors to the home.	**Met**
	Action taken as confirmed during the inspection: A visitor's book to record visitors to the home was available at reception and had been recorded.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time	The registered persons must ensure that registered nurses review patients' elimination records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records.	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced that elimination records had been completed appropriately.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that the identified patient's nutritional care plan is updated to reflect the current needs of the patient.	**Unable to validate**
	Action taken as confirmed during the inspection: The identified patient was no longer accommodated in the home.	
Area for improvement 3 **Ref**: Standard 4 Criteria (9) **Stated:** First time	The registered person shall ensure that repositioning records evidence each occasion the patient is repositioned and records include evidence of skin checks.	**Met**
	Action taken as confirmed during the inspection: A review of three repositioning records evidenced that this area for improvement is now met.	
Area for improvement 4 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure training is provided to confirm that staff involved in providing/assisting with patients' meals can differentiate between the different prescribed textures of meals.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of training records evidenced that this area for improvement is now met.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. Staff rotas confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff. Discussion with staff, patients and patients' representatives evidenced that there were no concerns regarding staffing levels. Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Glenkeen House. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients' needs in a timely and caring manner.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC).

We discussed the provision of mandatory training with staff and reviewed staff training records. A system was evident to ensure compliance with mandatory training compliance. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients. The registered manager was aware of and had made preparation for training on the implementation of new nutritional guidelines.

Discussion with staff and the registered manager confirmed that staff were coached through annual staff appraisals and twice yearly supervisions.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. An adult safeguarding champion had been identified and had attended training pertinent to the role.

Review of three patients' care records evidenced that a range of validated risk assessments were completed and had been reviewed as required. These assessments informed the care planning process.

We reviewed accidents/incidents records since the previous care inspection in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Notifications were submitted to RQIA in accordance with regulation.

Discussion with the registered manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. This information was also reviewed as part of the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. There was evidence of recent refurbishment of bedrooms on the first floor. The home was found to be warm, fresh smelling, well decorated and clean throughout. Two patients commented positively on the cleanliness of the home during consultation. Fire exits and corridors were observed to be clear of clutter and obstruction. Stairwells were also observed to be clear. Compliance with best practice in infection prevention and control (IPC) had been well maintained. Isolated IPC issues were managed during the inspection. However, an identified storage room within the home was observed to be cluttered and items had been stored in a manner which would not comply with a safe working environment. This was discussed with the registered manager and identified as an area for improvement.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, staff training and development, monitoring registration status of staff and the home's general environment.

Areas for improvement

An area for improvement was identified under standards in relation to safe storage.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Comments from staff included teamwork was, "Very good". Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge.

Electronic record keeping was maintained in the home. As previously stated, appropriate risk assessments had been conducted on admission; reviewed as required and had informed care

plans. We reviewed three patient care records for the management of nutrition, falls and wound care.

Wound care records had been maintained in accordance with best practice. An initial wound assessment had been completed and had informed the wound care plan. The wound care plan had been updated appropriately to reflect changes to the wound dressing regime. A body map had been completed and there was a photograph of the wound within the records. Progress of the wound had been recorded well at the time of wound dressing on evaluation records.

As previously stated, accident records had been maintained appropriately following a fall. The patient's falls risk assessment and falls care plan had been updated following the fall. However, a review of one patient's care records in respect of nutrition contained conflicting information. The patient's care plan did not correspond with the recommendations of the speech and language therapist. This was discussed with the registered manager and identified as an area for improvement.

Supplementary care records such as bowel management, repositioning and patients' food and fluid intake records were reviewed. Records reviewed had been completed contemporaneously and in accordance with best practice.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to risk assessment, handover and teamwork.

Areas for improvement

An area for improvement was identified under standards in relation to updating patient care records to reflect the recommendations of another health professional.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences.

A relatives' noticeboard was positioned on the wall of the corridor beside the dining room. Details displayed included the arrangements for religious services and Eucharistic minister visits. There were results displayed from a client satisfaction survey conducted in January 2018 and a list of the activities planned for patients in the home. The home employed a dedicated activity therapist who advised that activities scheduled could be altered to facilitate patient preferences.

The serving of lunch was observed in the dining room on the ground floor. A choice of meals was evident for the lunch and evening meal. The mealtime was well supervised. Patients were seated around tables which had been appropriately set for the meal. Food was served directly from the kitchen when patients were ready to eat or be assisted with their meals. Food was covered when transferred from the dining area to the patients' preferred dining area such as their bedroom. Staff were observed to encourage patients with their meals and patients were observed to be assisted in an unhurried manner. The food served appeared nutritious and appetising. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors where required. A range of drinks were offered to the patients. Patients appeared to enjoy the mealtime experience and spoke positively on the quality of the food. Patients also confirmed that they could request food and/or snacks at any time during the day in addition to mealtimes and the tea trolley.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

"Just a little note to thank you from the bottom of our hearts for all the care from the laundry, kitchen, carers, nursing and auxiliary staff for the exceptional way you care for mum. It's sincerely appreciated."
"We can't praise your staff highly enough for all they do."
"To all the staff in Glenkeen, sincere best wishes to you all. Your support to me I will never forget."

Consultation with nine patients individually, and with others in smaller groups, confirmed that living in Glenkeen House was a positive experience. Ten patient questionnaires were left for completion. None were returned within the timeframe.
Patient comments:

"The place is kept clean and tidy. Staff here are very cheery."
"It is very good. Best place ever I was in."
"I don't mind coming here."
"I have no complaints with this place."
"I get my milky coffee every morning. The home is spotlessly clean."
"The home is very good. Very good nurses here."

Four patient representatives were consulted during the inspection. Ten relative/representative questionnaires were left for completion. None were returned. Some patient representatives' comments were as follows:

"I have no complaints about this home. The staff are lovely and the personal care is fantastic. All we do is buy the toiletries."
"I am made to feel welcome any time I am in. Staff are always pleasant."
"It is a lovely home. The layout of the home just works. Staff are always with the patients. Staff are fantastic here."

Nine staff were consulted during the inspection. Staff were asked to complete an online survey; we had no responses within the timescale specified. Comments from staff consulted included:

"I really enjoy my job."
"It is good here. No two days are the same."
"It's very good for me here."
"This is one of the better homes I have worked in."
"It can be very busy here but enjoyable."
"I really like it here."

Any comments from patients, patient representatives and staff in returned questionnaires or online responses received after the return date will be shared with the registered manager for their information and action, as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home in maintaining the dignity and privacy of patients and valuing patients and their representatives.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with the registered manager and staff, and observations confirmed that the home was operating within its registered categories of care.

Review of the home's complaints records and discussion with the registered manager evidenced that complaints received were recorded and managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the registered manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, care records, wound care and infection prevention and control practices. Care record audits were reviewed. Auditing records included an action plan and a review of actions taken. Records were signed and dated appropriately.

Quality monitoring visits were completed on a monthly basis in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jacqueline McShane, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 47 **Stated:** First time **To be completed by:** 15 November 2018	The registered person shall ensure that items stored in the home are done so in a safe manner and promote a safe and healthy working environment. Ref: 6.4
	Response by registered person detailing the actions taken: The activity store room has been tidied ensuring no items are left on the floor creating a safe and healthy working environment and will be checked regularly to ensure compliance
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 30 November 2018	The registered person shall ensure that recommendations from other health care professionals are documented; adhered to and care provided evidenced within the patient's care records or the reason not complied with documented. Ref: 6.5
	Response by registered person detailing the actions taken: Any correspondence recommended from other health care professionals are documented and adhered to. Care plans are updated to reflect any changes and all staff are made aware of any changes to be implemented to the resident's care needs within the home

Please ensure this document is completed in full and returned via Web Portal

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