Unannounced Care Inspection Report
14 September 2017

Glenkeen House

Type of Service: Nursing Home (NH)
Address: 100 Glenkeen Church Road, Randalstown, BT41 3JX
Tel No: 028 9447 9794
Inspector: Aveen Donnelly

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 Individuals:** 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 Residential Care (RC) I – Old age not falling within any other category. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 40 The home is also approved to provide care on a day basis to 5 persons

4.0 Inspection summary

An unannounced inspection took place on 14 September 2017 from 09.20 to 14.30 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 DHSSPS Care Standards for Nursing Homes 2015.

The term 'patients' is used to describe those living in the home 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.

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment. The patient care records were generally well maintained and reflective of the patients' needs; and communication between residents, staff and other key stakeholders was well maintained.

Patients were treated with dignity and their privacy was important to staff; activities were well managed. There were also examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships within the home.

Areas for improvement made under the regulations related to the wound care records; and the variety of meals offered to patients. Areas for improvement made under the care standards related to the monitoring of patients' elimination records; and in relation to the system for managing alerts for staff that had sanctions imposed on their employment by professional bodies.

Patients said they were generally happy living in the home. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

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	2	2

Details of the Quality Improvement Plan (QIP) were discussed with Jackie 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 31 August 2016

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 21 August 2017. 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 inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- 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 quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report

- pre inspection assessment audit.

During the inspection the inspector met with five patients, three care staff, two registered nurses and one patients' representative. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- staffing arrangements in the home
- one staff personnel file to review recruitment and selection
- staff induction, supervision and appraisal records
- staff training records for 2016/2017
- accident and incident records
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- emergency evacuation register
- six patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- patient register
- annual quality report
- compliments records
- RQIA registration certificate
- certificate of public liability
- audits in relation to care records and falls
- complaints received since the previous care inspection
- minutes of staff', patients and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports 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, partially met or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 6 June 2016

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

6.2 Review of areas for improvement from the last care inspection dated 6 June 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 38.3 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of the recruitment processes confirmed that this recommendation had been 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 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 for the week commencing 10 September 2017 evidenced that the planned staffing levels were generally adhered to.

Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Discussion with patients and their representatives evidenced that there were no concerns regarding staffing levels.

Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

A review of one personnel file and discussion with the registered manager evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their registrations were checked with NMC and NISCC, to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed

with Access NI and satisfactory references had been sought and received, prior to the staff member starting their employment.

A record of staff including their name, address, contact number, position held, contracted hours, date of receipt of Access NI certificate, date commenced and date position was terminated (where applicable) was maintained and provided an overview of all staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

Newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence.

There were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed face to face 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 adult prevention and protection from harm. The records reviewed confirmed that the majority of staff had, so far this year, completed their mandatory training.

Observation of the delivery of care evidenced that training had been embedded into practice. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly quality monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with NMC. Similar arrangements were in place to ensure that care staff were registered with NISCC.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had.

There were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. Discussion with the registered manager also evidenced that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of patient care records evidenced that validated risk assessments were completed as part of the admission process and were reviewed as required. 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 were consistently completed following each incident and that care management and patients' representatives were notified appropriately.

Infection prevention and control measures were adhered to and equipment was stored appropriately. There were processes in place to check that emergency equipment, such as the suction machines, were regularly checked as being in good order and fit for use. This meant that in the event of an emergency the equipment was ready for use.

A review of the home's environment was undertaken which included a number 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. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Fire exits and corridors were observed to be clear of clutter and obstruction. The emergency evacuation register was up to date and included the details of the last patient admitted to the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Review of six patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and language therapist (SALT), dietician and Tissue Viability Nurse specialists (TVN).

Discussion with registered nurses and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Where patients were prescribed antibiotic therapy for the treatment of acute infections, care plans had been developed in relation to this; and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

Patients who had been identified as being at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner.

Patients who were identified as requiring a modified diet, had the relevant risk assessments completed. Care plans in place were reflective of the recommendations of SALT and care plans were kept under review.

A sampling of food and fluid intake charts confirmed that patients' fluid intakes were monitored and recorded in the daily progress notes. This is good practice.

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.

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

A record of patients including their name, address, date of birth, marital status, date of admission and discharge (where applicable) to the home, next of kin, general practitioner and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Despite these areas of good practice, some areas for improvement were identified. For example, a review of one patient's wound care records evidenced that although wound dressings were changed in keeping with the recommendations made by the TVN, wound assessments had not consistently been completed. It was also identified that one care plan was in place, despite there being two separate wounds present; and the care plan did not clearly indicate the frequency with which the dressing should have been changed. There was also no evidence that wound photography had been used in keeping the National Institute of Clinical Excellence (NICE) guidelines. This has been identified as an area for improvement under the regulations.

There was also no evidence that the patients' elimination records were being monitored by the registered nurses. For example, there were many gaps in the completion of bowel functioning records and therefore it was difficult to ascertain if any appropriate action had been required or taken. This has been identified as an area for improvement under the care standards.

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

Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent general staff meeting was held on 9 August 2017. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

A patients' meeting had been held on 25 July 2017. A relatives' meeting had been scheduled to take place on 26 July 2017; however no relatives attended this. All those consulted with confirmed that if they had any concerns, they could raise these with the staff and/or the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping; oversight of weight loss; and communication between residents, staff and other key stakeholders.

Areas for improvement

An area for improvement made under the regulations related to the wound care records. An area for improvement made under the care standards related to the monitoring of patients' elimination records.

	Regulations	Standards
Total number of areas for improvement	1	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 interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients 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. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal in the dining room. The lunch served appeared appetising and the majority of patients spoken with stated that they were satisfied with the meals provided. The atmosphere was quiet and tranquil and patients were encouraged to eat their food; assistance was provided by staff, as required.

We also observed that the menu was displayed and reflected the meal which was served. However, there were some areas for improvement identified in relation to the management of meals. For example, the review of the three weekly menu identified that it was not varied, particularly in relation to the choices that were available to patients who required a modified diet. Only a small number of patients were asked in advance what they wanted to eat; and there was no system in place to record patients' meal choices. This has been identified as an area for improvement under the regulations.

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. One staff members was designated to provide activities in the home. There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. Advice was given to the registered manager in relation to displaying the planned activities in a format the patients could understand.

There was evidence of regular church services to suit different denominations. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

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. An annual quality audit had been undertaken in 2016; views and comments recorded were analysed and areas for improvement had been 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 their relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for the 'care, love, compassion and warmth' shown to family members, when their loved one was receiving end of life care.

During the inspection, we met with five patients, three care staff, two registered nurses and one patients' representative. Some comments received are detailed below:

Staff

"The care is brilliant, we do our best."
"The care is very good, we enjoy the chat with the residents."
"The care is excellent, I absolutely love my job."
"I have no concerns, it is very good."
"Everything is fine, no concerns here."

Patients

"It is very good, they give me a cup of tea at 5am every day."
"I like it here, it's homely."
"It is good, the staff are happy, no complaints here."
"They are dead on here."
"All is ok in this place."

Patients' representative

"Everything is going well, the girls are very nice."

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. Seven staff, seven patients and four relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

Patients: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One written comment was received including 'I do not know who the manager is.'

Relatives: respondents indicated that they were 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One respondent provided written comment in relation to the environment and to the delivery of effective care. Following the inspection, this comment was relayed to the registered manager to address.

Staff: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. Two respondents provided written comments in relation to staffing levels; one comment related to the cleaning of seating within the home. Following the inspection, these comments were relayed to the registered manager.

Any comments from patient representatives and staff in returned questionnaires 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, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Activities were well managed.

Areas for improvement

An area for improvement made under the regulations related to the variety of meals offered to patients.

	Regulations	Standards
Total number of areas for improvement	1	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.

Observation of patients and discussion with the registered manager 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.

Staff consulted with stated that there were good working relationships and that management were responsive to any suggestions or concerns raised. All those consulted with described the registered manager in positive terms. Staff described how they felt confident that the registered manager would respond positively to any concerns/suggestions raised.

There was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities and 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 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 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 confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Discussion was undertaken in relation to the complaints procedure; which needed to include the details for contacting the Patient Client Council. The registered manager agreed to address this matter.

Systems were 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 and there was evidence that the necessary improvements had been embedded into practice.

A review of the patient falls audit evidenced that this was analysed to identify patterns and trends, on a monthly basis. An action plan was in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

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; however the system in place for managing staff alerts was not sufficiently robust given and did not evidence all the alerts, which had been issued by the Chief Nursing Officer (CNO). These relate to staff that had sanctions imposed on their employment by professional bodies. This has been identified as an area for improvement under the care standards.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement.

Areas of good practice

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

Areas for improvement

An area for improvement made under the care standards related to the system for managing alerts for staff that had sanctions imposed on their employment by professional bodies.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jackie 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (1) (a) and (b) **Stated:** First time **To be completed by:** 12 November 2017	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. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Whenever a patient has more than 1 wound present a separate care plan will be devised for each wound and not 1 care plan as had been the previous case. A photograph will be taken of the wounds in keeping with the National Institute of Clinical Excellence (NICE) Guidelines
Area for improvement 2 **Ref:** Regulation 12 (4) (d) and (e) **Stated:** First time **To be completed by:** 12 November 2017	The registered persons shall ensure that the provision of meals is reviewed, to ensure that the meals served are varied and that records are maintained to evidence that all patients are given a choice in relation to their meals. This relates particularly to, but is not limited to patients who require a modified diet. **Ref: Section 6.6**
	Response by registered person detailing the actions taken: The menus have been reviewed and a varied menu is provided, that present records are reviewed to evidence that all patient's are given a choice in relation to their meals.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 12 November 2017	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. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: A new elimination record has been devised that enables registered nurses to review the records on a daily basis and record any actions in the daily records. Entries are recorded on a daily basis including when there has been no bowel movement

Area for improvement 2 **Ref**: Standard 35.18 **Stated:** First time **To be completed by:** 12 November 2017	The registered persons shall implement a robust system to manage alerts received in relation to medication, equipment and devices; and Chief Nursing Officer (CNO) alerts regarding staff who have sanctions imposed on their employment by professional bodies **Ref: Section 6.7**
	Response by registered person detailing the actions taken: Files are in place so that care staff alerts from NISCC and Chief Nursing Officer (CNO) alerts are held separately. Alerts received in relation to medication, equipment and devices are also held in a separate file

The Regulation and Quality Improvement Authority

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