Glendun Nursing Home
RQIA ID: 1415
67 Knocknacarry Road
Cushendun
BT44 0NS

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Unannounced Care Inspection
of
Glendun Nursing Home

16 November 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 16 November 2015 from 10:15 to 16:15 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Glendun Nursing Home 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 18 January 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	3

The details of the Quality Improvement Plan (QIP) within this report were discussed with the responsible individual, Mr David Morgan at the conclusion of the inspection; and with the registered manager Ms Clare Burke, by telephone on 24 November 2015, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Glendun Nursing Home Ltd Mr David Morgan – responsible individual	**Registered Manager:** Ms Clare Burke
Person in Charge of the Home at the Time of Inspection: Registered Nurse R McKay	**Date Manager Registered:** 4 June 2015
Categories of Care: NH – I, PH and PH(E) RC – I, PH(E), MP(E) and DE Maximum of 20 residential beds. Maximum of 5 residents within category RC-DE	**Number of Registered Places:** 46
Number of Patients Accommodated on Day of Inspection: NH- 22 RC- 19	**Weekly Tariff at Time of Inspection:** £480 - £603

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were examined:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the returned quality improvement plans (QIP) from the last care inspection
- the previous care inspection report
- pre-inspection assessment audit.

During the inspection the delivery of care and care practices were observed. A review of the general environment was also undertaken. The inspection process allowed for consultation with seven patients individually and with others in small groups, four relatives, four care staff, one registered nurse and two housekeeping staff.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes
- duty rotas for nursing and care staff from 9-22 November 2015
- training records
- staff induction templates
- compliment records
- three patient care records including care charts
- palliative care/end of life/grievance and bereavement resource files.

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 18 January 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection.

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 27(20)(t) **Stated:** First time	The registered person shall, having regard to the number and needs of patients, ensure that – (t) a risk assessment to manage health and safety is carried out and up dated when necessary. Reference to this is made in that a risk assessment must be carried out on all radiators/hot surfaces in accordance with current safety guidelines with subsequent appropriate action.	**Met**
	Action taken as confirmed during the inspection: The responsible individual confirmed that the registered manager had addressed this requirement. Following the inspection the registered manager confirmed by email on 24 November 2015 that this requirement had been met.	

Requirement 2 **Ref**: Regulation 20(1) (a) **Stated:** First time	The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of patients – (a) Ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients. Reference to this is made in that a review of the skill mix of trained staff and senior care assistant staff must be undertaken so it accounts for the patient/resident dependencies, over a 24 hours period taking account of the size and layout of the home.	**Met**
	Action taken as confirmed during the inspection: Discussion with the responsible individual, staff, patients and relatives; and a review of duty rotas from 9-22 November 2015 evidenced that staffing levels met the assessed needs of the patients accommodated. Discussion with the nurse in charge and senior care assistants confirmed that a review of staffing had been undertaken. Senior care assistants on duty were responsible for care delivery for residential residents which included the administration of medications. There were no concerns raised regarding staffing levels. Based on the available evidence, this requirement was assessed as met.	
Requirement 3 **Ref**: Regulation 19(1) (a) Schedule 3 (3) (k) **Stated:** First time	The registered person shall – (a) Maintain in respect of each patient a record which includes the information, documents and other records specified in schedule 3 relating to the patient; (b) A contemporaneous record of all nursing provided to the patient including a record of his condition and any treatment, or surgical intervention Reference to this is made in that the use of terms such as “unsettled”, “aggressive” must be refrained from, and such behaviour recorded in sufficient detail with a recorded statement of care/treatment given and effect of same.	**Met**

	Action taken as confirmed during the inspection: Review of three patient care records evidenced that this requirement as stated had been met.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 25.11 **Stated:** First time	Working practices are systematically audited to ensure they are consistent with the home's policies and procedures, and action is taken when necessary. Reference to this is made in that: • The registered manager should sign all accident/incident reports on a regular and up to date basis as reviewed/inspected • Confirmation should be recorded on whether the patient's/resident's aligned care manager was notified of the event.	**Met**
	Action taken as confirmed during the inspection: Review of records including regulation 30 notifications to RQIA confirmed that this recommendation had been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available in relation to communication. There was no date on the policy. The registered nurse in charge of the home (RN) confirmed that the registered manager had undertaken a review of the policies and procedures pertaining to the inspection themes and focus. Copies of revised policies and procedures were available with evidence that some staff had read them.

Discussion with the registered manager, by telephone, on 24 November 2015 confirmed that a review of all policies and procedures was needed and would be undertaken in accordance with the DHSSPS Care Standards for Nursing Homes (April 2015).

Discussion with staff evidenced that some had knowledge of the new policies and procedures and but also that none of the staff spoken with were aware of the regional guidance document 'Breaking Bad News' (February 2003). A recommendation was made.

Discussion with the nurse in charge, staff and a sampling of training records evidenced that staff had or would complete training in relation to communicating effectively before the end of the inspection year.

The registered manager confirmed that she was working with the Northern Health and Social Care Trust (NHSCT) nurse facilitators for the nursing home 'In reach' programme which included the development of training programmes specific to nursing homes. This is good practice.

Is Care Effective? (Quality of Management)

Care records reviewed included reference to the patient's specific communication needs and actions required to manage barriers such as, language, culture, cognitive ability or sensory impairment. There was also evidence that patients and their representatives were included in discussions regarding communication and treatments options, where appropriate.

Discussion with four relatives confirmed that communication was appropriate and effective.

Staff consulted clearly demonstrated their ability to communicate sensitively with patients and/or representatives. Care staff confirmed that when or if 'bad news' had to be communicated, they would refer relatives or the patient, to the nurse in charge of the home regarding health and care matters; but that they would be comfortable and confident of managing the initial enquiry or concern raised.

Registered nurses consulted demonstrated awareness and knowledge of how to communicate sensitively and effectively with their patients, relatives, the staff team and management.

Is Care Compassionate? (Quality of Care)

Observation of care delivery and interaction between patients and staff clearly demonstrated that communication was compassionate and considerate of the patient's needs. Patients were treated with dignity and respect and responded to in a timely manner.

Patients who could verbalise their feelings on life in Glendun Nursing Home commented positively in relation to the care they were receiving and the attitude of staff. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

Positive comments were also viewed in letters and cards received by the home from relatives. Four relatives spoken with confirmed that staff were caring, compassionate and sensitive towards their loved one but also toward them. They described the home as "homely and relaxed".

Areas for Improvement

It was recommended that staff should be aware of the content of the revised policies/procedures including the relevant regional guidance which underpins care delivery, commensurate with their role and function.

Number of Requirements:	**0**	**Number of Recommendations**:	**1**

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013. As stated in section 5.3 the registered manager had undertaken a review of the policies and procedures pertaining to the inspection themes and focus. Copies of revised policies and procedures were available with evidence that some staff had read them.

Staff spoken with clearly demonstrated knowledge of care delivery in relation to palliative and end of life care. Staff described experiences of how they supported patients, relatives and colleagues. However, staff were not aware of the regional best practice guidelines which underpin their practice. A recommendation was made previously in this regard.

Confirmation was provided that staff were to receive up dated training in the management of palliative care, death, dying and bereavement. As stated previously the registered manager confirmed that she was working with the NHSCT nurse facilitators which included the development of a training programme in relation to palliative and end of life care, specific to the nursing home. This training was to be delivered before the end of the inspection year.

Discussion with nursing staff and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with staff and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or medications was in place. There was evidence of input from local GP practices in relation to enabling patients and families to choose to be nursed in their home – Glendun Nursing Home.

Is Care Effective? (Quality of Management)

Care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A specific 'end of life strategy' with accompanying documents was available to staff. Care records reviewed evidenced that these documents were utilised in assessing and planning end of life care.

Discussion with the nurse in charge and staff evidenced that reasonable arrangements for relatives/representatives to be with patients who had been ill or dying were made. Staff confirmed that relatives were supported with tea, coffee, meals and advice as required.

A review of notifications to RQIA since the previous inspection confirmed that any death occurring in the home was notified appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. Staff consulted demonstrated an awareness of patients' expressed wishes and needs as identified in their care plan.

Staff spoken with demonstrated clearly their compassion for the patients, their relatives and friends. The inspector commended how staff interacted with patients and of the detailed knowledge demonstrated to ensure patients were afforded privacy, dignity and respect.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes; for family/friends to spend as much time as they wish with the person. All staff spoken with described how they would provide support to families who were 'sitting with loved ones'.

Review of the compliment records evidenced that arrangements in the home were sufficient to support relatives during this time.

There was evidence within compliment records that relatives had commended the management and staff for their efforts towards the family and patient. Some examples of comments made by relatives included the following:

"You provided a warm homely atmosphere and we were made so welcome no matter what time we visited."

"…to express our sincere thanks to you and the staff of Glendun Nursing Home for all you did to facilitate Mass for the family at … bedside."

"To all staff for your unending care and attention to …"

"…to all the staff we would like to say to each and every one of you a big thank you for the wonderful care given to…in [their] last days."

From discussion it was evident that arrangements were in place to support staff following the death of a patient. Staff described how they supported colleagues and that they had an opportunity to pay their respects by attending the funeral. Staff said they found this helpful in expressing their sympathy toward the family and in paying their last respect to the patient.

Areas for Improvement

It was recommended previously that staff should be aware of the content of the revised policies/procedures including the relevant regional guidance which underpins care delivery, commensurate with their role and function.

Number of Requirements:	**0**	**Number of Recommendations:** * recommendation made is stated under Standard 19; refer to section 5.3	**1 ***

5.5 Additional Areas Examined

5.5.1 Consultation with Patients, Staff and Patient Representative/Relatives

Patients

Seven patients were spoken with individually and others in small groups. Patients were complimentary regarding the standard of care they received, the attitude of staff and the food provided. There were no concerns raised with the inspector.

Eight questionnaires for patients were left with the nurse in charge for distribution. One had been returned at the time of writing this report. The respondent indicated that they were 'very satisfied' with all aspects of their care.

Staff

Staff spoken with raised no concerns.

In addition to speaking with staff on duty, eight questionnaires were provided for staff not on duty. The nurse in charge agreed to forward these to the staff selected. At the time of writing this report three had been returned. All three staff indicated that they were 'very satisfied' with the training provided, care delivered to patients and that they felt supported by senior staff and management.

Additional comments recorded included:

"Good practice is followed and all patient wishes are respected".

"I feel that clients are attended to with compassion and care in end of life care and relatives are treated with care and compassion also".

"Training for staff is improving…patient care carried out".

"Staff appear to build up a good rapport with clients and their relatives and there is a good atmosphere in the day to day running of the home".

Representatives/Relatives

There were no concerns raised by the four relatives spoken with during the inspection.

In addition questionnaires were provided for patient representatives/relatives for distribution by the nurse in charge. At the time of writing this report four were returned. Respondents indicated that they were either 'satisfied' or 'very satisfied' with the care and services provided for their loved ones.

Additional comments recorded included:

"The home is an 'A' class establishment. Staff TOP NOTCH!! Great empathy with whoever is in their care. No barriers with relatives. Direct and open in all aspects".
"The only home I have visited where the patient is priority. Staff are there for them not the other way round. Staff very patient and take time with all".

5.5.2 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms, bathrooms, lounge and dining rooms and stores on each floor.

The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients were observed relaxing in their bedrooms or in one of the lounge areas available. Patients spoken with were complimentary in respect of the home's environment.

Discussion took place in respect of the management of the internal smoking room. It was agreed that this matter would be discussed in full with the estates inspector during the planned estates inspection on 24 November 2015.

In one bedroom it was observed that a single bed mattress was in use as a 'fallout' or 'crash mat' in the prevention of injury following a fall from bed. Review of the patient care plans indicated that this patient required bedrails. The purpose of the mattress was discussed with the nurse in charge. Before the conclusion of the inspection the nurse in charge confirmed that she had reviewed the patient's needs and had removed the mattress. She also confirmed that staff would be informed that equipment was only to be used for the purpose it was designed.

5.5.3 Record Keeping

Care records examined were found to be generally maintained in accordance with, regulatory, professional and minimum standards. Additional care charts maintained in patient's bedrooms were found to be inconsistently recorded and in particular those indicating the application of topical medications. This was discussed during feedback with the responsible person and the registered manager, by telephone on 24 November 2015. A recommendation was made.

Nursing and care staff duty rotas from 9 to 22 November 2015 were reviewed. The registered manager's hours had not been recorded in advance and the hours worked by the registered manager as the nurse in charge of the shift had not been recorded. A recommendation was made.

5.5.4 Registration of Categories of Care

Review of patients' assessed needs indicated a potential breach of regulations relating to the home's registered categories of care. Following explanation from the responsible person a discussion took place in respect of making application to RQIA to vary the home's registration. requirement was made that an application to vary registration be made to RQIA as soon as possible. RQIA received an application of variation 25 November 2015. In addition a letter was issued outlining responsibilities in this area. A requirement was made.

Areas for Improvement

A recommendation was made that patient records were maintained contemporaneously and therefore accurate in relation to the delivery of care and that the records are held confidentially to maintain the patient right to privacy.

A recommendation was made that the registered manager's hours are recorded in advance and that the registered manager hours worked as the nurse in charge of a shift are clearly

recorded against the hours worked supernumerary. This recommendation was discussed in detail with the registered manager, by telephone, on 24 November 2015.

It was required that the nursing home not provide accommodation for any person outside of the registered categories of care.

Number of Requirements:	1	Number of Recommendations:	2

6 Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr D Morgan, responsible individual, and Mrs C Burke, 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 within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that any requirements and recommendations set out in this report will provide the registered person/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 15(1)(e) **Stated:** First time **To be Completed by:** 30 November 2015.	It is required that the registered persons ensure that nursing home does not provide accommodation for any person outside of the registered categories of care. **Ref: Section 5.5.4**
	Response by Registered Person(s) Detailing the Actions Taken: An application for Variation to Registration was submitted to RQIA on 24 November 2015
Recommendations	
Recommendation 1 **Ref**: Standard 36 **Stated:** First time **To be Completed by:** 31 January 2016	It is recommended that staff should be aware of the content of the revised policies/procedures including the relevant regional guidance which underpins care delivery, commensurate with their role and function. **Ref: Section 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Individual 'Staff Policy Awareness' forms are in place which staff complete when they have read any Policy & Procedure and any relevant Regional Guidance
Recommendation 2 **Ref**: Standard 37 **Stated:** First time **To be Completed by:** 31 December 2015	It is recommended that patient records are maintained contemporaneously and therefore accurate in relation to the delivery of care and that the records are held confidentially to maintain the patient's right to privacy. **Ref: Section 5.5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Records pertaining to the application of Topical Preparations are now located in the Homes Treatment Room along with the Topical Medication to facilitate accurate & timely completion of records. Folders for storage of records are available in all bedrooms to maintain confidentiality and the patients right to privacy.

Recommendation 3 **Ref**: Standard 41 **Stated:** First time **To be Completed by:** 31 December 2015	It is recommended that the registered manager's hours are recorded in advance and that the registered manager hours worked as the nurse in charge of a shift are clearly recorded against the hours worked supernumerary. **Ref: Section 5.5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Registered Managers hours are recorded in advance.

Registered Manager Completing QIP	Clare Burke	**Date Completed**	08/01/2016
Registered Person Approving QIP	David Morgan	**Date Approved**	08/01/2016
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	13/01/2016

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