Galgorm
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90 Galgorm Road
Ballymena
BT42 1AA

Inspector: Lyn Buckley
Inspection ID: IN021986

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Unannounced Care Inspection
of
Galgorm Care Home

3 November 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 3 November 2015 from 11:15 to 15:30 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 areas of concern. A Quality Improvement Plan (QIP) is not included in this report.

For the purposes of this report, the term 'patients' will be used to described those living in Galgorm Care 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 20 April 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	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Four Seasons health Care Dr Maureen Claire Royston – responsible person	**Registered Manager:** Mrs Lisa McDonald
Person in Charge of the Home at the Time of Inspection: Lisa McDonald	**Date Manager Registered:** 16 January 2015
Categories of Care: NH - I, PH, PH(E) and TI RC – I PH, and PH(E) Maximum of 8 persons within RC category of care. Maximum of 3 persons within NH-TI category of care.	**Number of Registered Places:** 35
Number of Patients Accommodated on Day of Inspection: 28	**Weekly Tariff at Time of Inspection:** £470 - £637

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 five patients individually and with others in small groups, two care staff, two registered nurses, two catering staff, two housekeeping staff, two other support staff and a visiting healthcare professional.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes
- duty rotas for week commencing 2 November 2015
- training records
- staff induction templates
- compliment records
- three patient care records
- 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 20 April 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 Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 6.1 **Stated:** First time	The registered person should consider how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager, staff and observation evidenced that this recommendation had been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. Discussion with staff confirmed that they were knowledgeable regarding this policy and procedure.

A sampling of training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives. This training was included within the customer care training. The registered manager confirmed that additional sessions of this training were scheduled and staff required to attend.

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 for treatment options, where appropriate.

Staff consulted demonstrated their ability to communicate sensitively and effectively with patients and/or representatives.

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.

The inspection process allowed for consultation with five patients individually and with others in small groups. Patients who could verbalise their feelings on life in Galgorm Care Home commented positively in relation to the care they were receiving and in relation to 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.

One relative spoken with confirmed that they were involved in the care planning process along with their loved one, that all staff were sensitive regarding communication needs and that they were kept informed of any changes in the care needs of their loved one.

Positive comments were also viewed in letters and cards received by the home from relatives.

Areas for Improvement

There were no requirements or recommendations made.

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

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 Guidelines and Audit Implementation Network (GAIN) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Care Homes December 2013. A resource file on palliative care/end of life/grief and bereavement was available to staff.

Training records evidenced that nursing and care staff were trained in the management of death, dying and bereavement in July and October 2015. Additional sessions were planned for ancillary staff. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the GAIN Palliative Care Guidelines, November 2013.

Discussion with the registered manager and nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with nursing 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 drugs was in place and discussion with registered nurses confirmed their knowledge of the protocol.

Is Care Effective? (Quality of Management)

A review of care records evidenced that, where required, 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.

Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. This discussion was documented in the records reviewed as taking place after the patient had settled into the home rather than on the day of admission. The discussion was usually conducted by the registered manager or a registered nurse.

Following discussion regarding end of life care, a care plan was developed to ensure the patient's wishes and preferences were met.

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

A review of notifications of death to RQIA during the previous inspection year 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 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 informed the inspector of how they could provide support to families who were 'sitting with loved ones' who were dying.

From discussion with the registered manager, staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/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:

"A sincere thank you for all the love and care given to… There were many smiles and happy moments in amongst the tears and we appreciate all of you who made a difference…"

"Over the many years you were all very good to … and we appreciated it very much"

"Thank you for all the love, care and attention given…"

"Thank you so much for your kindness and care."

Discussion with the registered manager confirmed that no concerns had been raised in relation to the arrangements regarding the end of life care of patients in the home.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death and to support each other following a death in the home.

Areas for Improvement

There were no requirements or recommendations made.

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

5.5 Additional Areas Examined

5.5.1 Consultation with Patients, Staff and Patient Representative/Relatives

Patients

RQIA met and spoke with five patients individually and with others in small groups. Patients were very complimentary regarding the standard of care they received, the attitude of staff and the food provided. One patient stated, "They have me ruined and spoilt – the girls are angels; all the staff are lovely."

There were no concerns raised with the inspector.

Six questionnaires for patients were left with the registered manager for distribution and six were returned. Patients indicated that they were very satisfied with the care they received.

Additional comments recorded included:
"I am very happy I came here, the girls are all lovely and I have so much fun with them…"

"I like to stay in my room and the staff fully respect that. They call down in to see me and to have a chat…I enjoy that."

"I feel very happy here. I settled in well, all the girls are lovely and I enjoy talking to them."

Staff

In addition to speaking with staff on duty six questionnaires were provided for staff not on duty. There were no concerns raised by staff. The registered manager agreed to forward these to the staff selected. At the time of writing this report none had been returned.

Representatives/Relatives

In addition to speaking with one relative, six questionnaires were provided for patient representatives/relatives. The registered manager agreed to distribute these. At the time of writing this report none had been returned.

The relative spoken with commented positively regarding the care, staff and environment. There were no concerns raised by the relative.

5.5.2 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms and bathrooms on each floor. The home was found to be warm, well decorated, fresh smelling and clean.

Areas for Improvement

There were no areas of improvement for the home in respect of the additional areas examined.

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

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Lisa McDonald	**Date Completed**	27.11.15
Registered Person	Dr Claire Royston	**Date Approved**	27.11.15
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	01/12/15

Please provide any additional comments or observations you may wish to make below:

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address