Unannounced Care Inspection Report
11 October 2016

Galgorm

Type of Service: Nursing Home
Address: 90 Galgorm Road, Ballymena, BT42 1AA
Tel no: 028 2565 1365
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Galgorm took place on 11 October 2016 from 09.30 to 14.15 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

There was evidence of competent and safe delivery of care on the day of inspection. Staff were required to attend training and the observations of care delivery evidenced that the knowledge and skills gained through training, were embedded into practice. Staff confirmed that there were good communication systems and teamwork in the home, including; staff appraisal and supervisions. Staff advised that the registered manager was very supportive and approachable and any concerns raised were dealt with effectively.

Is care effective?

There was evidence of positive outcomes for patients living in Galgorm. Review of records evidenced that regular communication had occurred with patient representatives regarding any changes in the patient's condition. Care records in the majority were completed to a satisfactory standard however shortfalls were identified and recommendations have been made accordingly.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. The comments received from patients and their representatives were positive and praiseworthy of staff.

A recommendation has been made in regards to the arrangements in place for personal care.

Is the service well led?

There was evidence of good leadership in the home and effective governance arrangements.

Discussion with the registered manager and staff; and a review of records evidenced that systems were in place to monitor and report on the quality of nursing care and other services provided.

It was observed that the registered manager had robust systems in place to ensure they had oversight of the governance systems in the home. The registered manager spoke of the importance of staff having access to all relevant information in her absence. Files were observed to be well organised, clearly labelled and easy to access. The registered manager's organisational skills and record management were commended during the inspection.

A recommendation has been made in regards to the management of complaints.

For the purposes of this report the term 'patients' will be sued to describe those living in Galgorm which provides both nursing and residential care.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with Lisa McDonald, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 1 July 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Mrs Lisa McDonald
Person in charge of the home at the time of inspection: Mrs Lisa McDonald	**Date manager registered:** 16 January 2015
Categories of care: RC-I, RC-PH, RC-PH(E), NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 35

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report
- pre-inspection assessment audit.

During the inspection we met with 12 patients and the majority of others in smaller groups, two care staff, two registered nurses, three ancillary staff members and one patient's representatives.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty during the inspection. Five patient, 10 staff and 10 patient representative questionnaires were issued for distribution and a request was made for them to be returned within an identified timeframe.

The following information was examined during the inspection:

- duty rota for the period 3 – 17 October 2016
- three patient care records
- staff training records
- staff induction records
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- two recruitment files
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 1 July 2016

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

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 03 November 2016

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

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. A review of the staffing rota from 3 to 17 October 2016 evidenced that the planned staffing levels were adhered to. In the absence of the registered manager a registered nurse was designated as the person in charge of the home. The duty file contained additional information to guide the person in charge of the home. These included however not limited to; the procedure for reporting adult safeguarding including contact details, the policy and procedure for a missing patient, contact details for staff and senior management. This is good organisational management.

Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Staff consulted confirmed that planned staffing levels met the assessed needs of the patients. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

A review of personnel files for two staff members demonstrated that all relevant information as outlined in Regulation 21, Schedule 2 of the Nursing Home Regulations (Northern Ireland) 2005 had been sought and retained.

Discussion with staff and a review of records evidenced that staff completed an induction at the commencement of their employment. A discussion with one staff member who had recently commenced employment advised that the induction process was robust and provided the necessary information for them to carry out their role and responsibilities. A mentor is assigned to each new employee to provide them with the necessary support to enable them to fulfil their role. The induction booklet is completed by the mentor and staff member as each area is completed and at the completion of the induction process the registered manager also signs the booklet to confirm the induction process is complete.

Discussion with the registered manager and review of training records evidenced that a system was in place in place to ensure staff attended mandatory training. Training is delivered both by 'e-learning' and also 'face to face' training in some identified areas for example; fire safety, moving and handling and cardio-pulmonary resuscitation (CPR). The registered manager advised that training records are reviewed on a frequent basis. Staff who have not completed mandatory training requirements receives a written correspondence advising them of what training has to be completed and continued non-compliance results in staff not being rostered for duty. The overall compliance for mandatory training compliance was 89 per cent to date.

Staff spoken with demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manager confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the homes policies and procedures. RQIA were notified appropriately.

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

Review of 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.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were 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.

A review of notifications submitted to RQIA since the last care inspection evidenced that these were managed appropriately. However, during discussion with staff it became evident that the homes lift had been out of action due to an operational fault the week prior to this inspection and had only recently became operational. This incident had not been notified to RQIA and a discussion with the registered manager indicated that this was an oversight on their behalf. The registered manager agreed to submit a notification retrospectively to RQIA in regards to same.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, fresh smelling and clean throughout. During the inspection, ancillary staff were observed carrying out their domestic duties and it was evident that they took pride in their work and the environment of the home.

Some chairs in lounge areas were observed as damaged and torn. The registered manager advised that plans were in place for the refurbishment of some identified areas of the home and the replacement of comfort chairs were included. This information was also recorded in the monthly monitoring reports.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.4 Is care effective?

Review of three 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 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 review of care records evidenced that 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 Nurses (TVN).

A care record reviewed for a recent admission evidenced that risk assessments and care plans had been completed within five days of admission to the home as per the DHSSP'S Care Standards for Nursing Homes, 2015.

A care record reviewed in relation to wound management identified that registered nurses were not always completing the appropriate documentation to evidence the delivery of care in this regard. For example; a review of documentation indicated that a dressing regime had not been adhered to, as the registered nurse had not updated the required documentation. The registered nurse was on duty at the time of inspection and confirmed that the dressing had been changed and acknowledged that they had not recorded the nursing intervention accordingly. This matter was discussed with the registered manager and a recommendation has been made.

In addition to the aforementioned, a review of care records evidenced that registered nurses were leaving "gaps" in some records examined to enable their colleagues to record entries retrospectively. This practice is not in keeping with NMC guidelines on record keeping and a recommendation has been made in this regard.

A discrepancy was identified in regards to the treatment plan in place for another identified patient. During discussion with a registered nurse it became apparent that a communication held by a registered nurse and a General Practitioner had not been recorded. This was a further example of records not being maintained appropriately. It was agreed that the home would follow this matter up with the general practitioner for clarity and confirmation of the treatment to be delivered in consultation with the identified patient. Post inspection, an email correspondence has been received by RQIA, to confirm that appropriate actions have been taken and the care plan has been updated to reflect the treatment and care required in this regard.

Another care plan was reviewed in regards to the management of weight loss. Risk assessments had been completed and a care plan was developed accordingly. Appropriate referrals had been made to the dietician when the weight loss was first identified. Some of the interventions identified in the care plan were not being adhered to, for example; the care plan advised that the patient was to be weighed 'weekly' and a record of 'food and fluid' intake was to be maintained. Although, a record of 'food and fluid' intake had been maintained this action was discontinued as registered nurses advised that the patient was eating and drinking well, even though a re-referral had been made to the dietician and the MUST score remained unchanged. This matter was discussed with the registered manager who agreed to take immediate actions to ensure that the care plan was being adhered to in this regard. A recommendation has been made that registered nurses are provided with an update in training for the management of nutrition this should include nutritional screening.

Discussion with staff evidenced that registered nursing staff were required to attend a handover meeting at the beginning of each shift. The information received then was disseminated to care staff accordingly. A discussion with staff indicated that this system was effective to ensure staff were kept up to date of any changes in the patient's condition.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained. A review of records evidenced that staff meetings had been held across all teams. Minutes of the meetings were available and the minutes of the most recent staff meeting were held in the duty file with a register for staff to record when they had read same. This is good practice. The minutes reviewed did not include an action plan; the registered manager advised that this was because, no actions were required. The registered manager agreed that if no actions resulted from meetings held in the future that this information would be recorded accordingly.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager.

A review of records evidenced that arrangements were in place to facilitate relatives meetings. The registered manager advised that meetings scheduled previously had not been attended. The registered manager advised that the home operated an 'open door' policy and this also enabled relatives to raise any concerns. The registered manager advised that she took random opportunities to communicate with relatives when they were visiting to gain an understanding of their experience of the home and the care received by their loved ones. A record was available to evidence this information. This is good practice.

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

Areas for improvement

Recommendations have been made in regards to care planning and record keeping. A recommendation has also been made in regards to training in nutritional management for registered nurses.

Number of requirements	0	**Number of recommendations**	3

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, the foyer or in their bedroom, as was there personal preference. We observed numerous occasions when staff offered patients choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding the patients' likes and dislikes and individual preferences.

The majority of patients were observed as well-presented and comfortable in their surroundings. Although, some aspects of personal care observed had not been completed to a satisfactory standard and lacked attention to detail for some identified patients. A review of records completed for the delivery of personal care did not always accurately reflect the care delivered. This was brought to the attention of staff on duty who agreed with the observations made. A recommendation has been made in this regard.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be relaxed and comfortable in their surroundings.

One patient's representatives spoken with confirmed that they were made to feel welcome into the home by all staff. They spoke very positively about the care and services afforded to their loved one.

They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

In addition questionnaires were provided by RQIA to the registered manager for distribution. These included 10 questionnaires for staff and relatives/patient representatives and five for patients. At time of issuing this report, three staff returned their questionnaires within the identified timeframe. All responses received were positive across the four domains. No questionnaires were returned by patients and their representatives within the time frame.

The home had engaged in a project "AGEWELL" and over a five week period students from Ballymena Academy attended the home and worked with the patients to develop a range of artworks which were displayed in the home. A group of patients attended Carrickfergus Castle for an art exhibition where their work was exhibited.

The registered manager advised that the home had also received an award for the 'Best Kept Grounds' awarded by the Northern Ireland Amenity Council. This project involved staff, patients and their representatives.

The home is commended for their efforts and achievements in regards to both projects. This demonstrates the homes willingness to engage and provide opportunities for social inclusion in community events.

Areas for improvement

The arrangement for personal care ensures that patients are respected and their rights to dignity are upheld at all times.

Number of requirements	0	**Number of recommendations**	1

4.6 Is the service well led?

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed. Discussion with the registered manager and a review of patient information evidenced that the home was operating within its registered categories of care.

Staff spoken with were knowledgeable regarding line management and who they would escalate any issues or concerns to; this included that reporting arrangements when the registered manager was off duty.

A copy of the complaints policy was displayed in the home. A review of the home's complaints record evidenced that complaints were not managed fully in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The records reviewed did not always record whether or not the complainant was satisfied with the outcome of the investigation. A recommendation has been made.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents/accidents. 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.

It was observed that the registered manager had robust systems in place to ensure they had oversight of the governance systems in the home. The registered manager spoke of the importance of staff having access to all relevant information in her absence. Files were observed to be well organised, clearly labelled and easy to access. The registered manager's organisational skills and record management were commended during the inspection.

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.

Discussion with the registered manager and review of records evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement.

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

Areas for improvement

A recommendation has been made in regards to the management of complaints.

Number of requirements	0	**Number of recommendations**	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Lisa McDonald, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements: No requirements resulted at this inspection

Recommendations

Recommendation 1 **Ref**: Standard 4 Criteria 8 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out to each patient. The outcomes of such actions are recorded. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Registered nurses have received clinical supervision on documenting all interventions contemporaneously.
Recommendation 2 **Ref**: Standard 37 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that records are maintained in accordance with legislative requirements and best practice guidance. This recommendation relates specifically to “gaps” being left for staff to record entries retrospectively. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Registered nurses have received clinical supervision on adhering to NMC guidelines and company policy regarding completion of resident records. This will monitored as part of the resident care Traca audit .
Recommendation 3 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 30 December 2016	The registered provider should ensure that registered nurses are provided with training in nutritional management to include the nutritional screening tool. The registered manager should ensure that actions and care interventions are appropriate and reflective of best practice guidance in this area of practice. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Registered nurses have received a training update in managing the MUST nutritional screening tool.
Recommendation 4 **Ref**: Standard 6 Criteria 1 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that the arrangements for personal care ensure that patients are respected and their dignity is upheld at all times. Records for delivery of personal care should be monitored to ensure they accurately reflect care delivery in this regard. **Ref: Section 4.5**

	Response by registered provider detailing the actions taken: All staff have received clinical supervision regarding personal care and upholding dignity. The daily care form has been amended to reflect this discussion and allow for more accurate recording of the care given by each member of staff.
Recommendation 5 **Ref**: Standard 16 Criteria 11 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that records of complaints includes whether or not the complainant was satisfied with the outcome and how this level of satisfaction was achieved in accordance with the DHSSPS Care Standards for Nursing Homes, 2015. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Complaints response letter has been amended to include a 14 day time frame where if the complainant has not responded it is concluded that that the process has been dealt with to their satisfaction.

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

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