Inspection Report

24 June 2021

Galgorm

Type of service: Nursing (NH)
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual** Mrs Natasha Southall	**Registered Manager:** Ms Lisa McDonald **Date registered:** 16 January 2015
Person in charge at the time of inspection: Ms Lisa McDonald	**Number of registered places:** 35 A maximum of 3 patients in category NH-TI. There shall be a maximum of 1 named resident receiving residential care in category RC-I.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 22
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 35 patients. Patient bedrooms are located over the two floors. Patients have access to communal lounges, dining room and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 24 June 2021, from 9.30 am to 4.00 pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home 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.

It was positive to note that the existing areas for improvement had been met and no new areas requiring improvement were identified.

RQIA were assured that the delivery of care and service provided in Galgorm was safe, effective, compassionate and that the home was well led.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Lisa McDonald, Manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke with 10 patients, one relative and eight staff. Patients told us that they felt well cared for, enjoyed the food and that staff were helpful and friendly. Patients told us "I'm as happy as the day's long" and "I wouldn't like to move from here, I am very settled." Relatives said communication was good and their loved one was well looked after.

One patient questionnaire was returned with a very satisfied response to all questions regarding care provision. No feedback from the staff online survey was received. Staff were complimentary in regard to the home manager and spoke of how much they enjoyed working with the patients. One staff member commented "I can't imagine working anywhere else, I am very happy here".

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 3 December 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 30(1) **Stated:** First time	The registered person shall ensure that RQIA is appropriately notified of any accident in the home where medical advice is sought.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced this area for improvement has been met.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure the following in regard to those patients who are assessed as requiring a pressure relieving mattress: • The type of mattress in use must reflect the patients assessed need • The mattress should be set correctly to meet the assessed need of the patient • The type of mattress and correct setting must be documented correctly on the patients repositioning chart and care plan.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced this area for improvement has been met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect patients.

There were systems in place to ensure staff were trained and supported to do their job.

A system was in place to ensure that staff completed their training. All staff were provided with a comprehensive induction programme at the commencement of their employment to prepare them for working with the patients.

Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

Staff said there was good teamwork in the home and that they felt well supported in their role.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty. It was noted that there were enough staff in the home to respond to the needs of the patients in a timely way.

Call bells were answered promptly by staff who were observed to respond to requests for assistance in a caring and compassionate manner. It was clear through these interactions that the staff and patients knew one another well.

There were safe systems in place to ensure that staff were recruited and trained appropriately; and that patient needs were met by the number and skill of the staff on duty.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs; and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails and alarm mats. It was established that safe systems were in place to manage this aspect of care.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. The care records reviewed were up to date and evidenced consistent delivery of pressure area care to patients.

Examination of records and discussion with the manager confirmed that the risk of falling and falls were well managed. Review of records confirmed that staff took appropriate action in the event of a fall, for example, they completed neurological observations and sought medical assistance if required. The appropriate care records were reviewed and updated post fall. Staff also completed a post fall review to determine if anything more could have been done to prevent the fall.

Patients who required care for wounds had this clearly recorded in their care records. There was evidence that nursing staff had consulted with specialist practitioners in the management of wounds, for example, the Podiatrist, and were following any recommendations made by these professionals.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. The mealtime was a pleasant and unhurried experience for the patients.

The food served was attractively presented and smelled appetising and portions were generous. There was a variety of drinks available. Staff attended to patients in a caring and compassionate manner. If required, records were kept of what patients had to eat and drink daily. Patients spoke positively in relation to the food provision in the home.

There was a system in place to ensure that all staff were aware of individual patient's nutritional needs and any modified dietary recommendations made by the Speech and Language Therapist (SALT).

Nutritional assessments had been conducted on a monthly basis by staff using the Malnutrition Universal Screening Tool (MUST), and there was evidence that patients' weight was checked at least monthly to monitor weight loss or gain.

There were systems were in place to ensure that patients' needs were individually assessed and their care needs met. Care documentation was up to date and evidenced regular review.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. Patients' bedrooms were personalised with items important to the patient. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

It was observed the bath within an upstairs communal bathroom was not in working order; this was discussed with the manager who advised that there is an agreed refurbishment plan for this bathroom but to date the work has not commenced. As the home currently does not have an immersion bath facility available in order to provide the patients with the choice of either a bath or shower this work if possible should be expedited; the manager agreed to discuss this with her line manager. The progress of this refurbishment will be followed up on a future inspection.

There was evidence throughout the home of 'homely' touches. Patients' artwork, pet goldfish, newspapers, magazines and jugs of juice or water were available in lounges and bedrooms and patients were offered suitable drinks and snacks between their main meals.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Authority (PHA).

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

Visiting arrangements were managed in line with DoH and IPC guidance.

There were systems in place to ensure that the risk of infection and the internal environment of the home were well maintained in order that patients were comfortable and safe.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. Patients confirmed they could remain in their bedroom or go to the communal lounges when they wished.

There was a range of activities provided for patients by activity staff. Patients had been consulted and helped plan their activity programme. The range of activities included social, cultural, religious, spiritual and creative events. The activity staff member told us of how the patients had enjoyed getting the garden ready for the summer. Window plant boxes were seen on several patients' window sills. The patients also recently enjoyed a farewell visit from their P7 friends from the local primary school who they have been engaging with all year.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic.
Staff assisted patients to make phone or video calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

There were systems in place to support patients to have meaning and purpose to their day within Galgorm.

5.2.5 Management and Governance Arrangements

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. There was evidence of auditing across various aspects of care and services provided by the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

Review of the home's record of complaints confirmed that these were well managed and used as a learning opportunity to improve practices and/or the quality of services provided by the home.

Staff commented positively about the manager and described her as supportive, approachable and always available for guidance.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

There were robust systems in place to monitor the quality of care and services provided and to drive improvement in the home.

6.0 Conclusion

Patients looked well cared for and were seen to be content and settled in the home. Staff treated patients with respect and kindness. The home was clean, tidy and well maintained.

The outcome of this inspection concluded that all areas for improvement identified at the last care inspection had been met and no new areas for improvement were identified.

Based on the inspection findings and discussions held RQIA are satisfied that this service is providing safe, effective care in a caring and compassionate manner; and that the service is well led by the manager.

Thank you to the patients, relatives and staff for their assistance and input during the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Lisa Mc Donald, Manager.

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