Unannounced Care Inspection Report
9 May 2017

Glencarron

Address: 6 Creamery Road, Crossmaglen, BT35 9AD
Type of Service: Nursing Home
Tel No: 028 3086 8366
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Glencarron took place on 9 May 2017 from 09.55 to 18.00 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?

RQIA were suitably informed of notifications under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A safe system for monitoring compliance with mandatory training was in place. Arrangements were in place for monitoring the registration status of nursing and care staff. One requirement was made in this domain in regard to the management of a patient following a fall where a head injury could potentially have occurred. Two recommendations were made in regards to the provision of an induction completion statement and a review of commodes provided within the home.

Is care effective?

Risk assessments had been conducted and informed subsequent care plans. Staff demonstrated confidence and awareness in raising any potential concerns to the relevant people. Staff meetings were held regularly. There was evidence of engagement with patients' representatives. One requirement was made in this domain in relation to the recording of wound management. Two recommendations were made in relation to the recording of nutritional supplements and evidence of patient/representative involvement in care planning.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report. No requirements or recommendations were made in the compassionate domain.

Is the service well led?

Monthly monitoring visits were conducted consistently and corresponding reports were present and available for review. A notice was displayed informing patients/relatives of the availability of these reports. Many compliments had been received by the home in relation to the care and compassion provided to patients/relatives and some of these comments are contained within this report. Appropriate certificates of registration and public liability insurance were on display. One recommendation has been made to ensure actions identified to address shortfalls in care plan audits are reviewed to ensure completion.

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	2	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with Veronica Cosgrove, Clinical Sister, 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 announced premises inspection undertaken on 7 December 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: Glencarron Homes Ltd Brendan Liddy Bridget Liddy	**Registered manager:** Oonagh Grant
Person in charge of the home at the time of inspection: Veronica Cosgrove (Clinical Sister)	**Date manager registered:** 21 December 2011
Categories of care: NH-DE, NHPH, NH-PH(E), NH-I Of the 44 residents accommodated there shall be a maximum of 4 assessed as NH-DE and a maximum of 10 in categories NH-PH & NH-PH(E). The home is also approved to provide care on a day basis for a maximum of 9 persons or a maximum of 5 persons of high dependency.	**Number of registered places:** 44

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 and the returned QIP
- pre inspection assessment audit

During the inspection we met with17 patients individually and others in small groups, three patient representatives, four care staff, two registered nurses and one ancillary staff member.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Ten patient, 10 staff and eight patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- competency and capability assessments for nurse in charge
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- duty rota for week commencing 8 May 2017

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 December 2016

The most recent inspection of the home was an announced premises inspection. The completed QIP was returned and approved by the estates inspector and will be validated at the next premises inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 26 April 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 19 (1)(b) **Stated:** First time	The registered person must ensure that patient care records maintained within the home are stored securely in line with legislative and professional guidance.	**Met**
	Action taken as confirmed during the inspection: Care records were safely stored in lockable cupboards at the nursing stations.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 32 **Stated:** Second time	The registered persons should ensure that a policy in relation to palliative care/death and dying is developed with reference to current best practice guidelines and this shared with staff.	**Met**
	Action taken as confirmed during the inspection: The policy in relation to palliative care/death and dying has been developed and now makes reference to current best practice. The policy is available for staff to review.	
Recommendation 2 **Ref:** Standard 41 **Stated:** First time	The registered person should review staffing levels to ensure that at all times there are sufficient numbers of staff and skill mix deployed to meet the needs of the patients in the home.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and staff and a review of the duty rota confirmed that this recommendation has now been met.	
Recommendation 3 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Met**

	Action taken as confirmed during the inspection: Discussion with the manager and a review of the environment confirmed that this recommendation has now been met.	
Recommendation 4 **Ref:** Standard 36 (Criteria 4) **Stated:** First time	The registered person should develop and implement a system to ensure a systematic three yearly review for the updating of policies and procedures with full compliance to be achieved by 30 December 2016. Particular attention should be paid to the complaints policy The policies and procedures should be made readily available to staff when reviewed and any new addition to the policy or procedure brought to staffs attention.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager following the inspection evidenced that a system was in place to ensure a three yearly review of all policies.	
Recommendation 5 **Ref:** Standard 17 **Stated:** First time	The registered person should ensure a system is in place to manage urgent communications, safety alerts and notifications.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and staff and a review of records confirmed that this recommendation has been met.	

4.3 Is care safe?

The 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 8 to 14 May 2017 evidenced that the planned staffing levels were adhered to. Discussion with staff, patients and their representatives evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. However, there was no evidence of a completion statement at the end of the induction booklet with evidence of signatures and dates from the new employee and the staff member responsible for completion of the induction or oversight of the registered manager. A recommendation was made.

Discussion with staff and a review of records sent to RQIA following the inspection evidenced that a system was in place to review staffs' supervisions and appraisals.

Discussion with the manager and review of training records evidenced that a system was in place to monitor staff attendance at mandatory training. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice.

Discussion with the 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).

The manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

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.

Review of notifications forwarded to RQIA from 26 April 2016 confirmed that these were appropriately managed. Accidents and incidents were reviewed monthly to identify any potential patterns or trends. Inspection of accident records evidenced that three unwitnessed falls had occurred. Records indicated that central nervous system (CNS) observations were not taken immediately following the incident and monitored for 24 hours. This was discussed with the manager and a requirement was made to ensure post falls management was conducted in compliance with best practice guidance.

A review of the home's environment was undertaken and included observations of a number of bedrooms, bathrooms, lounges, dining rooms and storage areas. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Bedrooms and communal areas were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were well maintained, although, a recommendation was made to review commodes in the home to ensure that commodes which are rusting are repaired/replaced to ensure that they can be cleaned effectively.

Areas for improvement

It is recommended that a completion statement is added to the end of the induction booklet to confirm that the induction has been completed. This statement should also include date and signature from the new employee and the staff member responsible for inducting the new employee with oversight from the registered manager.

It is required that post falls management is conducted in compliance with best practice guidance.

It is recommended that all commodes in the home are reviewed and those commodes found to be rusting are repaired/replaced to ensure that they can be cleaned effectively.

Number of requirements	1	Number of recommendations	2

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. Care plans had been personalised to meet the individual needs of the patients and had been reviewed monthly.

Review of records pertaining to the management of wounds evidenced that registered nurses were not adhering to regional guidelines and the care planning process. There was evidence within one patient's care records that the wound care plan had been amended. However, there was no evidence of the date of change or the signature of the person who had made the change. Wound observation charts had not been completed appropriately at the time of wound dressing to monitor the progress of the wound. These deficits were discussed in detail with the manager and a requirement was made to ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.

Supplementary care records in regards to bowel management, repositioning and food/fluid intake were reviewed. Overall, bowel management and repositioning had been recorded well. A daily food/fluid intake chart had been completed on patients who required monitoring. A recommendation was made following a review of the food/fluid intake charts to ensure that any nutritional supplements given to the patient were also recorded within these charts.

Patient/representative involvement in care assessment and planning was included within one of the patient care records reviewed in the form of a signed care plan agreement form. There was insufficient evidence, within the two other patients' care plans reviewed, of actual and meaningful patient/ representative input into the care planning process. A recommendation was made.

Discussion with the manager and staff confirmed that staff meetings were conducted regularly. Minutes of the meetings were available for review and included details of attendees; dates; topics discussed and decisions made. The manager also confirmed that relatives meetings were conducted annually.

The manager confirmed that they operate an 'open door policy' and are available to discuss any issues with staff, patients and/or relatives. The manager also confirmed that they would undertake a daily walk around the home and would avail of the opportunity to engage with patients and relatives at this time. A 'relatives' noticeboard was maintained at the front of the home and contained information in regard to safeguarding and complaints. Pictures and names of staff were displayed on the noticeboard.

Staff consulted 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. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Areas for improvement

It is required that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.

It is recommended that any nutritional supplements consumed by patients are recorded within food/fluid intake charts.

It is recommended that patients/representatives are involved in the care planning process and that this is evidenced within the patients' care records.

Number of requirements	1	Number of recommendations	2

4.5 Is care compassionate?

Two registered nurses, four carers and one ancillary staff member were consulted to ascertain their views of life in Glencarron. Staff confirmed that when they raised a concern, they were happy that the home's management would take their concerns seriously. Ten staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Seven of the questionnaires were returned within the timescale for inclusion in the report.

Some staff comments were as follows:
"We all work well together here."
"It's dead on, I like it here."
"All's working well. Good teamwork."
"I love working here."
"It's lovely. Everyone is so friendly and approachable."
"I love it here. No issues."

Twelve patients were consulted. 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. Ten patient questionnaires were left in the home for completion. Three patient questionnaires were returned.

Some patient comments were as follows:
"The care is fantastic."
"The staff are great."
"This place is ok."
"It's lovely here."
"This place is a good spot."

Three patient representatives were consulted with on the day of inspection. Eight relative questionnaires were left in the home for completion. Two relative questionnaires were returned. The respondents indicated that they were satisfied or very satisfied with the care provided in the home.

Some relatives' comments were as follows:
"The care is fabulous. Unbelievably good."
"I find the care here fine. All I ask the girls to do is done."
"The staff are amazing. They really give the personal touch."

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Staff interactions with patients were observed to be compassionate, caring and timely. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

The serving of lunch was observed in the main dining room downstairs. Patients were seated around tables which had been appropriately laid out for the meal. Food was served when patients were ready to eat or be assisted with their meals. Food appeared nutritious and appetising. A menu was on display on the door leading to the lounge reflecting the food served. The mealtime was well supervised. Staff were observed to encourage patients with their meals. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors where required. Patients were observed to be assisted in an unhurried manner. Condiments were available on tables or offered to patients and a range of drinks were offered to the patients. Patients appeared to enjoy the mealtime experience.

Areas for improvement

No areas for improvement were identified during the inspection in the compassionate domain.

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

4.6 Is the service well led?

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

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

Discussion with the manager and review of the home's complaints records evidenced that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The complaints procedure was displayed on a relatives' noticeboard.

A compliments file was maintained to record and evidence compliments received.

Some examples of compliments received are as follows:
"Thank you so much for all the care and attention given to … . She was very content with you."
"I'll never forget the warmth shown to mum and the support given to me."
"The care and comfort you all gave … is much appreciated."
"Thank you to all the staff who took such good care of my aunt."

Discussion with the 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, monthly audits were completed in accordance with best practice guidance in relation to wound management, care records, accidents, environment and IPC. Two care plan audits conducted in March 2017 were reviewed. Shortfalls had been identified within the care records. However, there was no evidence that the actions required to address the shortfalls were completed and/or reviewed. A recommendation was made.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with the manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and trust representatives. A notice was on display at reception advising of the availability of the reports.

Areas for improvement have been identified in the safe, effective and compassionate domains with regard to post falls management, recording of wound care, induction statement, food/fluid chart completion, review of commodes, recording of patient/relative involvement in care planning and review of auditing. Compliance with these requirements and recommendations will further drive improvements in these domains.

Areas for improvement

It is recommended that actions identified to address shortfalls in care record audits are reviewed to ensure completion and this is evidenced within auditing documentation.

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 Veronica Cosgrove, Clinical Sister, 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 RQIA's office (non- paperlite) 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

Requirement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 10 May 2017	The registered person must ensure good practice guidance is adhered to with regard to post falls management. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All unwitnessed falls will now be accompanied by 24 hr neurological observations to determine/rule out any potential head injury.
Requirement 2 **Ref:** Regulation 19 (1) (a) Schedule 3 (1) (a) (b) (3) (K) **Stated:** First time **To be completed by:** 20 May 2017	The registered person must ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Our policy on wound management has been updated and a 'Standardised approach to Wound Care' Audit has been developed. This will ensure that all nurses have read and recorded the patient specific guidelines for the management of a wound.

Recommendations

Recommendation 1 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 30 June 2017	The registered person should ensure that a completion statement is added to the end of the induction booklet to confirm that the induction has been completed. This statement should also include date and signature from the new employee and the staff member responsible for inducting the new employee with oversight from the registered manager. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: It was unfortunate that the particular induction file you selected was not completed in the required manner. This was an exception, as a rule all induction booklets are signed off by myself, dated and co signed by the new employee

Recommendation 2 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time **To be completed by:** 10 June 2017	The registered person should ensure that all commodes in the home are reviewed and those commodes found to be rusting are repaired/replaced to ensure that they can be cleaned effectively. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Commode have since been removed and new supply in use.
Recommendation 3 **Ref:** Standard 12 Criteria (27) **Stated:** First time **To be completed by:** 12 May 2017	The registered person should ensure that any nutritional supplements consumed by patients are recorded within food/fluid intake charts. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: All Care Staff have been advised that volume of Supplement Consumed must be recorded on food/fluid intake charts. This will be randomly audited until all Staff fully Comply.
Recommendation 4 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** First time **To be Completed by:** 30 June 2017	The registered person should ensure that care records evidence patients' and/or their representatives' involvement in the assessment/planning process to meet patients' care needs. If this is not possible the reason should be clearly documented within the care record. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Additional record keeping has been devised in order that every patient file be reviewed by patient or relative on a monthly basis so that their input into care planning is up to date and agreed.

Recommendation 5 **Ref:** Standard 35 **Stated:** First time	The registered person should ensure that actions identified to address shortfalls in care record audits are reviewed to ensure completion and this is evidenced within auditing documentation. **Ref: Section 4.6**
To be completed by: 30 June 2017	**Response by registered provider detailing the actions taken:** This will be discussed at our SN meeting scheduled for 12/6/17. Staff will be advised that despite requests from myself & Veronica to return their audits in a timely manner this is now a recommendation from RQIA. Diary entries for all audits handed out will be followed up more stringently.

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