Unannounced Care Inspection Report
11 June 2019

Greenvale House Nursing Home

Type of Service: Nursing Home
Address: 82-84 Mill Hill, Castlewellan, BT31 9NB
Tel No: 028 4377 8280
Inspectors: Dermot Walsh and Helen Daly

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 32 patients.

3.0 Service details

Organisation/Registered Provider: Greenvale House **Responsible Individual(s):** Margaret Foster Norman Foster Barbara Frances Foster	**Registered Manager and date registered:** Donna Elizabeth Fitzpatrick 20 February 2018
Person in charge at the time of inspection: Donna Fitzpatrick	**Number of registered places:** 32 1 named person in category NH-LD(E). The home is also approved to provide care on a day basis to 1 person.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. LD(E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 30

4.0 Inspection summary

An unannounced inspection took place on 11 June 2019 from 14.00 to 22.00 hours.

This inspection was undertaken by care and pharmacist inspectors.

The inspection assessed progress with all areas for improvement identified in the since the last care and medicines management inspections and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

There were examples of good practice found throughout the inspection in relation to staffing arrangements, adult safeguarding, recruitment practice, staff training and development, governance, risk assessment, care planning and with the environment. There were examples of good practice in relation to the management of medication changes, distressed reactions and pain. Further good practice was found in relation to compassionate care delivery and with maintaining good working relationships.

Areas for improvement were identified in relation to supplementary record keeping, the management of thickening agents, nutritional supplements and monitoring the storage temperature for medicines.

Patients described living in the home in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	2

Details of the Quality Improvement Plan (QIP) were discussed with Donna Fitzpatrick, registered Manager and Barbara Foster, responsible Individual, 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.

4.2 Action/enforcement taken following the most recent inspection dated 17 January 2019

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

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings; registration information; and any other written or verbal information received, for example, serious adverse incidents.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff week commencing 3 June 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment file
- three patient care records
- a sample of governance audits/records
- complaints record
- compliments received
- RQIA registration certificate
- management of medicines on admission and medication changes
- management of distressed reactions, pain, controlled drugs, antibiotics
- personal medication records, medicine administration records, medicines requested, received and transferred/disposed
- medicine management audits

Areas for improvement identified at the last medicines management and care inspections were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of outstanding areas for improvement from previous inspections

Areas for improvement identified at the last care and medicines management inspections have been reviewed. All identified areas for improvement have been met.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed that the number of staff and the skill mix of staff on duty at any given time was determined through regular monitoring of patient dependency levels in the home. A review of the duty rota for week commencing 3 June 2019 confirmed that the planned staffing level and skill mix was adhered too. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff. Patients' needs and requests for assistance were observed to have been met in a timely and caring manner. Patients and their visitors consulted spoke positively in relation to the care provision in the home. Staff consulted confirmed that they were satisfied the staffing arrangements in the home were suitable to meet patients' needs.

A review of a recently employed staff member's recruitment records confirmed that the appropriate pre-employment checks had been completed prior to the staff member commencing in post. References had been obtained and records indicated that AccessNI checks had been conducted.

Checks were evidenced to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC). Similar checks were made on care workers to ensure that they were registered on the Northern Ireland Social Care Council (NISCC) register and that no restrictions to their employment had been identified.

A record of any training that staff had completed was maintained in the home. Staff spoke positively in relation to the provision of training in the home. Staff confirmed that they were encouraged by the home's management to request additional training where they see that this would benefit them. Compliance with training was monitored monthly on a training matrix. A system was in place to communicate with staff whose training was about to lapse to ensure completion.

An adult safeguarding champion had been identified to manage any potential safeguarding incidents. Discussion with the registered manager confirmed that they were aware of the regional safeguarding policy and procedures. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

Discussion with the registered manager and a review of accident records evidenced that falls in the home had been managed in accordance with best practice. Falls risk assessments and care plans had been developed and updated regularly or following a fall. Accident records had been maintained appropriately.

We reviewed the home's environment undertaking observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Fire exits and corridors were observed to be clear of clutter and obstruction. Stairwells were also observed to be clear. Bedrooms and communal rooms were maintained clean and tidy. Compliance with best practice on infection prevention and control had been well maintained. There were no malodours detected in the home. Appropriate doors had been locked to promote patient safety. Patient equipment, such as hoists, were maintained visibly clean and decontamination records had been recorded.

Satisfactory systems for the following areas of the management of medicines were observed: staff training and competency, medicine records, the ordering and receipt of medicines, the administration of the majority of medicines, the management of controlled drugs, antibiotics, pain and distressed reactions.

The management of thickening agents was reviewed. Records of prescribing, care plans and speech and language assessments were in place. Registered nurses recorded each administration on the medication administration records. Care assistants had received training on the administration of thickening agents and a system was in place to record administration but the records were not being completed. Records for the administration of thickening agents must be accurately maintained. An area for improvement was identified.

The audits completed at the inspection indicated that the majority of medicines had been administered as prescribed. However, a number of audits on nutritional supplements could not be completed as balances remaining in the home prior to the new delivery had not been maintained. The registered manager should review the management of nutritional supplements so that there is evidence that they are being administered as prescribed. An area for improvement was identified.

In order to facilitate audit and disposal at expiry, the date of opening had been recorded on all medicines seen at the inspection apart from two insulin pens. It was acknowledged that this was an oversight as the date of opening had been recorded on all other insulin pens. The registered manager agreed to continue to reinforce this practice with all registered nurses. There was evidence that inhaled medicines were included in the registered manager's monthly audits. The audits completed at the inspection indicated that inhaled medicines were being administered as prescribed. Registered nurses had received training on the use of inhaled medicines following the last medicines management inspection.

Medicines were observed to be stored safely and securely. However, as identified at the last medicines management inspection a record of the daily treatment room temperature was not being recorded. The temperature of the treatment room should be accurately recorded each day. Corrective action should be taken if the temperature falls outside the recommended range (25°C). An area for improvement was identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, adult safeguarding, recruitment practice, staff training and development, monitoring registration status of registered nursing staff and care staff and with the environment. There were examples of good practice in relation to the management of medication changes, distressed reactions and pain.

Areas for improvement

Areas for improvement were identified in relation to the storage temperatures for medicines and the management of thickening agents and nutritional supplements.

	Regulations	Standards
Total numb of areas for improvement	2	1

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

There was evidence within three patients' care records reviewed that appropriate risk assessments were completed on admission and reviewed on a regular basis. Risk assessments had been completed on falls management, nutrition, pressure management and restraint. Care plans had been developed which were reflective of the risk assessments. The care plans had also been reviewed regularly or as the patients' needs changed.

On a monthly basis, a report was generated on each patient in the home with an update of each of their care plans. This was seen as a good practice and would benefit the home if the patient required an urgent admission to hospital as a means of sharing information.

Dietary requirements, such as the need for a gluten free or diabetic diet, were communicated through staff handovers. Information also included the consistency of patients' food and fluids. Training in using new International Dysphagia Diet Standardisation Initiative (IDDSI) indicators to ensure that patients were safely given the correct foods and fluids was implemented. Patients had been weighed regularly and a nutritional screening tool known as Malnutrition Universal Screening Tool (MUST) was implemented to determine the risk of weight loss or weight gain. Where a risk was identified there was evidence within patients' care records that advice was sought from an appropriate health professional such as a dietician or a speech and language therapist. Patient care records also evidenced that advice received from health professionals were incorporated within the patients' care plans. Patients and staff confirmed that they had 24 hour access to food and fluids. Patients and staff commented positively on the food provision in the home.

We reviewed the evening meal experience during the inspection. Patients dined in the main dining room or at their preferred dining area. The menu offered a choice of meal for lunch and evening meal. Food was served directly from the kitchen when patients were ready to eat or be assisted with their meal. Food taken outside of the dining room was covered on transfer. The food served appeared nutritious and appetising. Staff were knowledgeable in relation to patients' dietary requirements. Patients wore clothing protectors where required and staff wore aprons when serving or assisting with meals. Staff were observed chatting with patients when assisting with meals and patients were assisted in an unhurried manner. Condiments were available on tables. A range of drinks were offered to patients. Patients consulted confirmed that they enjoyed the meal.

Patients' risk of pressure related skin damage was assessed on their admission and reviewed on a monthly basis. When a risk was identified, such as immobility, poor diet or incontinence, a care plan was developed to guide staff in measures to prevent skin breakdown. Wound care records had been maintained appropriately. The wound care plan was reflective of recommendations from a tissue viability nurse. Wound observation charts had been completed at the time of wound dressing to monitor the progress of the wound treatment.

An area for improvement was identified in relation to shortfalls in the recording of repositioning and with the recording of fluid intake. Repositioning and fluid intake records had been maintained, however, improvements in relation to the detail of recording were identified.

Falls in the home were monitored on a monthly basis for any patterns and trends in times or locations of the fall. This would be to review the pattern to proactively plan measures to reduce the incidences of falls where possible.

When a restrictive practice, such as the use of bedrails or an alarm mat had been implemented, there was evidence within the patient's care records of an initial assessment completed to ensure safe use. This assessment was reviewed regularly. The continued use of restraint was monitored at the evaluation of the patients' care plans.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management.

Each staff member was aware of their roles and responsibilities within the team. Comments from staff included teamwork was: "excellent". Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge. Staff commented that the home's management were: "approachable" and "would listen to and act on concerns raised."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to risk assessment, care planning and teamwork.

Areas for improvement

An area for improvement was identified in relation to supplementary record keeping in respect of repositioning and fluid intake.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff were aware of individual patients' wishes, likes and dislikes. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were given choice, privacy, dignity and respect. Staff were also aware of patient confidentiality regarding the handling and use of patient information.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences.

An annual quality report had been completed in February 2019. The report included feedback from patients and their relatives on the services provided in the home.

Cards and letters of compliment and thanks were maintained in the home. Some of the comments recorded included:

- "Thank you for all you have done and your care and kindness to … We are also so grateful for your generosity to … family and friends."
- "Thank you for all the fantastic care given to granny. It meant so much … I'm so glad she was so settled and so well cared for at Greenvale."
- "Thank you for you kindness to … Your care was second to none."

Consultation with 12 patients individually, and with others in smaller groups, confirmed that living in Greenvale was a positive experience. Patient questionnaires were left for completion. None were returned.

Patient comments:

“The home is very good. We are well cared for. The food is very good and well presented.”
“This is a good place. Staff are brilliant.”
“I am very happy here.”
“The staff are very good here.”
“You get well fed here. They look after us well.”

Four patient representatives were consulted during the inspection. Patient representatives’ questionnaires were left for completion. None were returned. Some patient representatives’ comments were as follows:

“It is a very homily environment. I know … is safe here. Brilliant staff and the manager is very approachable.”
“This is a marvellous home. … gets great care. If you had to go into a home, this is the place.”
“The home is great. … is very well settled here. The food is very good.”
“… is so well settled. He loves it here. The nurses are so so good. The girls are always in and out to see him.”

Staff were asked to complete an online survey; we had no responses within the timescale specified. Comments from five staff consulted during the inspection included:

“I love it here. Everyone gets on well.”
“It was stressful but it has now picked up.”
“It is very rewarding work. You can be tired at the end of the day.”
“It’s good.”

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home in maintaining the dignity and privacy of patients and valuing patients and their representatives.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. This certificate identifies the management arrangements for the home and the maximum number of patients allowed to be accommodated in the home. Since the last care inspection, the management arrangements in the home had not changed. Discussion with the registered manager and staff, and observations confirmed that the home was operating within its registered categories of care.

A review of the duty rota clearly evidenced the identity of the nurse in charge of the home in the absence of the registered manager. A review of one staff's records, who had been nominated as nurse in charge, evidenced that they had undertaken an assessment to ensure that they had the appropriate knowledge to fulfil this role.

A system was in place to record any complaints received including all actions taken in response to the complaint. Patients and their visitors consulted during the inspection confirmed that they would have no issues in raising any identified concern with the home's staff or management.

Discussion with the registered manager and review of auditing records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, care records, wound care, the environment and the dining experience. The home identified a patient of the day where all records associated with the patient would be reviewed and updated.

Monthly monitoring visits to the home were conducted by the responsible individual and would review the care provision and service provision of the home. Reports were available for review by patients and their visitors, staff, Trust staff and other healthcare professionals.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of incidents, quality improvement and maintaining good working relationships.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Donna Fitzpatrick, registered manager and Barbara Foster, responsible individual, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the treatment room temperature is accurately monitored and recorded each day. Corrective action should be taken if temperatures outside the accepted range are observed. Ref: 6.3
	Response by registered person detailing the actions taken: A record sheet is now in place to ensure the daily record of the treatment room is monitored. It has been in range if should be outside the accepted range corrective aciton shall be taken.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that records for the administration of thickening agents are accurately maintained. Ref:6.3
	Response by registered person detailing the actions taken: The records for the use of thickening agents are now included in the daily records for food and snacks and are being completed by staff.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review and revise the management of nutritional supplements to ensure that there is evidence that they are being administered as prescribed. Ref: 6.3
	Response by registered person detailing the actions taken: The nutritional supplements are now included in the food and snack books as discussed. The nutritional supplements are also recorded in the MAR sheet that they are administered and taken by patients as prescribed.

Area for improvement 2 **Ref**: Standard 4 Criteria (9) **Stated:** First time **To be completed by:** 30 June 2019	The registered person shall ensure that supplementary record keeping in respect of food and fluid intake and repositioning are recorded accurately and consistently where required. Ref: 6.4
	Response by registered person detailing the actions taken: This has been reviewed with staff and more robust measures are now in place to ensure they are accurately and consistently recorded. They are also included in the management audits.

Please ensure this document is completed in full and returned via Web Portal

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