Unannounced Inspection Report
12 and 18 August 2020

Greenvale House Nursing Home

Type of Service: Nursing Home
Address: 82-84 Mill Hill, Castlewellan, BT31 9NB
Tel No: 028 4377 8280
Inspectors: John McAuley 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 nursing home registered to provide care for up to 32 patients.

3.0 Service details

Organization/Registered Provider: Greenvale House **Responsible Individual(s):** Margaret Foster Norman Foster Barbara Frances Foster	**Registered Manager and date registered:** Barbara Frances Foster Acting capacity
Person in charge at the time of inspection: Barbara Foster	**Number of registered places:** 32 One named person in category NH-LD (E). The home is also approved to provide care on a day basis to one 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:** 29 – 12 August 2020 30 – 18 August 2020

4.0 Inspection summary

An unannounced medicines management inspection took place on 12 August 2020 from 10.35 to 15.30 and an unannounced care inspection took place on 18 August 2020 from 09.20 to 14.30.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

This inspection sought to assess progress with issues raised in the previous quality improvement plan.

The following areas were examined during the inspection:

- Staffing
- Infection prevention and control (IPC)
- Care delivery
- Governance and management
- Medicines management

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	1	4

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Barbara Foster, 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.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the last care inspection
- the registration status of the home
- written and verbal communication received since the last care inspection
- the returned QIP from the last care inspection
- the last care inspection report.

During the inspection the inspector met with 20 patients and eight staff.

The following records were examined during the inspection:

- staff duty rota
- patients' care records
- monthly monitoring reports
- quality assurance report and audits
- accident and incident reports
- care records for patients who required modified diets
- care records for the management of pain and distressed reactions
- personal medication records, medicine administration records and medicine receipt and disposal records
- controlled drug record book
- governance and audit arrangements
- the management of medication related incidents

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the last inspection on 22 November 2019

Areas for improvement from the last inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** Second time	The registered person shall ensure that records for the administration of thickening agents are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of thickening agents for four patients. Up to date speech and language assessments and care plans were in place. Records of prescribing and administration, which included details of the recommended consistency level were maintained.	
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall ensure that medicines do not remain in use after their expiry date.	**Met**
	Action taken as confirmed during the inspection: Dates of opening had been recorded on all medicines including limited shelf-life medicines. All medicines were observed to be in date.	
Area for improvement 3 **Ref**: Regulation 16 (1) (2) (a) (b) **Stated:** First time	The registered person shall ensure that patients' care plans are developed in a timely manner following identification of assessed needs.	**Met**
	Action taken as confirmed during the inspection: An inspection of care records confirmed that these were completed in a timely manner.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 4 Criteria (9) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: Three of these records were inspected and found to be appropriately maintained.	

6.2 Inspection findings

6.2.1 Staffing levels

An inspection of the duty rota confirmed that it accurately reflected all of the staff working within the home. The duty rota identified the person in charge in the absence of the manager. The manager confirmed that a competency and capability assessment was in place for any member of staff who has the responsibility of being in charge in the absence of the manager. The manager was working regular shifts in the home as a nurse to cover nursing staff vacancies, with recruitment for this in place.

Staff on duty confirmed that they were satisfied with the staffing levels. Staff spoke positively about their roles and duties, the provision of training, managerial support, teamwork and morale. Staff also stated that they felt patients received a good standard of care, were treated with respect and dignity. Team working was also found to be evident amongst staff on how care was delivered.

Patients stated that they felt safe and that there was always staff available if they required assistance.

6.2.2 Safeguarding patients from harm

The manager demonstrated a good understanding of the safeguarding process, namely, how a safeguarding referral(s) would be made to the aligned health and social care trust, who would be contacted, what documents would be completed and how staff would co-operate and assist in any investigations.

Discussions with care staff confirmed that they had knowledge and understanding of the safeguarding policy and procedure and the whistleblowing policy. Staff stated that they would have no hesitation in coming forward to report any concerns and that they felt they would be supported by management to do so.

6.2.3 Environment

The home was clean, tidy throughout and the décor and furnishings were very well maintained. Residents' bedrooms were comfortable and tastefully furnished. Bathrooms and toilets were clean and hygienic. Communal sitting lounges and dining room were spacious and nicely furnished.

The proposed new bedrooms were also inspected and found to be of a high standard of finish in terms of facility, décor and furnishing.

The grounds of the home were very well maintained.

An audit is carried out monthly examining the complete environment and addressing areas that need attention or repair. This is good practice.

6.2.4 Infection prevention and control

Observation of care practices, discussion with staff and inspection of infection prevention and control (IPC) audits evidenced that infection prevention and control measures were adhered to. Staff were knowledgeable in relation to best practice guidance with regard to hand hygiene and use of personal protective equipment; staff were also observed to wash their hands and use alcohol gels at appropriate times.

Signage was provided outlining advice and information about COVID-19. Personal protective equipment was readily available throughout the home. Alcohol based hand sanitisers were available at the entrance and throughout the home. Laminated posters depicting the seven stages of handwashing were also displayed.

6.2.5 Care practices

Staff interactions with patients were polite, friendly, warm and supportive. Patients were at ease in their environment and interactions with staff. There was a pleasant atmosphere throughout the home. Staff were attentive and patients' expression of needs were promptly responded to by staff.

Patients were all being cared for in either of the two spacious lounges or their individual bedrooms and staff were knowledgeable of the need for social distancing and isolation of patients, when appropriate.

Feedback from patients in accordance with their capabilities was positive in respect of the provision of care and their relationship with staff. Some of the comments made included the following statements:

- "I honestly love it here. I couldn't be treated any better."
- "The staff are all good."
- "There's nothing at all wrong with here. I am very happy here."
- "The food couldn't be nicer and you can get what you want."
- "It really is very good here. I like it very much."

Those patients who could not articulate their views, through non-verbal cues and presentation appeared comfortable, content and at ease in their environment.

6.2.6 Care records

An inspection of two patients' care records was undertaken. Care records were well written and up-to-date. Records were individualised to the needs of the person. They included referral information received from a range of Health and Social Care Trust (HSCT) representatives and in addition included risk assessments and care plans.

Care plans were noted to provide details of the care required by individual patients. Staff record daily the care provided to patients. There was evidence that registered nurses assessed, evaluated and reviewed care in accordance with NMC guidelines. Care plans were based on the assessed needs of patients. Each had comprehensive monthly reviews of care/progress. There was evidence that the care planning process included input from patients and/or their representatives, as appropriate. An area of improvement was made to include in this care planning process the spiritual care for patients, including the contact details of the aligned clergy person. Discussions with staff and patients, and observations made provided assurances that care is provided in an individualised manner.

6.2.7 Dining experience

Discreet observation of the lunchtime meal found that staff assisted patients in a relaxed and unhurried manner taking time to chat to the patients.

The dining room was clean and table settings were noted to be well presented with appropriate napkins, cutlery and condiments. The meal was appetising and nicely presented, with good provision of choice in place. Staff were observed offering and providing assistance in a discreet manner when necessary.

Patients spoken with stated that the food was very good and that they were satisfied with the provision of choice.

A three weekly rotational menu was in place which was nutritional, wholesome and varied.

6.2.8 Governance

The home has a defined managerial structure as detailed in its Statement of Purpose.

An inspection of the last two months (30 June 2020 and 31 July 2020) monitoring reports for the responsible individual (s) were inspected. These reports were in good detail with comprehensive examination of the running of the home.

The home had completed an annual quality report in April 2020. This was completed by an external person to the home, in order to provide added assurances. This is good practice. The feedback from this was positive regarding a whole range of issues in the home.

An inspection of accident and incident reports from 18 May 2020 was undertaken. These events were found to be managed and reported appropriately.

A selection of audits was inspected in relation to: accidents and incidents, hand hygiene, IPC and nursing audits. These were completed regularly and any areas for improvement were identified and addressed.

Inspection of complaints records evidenced that complaints are taken seriously and managed appropriately. The last recorded complaint was in 7 May 2019. Patients were aware of how to make a complaint and stated that they felt such expressions would be dealt with appropriately. Staff stated that they would not hesitate to raise any concerns with management and they felt they would be supported in doing so.

A record of compliments was maintained, which validated praise and gratitude from relatives of former patients to the home.

Medicines management

6.2.9 Personal medication records and associated care plans

Patients in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This may be done by the GP or the pharmacist.

All patients in the home were registered with local GPs and medicines were reviewed and dispensed by the community pharmacist.

Personal medication records were in place for each patient. These contained a list of all prescribed medicines with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals e.g. medication reviews, transfers to hospital. The records reviewed had been fully and accurately completed. In line with best practice, a second registered nurse had checked and signed these records when they are written and at each update to provide a double check that they were accurate.

Satisfactory systems were in place for the management of pain, antibiotics and thickening agents.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for four patients. Records of prescribing and administration were maintained. Care plans directing the use of the medicines were in place. The reason for and outcome of each administration was recorded on some but not all occasions. For two patients the medicines were being administered regularly. The manager advised that the prescriber was aware of the regular use but a record of this was not maintained. The management of "when required" medicines for distressed reactions should be reviewed and revised. An area for improvement was identified.

6.2.10 Medicine storage, controlled drugs and record keeping

Medicines must be available to ensure that they are administered to patients as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that they are not administered in error and there is no unauthorised access.

The records inspected showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

On arrival at the home the treatment room was observed to be securely locked. The medicine trolleys and cupboards were tidy and organised so that medicines belonging to each patient could be easily located. Controlled drugs were stored in a controlled drug cabinet.

Medicines which needed to be stored at a colder temperature were stored in the medicines refrigerator. The maximum and minimum temperatures were monitored daily and were within the required range.

Medicines disposal was discussed with the registered manager. Medicines including the majority of controlled drugs were safely disposed of and detailed records were maintained. However, we noted that some controlled drugs in Schedule 4 Part (1) e.g. lorazepam and zolpidem, were not being denatured prior to disposal. Controlled drugs in Schedule 4 Part (1) must be denatured prior to disposal in order to render them irretrievable. An area for improvement was identified.

6.2.11 Administration of medicines

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of medicine administration records was reviewed; they had been fully and accurately completed. The completed records were filed once complete and were readily retrievable for medication review/auditing purposes.

The majority of medicines were maintained in the blister pack system and there was evidence that they were being administered as prescribed. Daily running stock balances were maintained for controlled drugs, nutritional supplements and the majority of medicines which were not supplied in the blister pack system. The date of opening was recorded on most medicines so that they can be easily audited. This is good practice. A monthly audit was also completed by the registered nurses and reviewed by the manager.

The audits we completed at inspection indicated that medicines were being administered as prescribed. However, significant audit discrepancies were observed in the administration of two inhaled medicines. It was agreed that running stock balance checks would be maintained from the date of the inspection onwards.

We reviewed the management of emollient preparations. The registered manager advised that these medicines were stored securely in patients' bedrooms and were administered by care assistants. However, registered nurses were signing the records of administration. The records of administration must be signed by the person who administers the medicine. An area for improvement was identified.

6.2.12 Management of medicines on admission/re-admission to the home

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

We reviewed the management of medicines for two patients who had recently been admitted from hospital. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. Personal medication records had been written by one registered nurse and verified and signed by a second registered nurse. Medicines had been accurately received into the home and administered in accordance with the prescriber's directions.

6.2.13 Medicine related incidents

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. The manager was familiar with the type of incidents that should be reported.

There had been one medication related incident identified since the last medicines management inspection. There was evidence that the incident had been investigated and learning had been shared with staff. The incident had been reported to the prescribers for guidance and to the appropriate authorities including RQIA.

6.2.14 Medicines management training

To ensure that patients are well looked after and receive their medicines, registered nurses who administer medicines to patients must be appropriately trained. The registered manager has a responsibility to check that registered nurses are competent in managing medicines and that they are supported to do this.

The manager advised that registered nurses had received a structured induction which included medicines management and that records of this activity were maintained. Update training had been provided within the last year and competency assessments had been completed by the deputy manager.

Care assistants who were responsible for the administration of thickening agents and topical preparations e.g. creams and emollients, received training on these delegated tasks during their induction. However, records of this training were not maintained. An area for improvement was identified.

Areas of good practice

Areas of good practice were found in relation to staffing, teamwork, feedback from patients and staff, the pleasant atmosphere and ambience of the home and most aspects of medicines management.

Areas for improvement

Five areas for improvement were made in relation to assessment and care planning for spiritual needs, records for the administration of emollients, the management of distressed reactions, the disposal of controlled drugs and training records for delegated tasks.

	Regulations	Standards
Total number of areas for improvement	1	4

6.3 Conclusion

Throughout the inspection, patients within the home were attended to by staff in a prompt and respectful manner. The environment was clean and tidy with a good standard of décor and furnishings. Staff demonstrated a good understanding of infection, prevention and control measures in place. Feedback from patients evidenced that they were very satisfied with the standard of care being provided. Areas for improvement made during this inspection with the manager received good assurances that these would be duly acted on.

7.0 Quality improvement plan

The one area of improvement identified during this inspection is detailed in the QIP. Details of the QIP were discussed with Barbara Foster, manager, 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 Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review the management of emollient preparations to ensure that records of administration are accurately maintained. Ref: 6.2.11 **Response by registered person detailing the actions taken:** Care staff have been trained on the administration of appropriate emollient and this will be included in the induction process.
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 14(11) **Stated:** First time **To be completed by:** 19 October 2020	The registered person shall include in this care planning process the spiritual care for patients, including the contact details of the aligned clergy person. Ref: 6.2.6 **Response by registered person detailing the actions taken:** Patients families have been contacted and information received and added to care plans for contact details of the aligned clergy person for each individual resident.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review and revise the management of distressed reactions. The reason for and outcome of administration should be recorded on all occasions. Regular use should be referred to the prescriber for review. Ref: 6.2.9 **Response by registered person detailing the actions taken:** Staff nurses spoke to and advised of the importance of recording the outcome of administration on all occassions. Those who regularly took their medications GP's where contacted and changed to a regular prescription instead of PRN dose.

Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review and revise the management of controlled drugs to ensure that controlled drugs in Schedule 4 Part (1) are denatured prior to disposal. Ref: 6.2.10
	Response by registered person detailing the actions taken: All controlled drugs in Schedule 4 Part (1) are denatured prior to disposal and record kept of same.
Area for improvement 4 **Ref**: Standard 20 (1) **Stated:** First time **To be completed by:** 19 October 2020	The registered person shall ensure that records of the training/supervision which is provided for care assistants on delegated tasks are maintained. Ref: 6.2.14
	Response by registered person detailing the actions taken: Tasks that are delegated to care assistants training will be included in the induction process when new carers are recruited.

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

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