

Inspection Report

Name of Service: Greenvale House Nursing Home

Provider: Greenvale House

Date of Inspection: 14 November 2024

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

1.0 Service information

Organisation/Registered Provider:	Greenvale House
Responsible Persons:	Mr Norman Foster Mrs Margaret Foster Mrs Barbara Foster
Registered Manager:	Mrs Winnie Eriyo- registration pending
Service Profile: This home is a registered nursing home which provides care for up to 36 patients living with dementia and general nursing care needs. There are a range of communal areas throughout the home and patients have access to an enclosed garden.	

2.0 Inspection summary

An unannounced inspection took place on 14 November 2024 from 9:30 am to 4:50 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 8 February 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As a result of this inspection all areas for improvement were assessed as having been addressed by the provider. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the 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 patient's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients told us they were happy with the care and services provided. Comments made included "the staff are marvellous" and "all the staff have a great way about them".

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

Patients told us that staff offered them choices throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support.

Families spoken with told us that they were very happy with the care provided and that there was good communication from staff with comments such as "the staff are exceptional, and the entertainment here is fantastic".

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. Review of staff recruitment records evidenced that reasons for gaps in employment were not always explored as required. An area for improvement was identified.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were generally satisfied with the staffing levels. A small number of staff raised some concern about the number of patients who required support at lunchtime. These comments were shared with the manager for them to address.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

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

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

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. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

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 may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was an opportunity for patients to socialise and the atmosphere was calm and relaxed. It was observed that patients were enjoying their meal and their dining experience. It was clear that staff had made an effort to ensure patients were comfortable.

The choice of meals on offer at lunchtime was discussed with the manager as all patients received the same meal. Whilst care staff recorded the quantity of each meal consumed by individual patients, there were no records of which dish they were served to confirm that patients were offered a choice and that they received a varied diet. This was identified as an area for improvement.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The importance of engaging with patients was well understood by the manager and staff understood that meaningful activity was not isolated to the planned social events or games. Patients' needs were met through a range of individual and group activities such as bingo, arts and crafts, short stories or hand massage. Life story work with patients and their families helped to increase staff knowledge of their patients' interests and enabled staff to engage in a more meaningful way with their patients throughout the day.

Patients were well informed of the activities planned for the month and of their opportunity to be involved and looked forward to attending the planned events. Patients spoke positively about recent events held in the home such as "American Country Gospel group", "Bus Trip to Killeel" and "Abba mania".

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse 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.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly. Records were maintained of when patients were assisted to reposition however, the records did not consistently evidence that patients were repositioned in accordance with their care plan. This was identified as an area for improvement.

Review of patient care records identified concerns in relation to wound management. For example, in one patient's care record, it was unclear if the wound had healed or not. In another patient's record there were two wound care plans in place but only one was required. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. Art and craft work undertaken by patients as part of the activity programme were on display throughout the home.

Review of records and observations confirmed that systems and processes were in place to manage infection prevention and control which included regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Winnie Eryio has been the manager in this home since 27 November 2023. An application for registration with RQIA has been received and is in progress.

Relatives and staff commented positively about the manager and described her as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and the quality of services provided by the home.

Patients and their relatives spoken with said that they knew how to report any concerns and said they were confident that the manager would address their concerns.

Compliments received about the home were kept and shared with the staff team.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with standards.

	Regulations	Standards
Total number of Areas for Improvement	0	4

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Winnie Eryio, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 38 Stated: First time To be completed by: 14 November 2024	<p>The registered person shall ensure gaps in employment are explored before staff commence working in the home.</p> <p>Ref: 3.3.1</p>
	<p>Response by registered person detailing the actions taken: The application forms are now being reviewed on receipt before the candidates are invited to an interview to ensure that the actual date, month and year of starting and ending employment is clearly indicated on the application form to cover all employment history. All gaps in employment are explored.</p>
Area for improvement 2 Ref: Standard 12 Stated: First time To be completed by: 30 November 2024	<p>The registered person shall ensure that records are maintained of the exact nature of each meal consumed by patients to evidence that a varied diet is provided and that patients are availing of choice.</p> <p>Ref: 3.3.2</p>
	<p>Response by registered person detailing the actions taken: All menus have been reviewed and uploaded onto the computer system. We are liaising with the families of residents who are unable to verbalise or indicate their meal choices so that they can help us identify the foods they used to like or dislike. We now have a clearly identifiable file where previous records of residents' meal choices are kept. We had a meeting with all Chefs and Kitchen assistants to ensure that they are all aware and clear of the expectations.</p>
Area for improvement 3 Ref: Standard 4.9 Stated: First time To be completed by: 30 November 2024	<p>The registered persons shall ensure that repositioning charts evidence that patients are repositioned in accordance with their care plan.</p> <p>Ref: 3.3.3</p>
	<p>Response by registered person detailing the actions taken: We have reviewed all care plans and risk assessments so that there is consistency in the periods of repositioning. We have developed a specific audit for repositioning.</p>

<p>Area for improvement 4</p> <p>Ref: Standard 4.8</p> <p>Stated: First time</p>	<p>The registered person shall ensure that care plans for wound care are contemporaneous and reflect the current needs of the patient.</p> <p>Ref: 3.3.3</p>
<p>To be completed by: 30 November 2024</p>	<p>Response by registered person detailing the actions taken: The wound care plans have all been thoroughly reviewed that so that there is no duplication of wound care plans. Staff have been reminded to close all healed wounds on the system. Staff are also including the status of wounds and dressings in their handover reports and mid morning huddles.</p>

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