



The Regulation and
Quality Improvement
Authority

Cornfield Care Centre
RQIA ID: 020082
Green Lane and Castle Lane Suites
51A Seacoast Road
Limavady
BT49 9DW

Inspector: Donna Rogan
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**Unannounced Care Inspection
of
Cornfield Care Centre**

23 February 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 23 February 2016 from 10.00 to 16.00 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying; and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. There were no requirements or recommendations made as a result of this inspection.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 24 November 2014.

1.2 Actions/Enforcement Resulting from this Inspection

Urgent actions or enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Marcus Jervis Nutt	Registered Manager: Heather Moore
Person in Charge of the Home at the Time of Inspection: Heather Moore	Date Manager Registered: 26 August 2015
Categories of Care: NH-I, NH-DE, NH-PH, NH-PH(E), NH-TI	Number of Registered Places: 52
Number of Patients Accommodated on Day of Inspection: 51 1 in hospital	Weekly Tariff at Time of Inspection: £638

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to inspection the following records were examined:

- 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 returned quality improvement plans (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report.

During the inspection, observation of care delivery/care practices and a review of the general environment were undertaken. The inspector met with approximately 30 patients, 10 care staff, three registered nurses, and eight visiting relatives. There were no visiting professionals available during the inspection.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- four patient care records
- accident/notifiable events records
- staff training records
- staff induction records
- competency and capability records
- policies for communication, death and dying and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Cornfield Care Home was an unannounced estates inspection dated 16 November 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the last care inspection 24 November 2014

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 Ref: Regulation 16 (1) Stated: First time	The registered person shall ensure that a specific care plan on continence care is available in patients care records.	Met
	Action taken as confirmed during the inspection: A review of care plans has been conducted and where relevant there was a specific care plan regarding continence care available within the care records.	
Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 Ref: Standard 5.3 Stated: First time	It is recommended that written evidence is available in patients care records to indicate that discussions had taken place between the patient/patient's representative and the nurse in regard to planning and agreeing nursing interventions.	Met
	Action taken as confirmed during the inspection In four care records reviewed, there was evidence to indicate that discussions had taken place between the patients and, where appropriate, the patients' representative and the registered nurse in regard to planning and agreeing nursing interventions.	
Recommendation 2 Ref: Standard 5.3 Stated: First time	It is recommended that a continence assessment is available in patients care records.	Met
	Action taken as confirmed during the inspection: There was evidence in the four patients' care records reviewed that they had continence assessments completed.	

<p>Recommendation 3</p> <p>Ref: Standard 12.5</p> <p>Stated: First time</p>	<p>It is recommended that the catering arrangements in the home are reviewed to ensure that patients receive their breakfast earlier than 10.25pm.</p> <hr/> <p>Action taken as confirmed during the inspection: All staff and patients spoken with confirmed that, where appropriate, breakfast is usually served by 09.30 unless otherwise specified or through patient choice.</p>	<p>Met</p>
<p>Recommendation 4</p> <p>Ref: Standard 20.8</p> <p>Stated: First time</p>	<p>It is recommended that registered nurses, as appropriate, receive training in male catheterisation.</p> <hr/> <p>Action taken as confirmed during the inspection: A review of the training records evidenced that 13 registered nurses had received training in male catheterisation on 28 and 30 January 2015.</p>	<p>Met</p>

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice. This included the regional guidelines on breaking bad news. Discussion with three registered nursing staff confirmed that they were knowledgeable regarding this policy and procedure.

A sampling of staff training records evidenced that 25 staff had attended training on Palliative Care over the following dates, 2 April 2015, 15 April 2015, 22 April 2015, 19 May 2015 and 30 November 2015. This training included the procedure for breaking bad news as relevant to staff roles and responsibilities and communicating effectively with patients and their families/representatives.

Two palliative link nurses have been appointed in the home and both had attended a Palliative Care Conference on 13 November 2015. Three registered nurses and four carers spoken with were knowledgeable about the important aspects to consider when communicating sensitively with their patients. The importance of good effective communication was included in all staff inductions to the home. It is also included in the competency and capability assessments of all registered nurses taking charge of the home in the manager's absence.

Is Care Effective? (Quality of Management)

The care records examined evidenced that patients' individual needs and wishes regarding end of life care had been discussed with their General Practitioner (G.P.). The care plans included reference to the patient's specific communication needs, including sensory impairment and cognitive ability.

A review of care records evidenced that, where appropriate, the breaking of bad news was discussed with patients and/or their representatives; options and treatment plans were also discussed, where appropriate. The records evidenced that with patients and/or their representative's consent, information had been shared with the relevant health care professionals.

Three nursing staff consulted with demonstrated their ability to communicate sensitively with patients and/or representatives when breaking bad news by emphasising the need for privacy, having sufficient time and emphasised the importance of good relationships with their patients. The nurses described to the inspector that when they are breaking bad news, they would sit down beside the patient, use a calm voice, speak clearly yet reassuringly, allow privacy, allow the patient to ask questions and display as much empathy as possible.

There was evidence within the four care records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and many staff interactions with patients, it was evident that communication was well maintained and patients were observed to be treated with dignity and respect. There were a number of occasions when patients had been assisted to redirect their anxieties by care staff in a professional and sensitive way.

The inspection process allowed for consultation with 30 patients who all stated that they were very happy with the quality of care delivered and with life in Cornfields Care Home. They confirmed that staff are polite and courteous and that they felt safe in the home. Eight patients' relatives/representatives discussed care delivery and also confirmed that they were very happy with the standards maintained in the home and the level of communication with all grades of staff.

A number of compliment cards were reviewed from past family members. All detailed a positive response in relation to their experiences of how staff communicated in a compassionate and thoughtful way throughout the end of life or palliative care process.

Discussion with ancillary staff such as those in the laundry, domestic and kitchen staff stated that nursing staff communicated regularly with them where needed regarding patients' needs. All stated that they were kept informed where required if patients' conditions were deteriorating. All staff spoken with felt that communication was exceptional regarding the theme of this inspection.

Areas for Improvement

There were no requirements or recommendations made regarding this standard.

Number of Requirements:	0	Number of Recommendations:	0
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5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Two registered nursing staff had been identified as the link nurses in palliative care and received formal training on 2 and 15 April 2015 alongside 21 other members of staff. Both palliative link nurses had also attended a Palliative Care Conference on 13 November 2015. Guidance documents on the management of palliative and end of life care and death and dying are held together in both units of the home. Staff spoken with were aware of the documents and were aware of where they were held.

The registered manager, three registered nursing staff and five care assistants were aware of the Gain Palliative Care Guidelines, November 2013. A copy of the guidelines were available in each unit of the home and all registered nursing staff spoken with were aware where they were retained in the home.

Discussion with three registered nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the registered manager, eight staff and a review of four care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or drugs was in place and discussion with two registered nursing staff confirmed their knowledge of the protocol.

The registered nursing staff confirmed that they are able to source a syringe driver via the community nursing team if required. It was also confirmed that registered nursing staff were trained in the use of this specialised equipment on 18 February 2015. Further training has been arranged.

Is Care Effective? (Quality of Management)

There was one patient considered as being at end of life in the home during the inspection. Three were recognised as requiring palliative care. A review of all four care records evidenced that patients' needs for palliative care was assessed and reviewed on an ongoing basis and documented in patient care plans. This included the management of hydration and nutrition, pain management and symptom management. The care records reviewed included families wishes and involvement and there was consultation with the patients regarding their wishes and feelings. Detail in the records was sensitive and provided clear information regarding consultations with allied professionals, disciplinary team, relatives and clergy. Discussion with staff indicated that care plans are updated as the patient's needs and wishes change.

Discussion with the registered manager, three registered nurses, four care staff and a review of care records evidenced that environmental factors had been considered when a patient was at the end of life. Staff informed the inspector that management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Facilities have been made available for family members to spend extended periods of time with their loved ones during the final days of life. Meals, snacks and emotional support had been provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that all had been appropriately reported.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of three care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences. Nursing staff were able to demonstrate an awareness of patients' expressed wishes and needs in respect of Do Not Attempt Resuscitation (DNAR) directives as identified in their care plan.

Arrangements were in place in the home to facilitate, as far as possible, the patient's wishes, for family/friends to spend as much time as they wish with the person. Staff discussed openly recent deaths in the home and how they had been able to accommodate and fully support the family members in staying overnight with their loved ones.

From discussion with the registered manager and staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

No concerns were raised by relatives in relation to the arrangements regarding the end of life care of patients in the home.

All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with the registered manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included 1:1 support from the registered manager and peer support through staff meetings.

Information regarding bereavement support services was available and accessible for staff, patients and their relatives.

Areas for Improvement

There were no requirements or recommendations made regarding this theme.

Number of Requirements:	0	Number of Recommendations:	0
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5.5 Additional Areas Examined

5.5.1 Comments by staff, patients and patient representatives

As part of the inspection process, patients, their representatives and staff were consulted and questionnaires issued. All comments were positive. Some comments received are detailed below:

Staff

Staff spoken with were positive regarding services the home and the management. They raised no concerns in discussion. Eight members of staff members completed questionnaires and all were satisfied with the training and services provided in the home in relation to end of life and palliative care.

The following comments were made:

- “very satisfied that patient consent and capacity to consent are sought”
- “management are very approachable regarding all aspects of the day to day running of the home”
- “all staff work as a team ensuring best practice/decisions are made in the best interests of patients”
- “we have a very good team of nurses in our unit”
- “patients’ needs are patient centred, we encourage relatives to complete life story books which we feel enhance their care”
- “I have found working in Cornfields Care Centre to be the most rewarding”
- “Cornfields is a lovely and caring environment to work in”
- “there is a high standard of care and a person centred approach”

Patients

Eleven patients completed questionnaires. The following comments were detailed in the questionnaires returned following discussions with patients:

- “staff are 100%, I get VIP treatment”
- “my relatives and friends are made welcome by staff”
- “I am able to make day to day choices”
- “I am very satisfied that I feel safe in the home”
- “staff are good, very good food, I am well treated”
- “staff are very friendly, good and we go out on day trips”
- “very satisfied that staff treat me with dignity and respect”
- “I am very well looked after”
- “the staff and the food are excellent”
- “I feel happy and my environment and care is safe”
- “it is really excellent here”

Patients' representatives

Eight visiting relatives/representatives stated in discussion that they could not ask for better care in the home and that staff were always available. They felt they had made the right decision choosing the home for their relative. Another visitor commented that they found staff to be very good and that they were full of care and compassion.

The following comments were made by relatives/representatives in four returned questionnaires:

- “very satisfied that the quality of care is good”
- “comfort and care are excellent. All staff are friendly and helpful and bend over backwards to help in ensuring mum is content”
- “I am satisfied that I could talk to staff if something was wrong”
- “when I visit, I am welcomed like a friend, offered tea and made to feel like I belong”

Number of Requirements:	0	Number of Recommendations:	0
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6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Heather Moore	Date Completed	3/4/16
Registered Person	Jervis Nutt	Date Approved	3/4/16
RQIA Inspector Assessing Response	Donna Rogan	Date Approved	8/4/16

Please provide any additional comments or observations you may wish to make below:

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations.