Annadale
RQIA ID: 1047
11 Annadale Avenue
Belfast
BT7 3JH

Inspector: Dermot Walsh
Inspection ID: IN021804

Tel: 028 9064 5900
Email: annadalenursinghome@hotmail.co.uk

Unannounced Care Inspection
of
Annadale

22 September 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 22 September 2015 from 09.40 to 16.40.

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. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

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 10 March 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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	3

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Winnie Mashumba, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Annadale Private Nursing Home Ltd William Gage	**Registered Manager:** Winnie Mashumba
Person in Charge of the Home at the Time of Inspection: Winnie Mashumba	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 38
Number of Patients Accommodated on Day of Inspection: 37	**Weekly Tariff at Time of Inspection:** £593 - £703

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 analysed:

- 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, the inspector met with 17 patients, three care staff, two registered nurses, two ancillary staff and one patient representative.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- a sample of staff duty rotas
- three patient care records
- accident/notifiable events records
- staff training records
- staff induction records
- policy documentation in respect of communicating effectively, palliative and end of life care
- complaints
- compliments
- best practice guidelines for palliative care and communication

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 10 March 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref:** Regulation 13 (4) (a) **Stated:** First time	All medicines must be stored in a secure place. Arrangements to ensure that medicines are securely stored should support the patients' wishes to self-administer their medicines.	**Met**
	Action taken as confirmed during the inspection: A tour of the home confirmed all medications were securely stored. No patients were noted to be self-administering their medications.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref:** Standard 19.1 **Stated:** First time	Care records should be further developed to include: • The specific type of continence products that patients' required • the patients' normal bowel pattern.	**Met**
	Action taken as confirmed during the inspection: A review of three care records evidenced that where specific continence products and normal bowel pattern are established that this is included in the care records.	

Recommendation 2 **Ref:** Standard 5.7 **Stated:** First time	Care plan evaluations should include a meaningful statement of the patient's condition, including any changes, since the previous review.	**Met**
	Action taken as confirmed during the inspection: Analysis of three care records evidenced meaningful statements of the patients' condition on evaluation review.	
Recommendation 3 **Ref:** Standard 12.12 **Stated:** First time	The management of patients weights should be reviewed and the following issues addressed: • referrals to healthcare professionals should be recorded in the individual patients care records • staff should follow up referrals in a timely manner • when a significant variation to patient's weights are recorded appropriate action is taken at the time of recording • weighing scales should be regularly calibrated and records maintained	**Met**
	Action taken as confirmed during the inspection: A review of two relevant care records evidenced appropriate referrals and follow up referrals were made to healthcare professionals. Follow up action was recorded at time of reporting. A record has been maintained to record the calibrations of weighing scales.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available regarding communication. A policy was also available regarding delivering bad news. Regional guidelines on 'Breaking Bad News' was available to staff. Discussion with five staff confirmed that they were knowledgeable regarding breaking bad news.

A sampling of training records evidenced that 34 out of 38 staff had completed training in relation to communicating effectively with patients and their families/representatives. Communicating effectively is also incorporated within palliative care training and person centred care training.

Is Care Effective? (Quality of Management)

There were no patients on the day of inspection identified as requiring end of life care.

Recordings within records included reference to the patient's specific communication needs.

There was no evidence recorded within four care records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their needs. Further clarification of this can be found in section 5.6.4.

Two registered nurses consulted demonstrated their ability to communicate sensitively with patients and/or their representatives when breaking bad news. They discussed the importance of an environmentally quiet private area to talk to the recipient and the importance of using a soft calm tone of voice as well as using language appropriate to the listener. Staff also described the importance of reassurance and allowing time for questions or concerns to be voiced. Care staff were also knowledgeable on breaking bad news and offered similar examples when they have supported patients when delivering bad news. Best practice guidelines on 'Breaking Bad News' was available in the home.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and staff interactions with patients, it was evident that effective communication was well maintained and patients were observed to be treated with dignity and respect.

The inspection process allowed for consultation with 17 patients both individually and with others in small groups. All patients stated they were very happy with the care they were receiving in Annadale Nursing Home. They confirmed that staff were polite and courteous and that they felt safe.

One patient representative commented, "The care in the home is excellent. Having our parents in here has really changed our lives."

Areas for Improvement

Patients and/or their representatives should be involved in the assessment; planning and evaluation of the patients care.

Number of Requirements:	**0**	**Number of Recommendations**:	**1**

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)

Policies and procedures on the management of palliative and end of life care, care of the dying and death of a resident were available in the home. These documents reflected best practice guidance such as – 'Strategic Thinking Limited 2015'. A copy of Gain Palliative Care Guidelines, November 2013 was available to staff in the home. Information leaflets, 'Living With a Terminal Illness and Looking For Support', were available at the entrance to the home.

Training records evidenced that staff were trained in the management of death, dying and bereavement. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013. Five staff had completed face to face training on palliative care. E-Learning palliative care training had been completed by 18 out of 38 staff. This had been identified in the previous home staff meeting and the remaining staff had been reminded to complete the e-learning training. All registered nursing staff had completed training recently on the use of syringe drivers.

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

Discussion with the registered manager and five staff 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 staff confirmed their knowledge of the protocol.

A palliative link care nurse has been identified for the home to guide and advise staff as necessary.

Is Care Effective? (Quality of Management)

Discussion with the registered manager and staff evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/ representatives to be with patients who had been ill or were dying. A quiet room has been identified for family/friends to have a private conversation or a rest. Staff consulted with were aware of the importance of providing refreshments at this time.

A review of notifications of death to RQIA during the previous inspection year, were deemed to be appropriate.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care.

Arrangements were in place to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. 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.

Some compliments were as follows:
'Thank you all again for making a very difficult year for mum the best it could have been.'
'You created a family atmosphere in Annadale giving the place an extra special feel.'
'We write to thank you for the loving care you gave our mum. Right from the beginning you made her feel welcome and it didn't take her or you long to get to know each other.'
'It has been reassuring for us to know dad was being cared for with dignity, respect and compassion.'

Discussion with the registered manager and a review of the complaints records evidenced that no concerns were raised 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.

Areas for Improvement

There were no areas for improvement in relation to palliative care / death and dying.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.5 Additional Areas Examined

5.5.1. Consultation with patients, their relatives/representatives and staff

During the inspection process, 17 patients, seven staff, and two patient representatives were consulted to ascertain their personal view of life in Annadale Nursing Home. Ten staff questionnaires and one patient questionnaire were completed and returned. Two patients' representative questionnaires were returned. Overall, the feedback from the patients, representatives and staff indicated that safe, effective and compassionate care was being delivered in Annadale Nursing Home.

Patient comments are detailed below:
"We are well looked after and comfortable here."
"The staff are very very nice. It's a lovely place."
"I'm very happy here. They're very good. Couldn't say a word against them."
"The care is very good. The staff are marvellous."

Patient representatives consulted with were very positive about the care their relative was receiving.

Relative comments are as follows:
"The staff are extremely friendly and helpful at all times."
"I am content my wife is well cared for particularly when I have to leave her in the evening."
"I find the home very good. The chef comes around every day to see if the patients are happy with the menu choice and offers alternatives if the patient isn't happy with the choice."

The general view from staff cited in completed questionnaires and during conversations was that they took pride in delivering safe, effective and compassionate care to patients.

Staff comments are as follows:
"I am very happy and very settled here. It's really good here. "
"The level of care is excellent. The staff have a great work ethic and a genuine interest in providing good care."
"It can be very stressful but I love it here."
"Management are very good when it comes to end of life care. They're very compassionate."
"I think it's very important that management and staff have a good relationship with communication as this makes for a good happy working environment which shows to the residents that they are cared about and that they come first at all times."

5.5.2. Infection Prevention and Control and the Environment

A tour of the home confirmed that rooms and communal areas were generally clean and spacious.

However, a range of issues were identified within the home which were not managed in accordance with infection prevention and control guidelines:

- not all signage was laminated to ensure the surface may be cleaned
- the type of shelving used in the identified storage area did not have a cleanable surface
- inappropriate storage in identified rooms
- unnamed skin cleansing foam was found in communal bathrooms and toilets
- a surface of an identified bedside table was significantly scratched exposing bare wood.

The above issues were discussed with the registered manager on the day of inspection. An assurance was provided by the registered manager that these areas would be addressed with staff to prevent recurrence. A recommendation was made that management systems are to be put in place to ensure compliance with best practice in infection prevention and control.

5.5.3. Activities

An activities co-ordinator and two activities therapists are employed in the home. Activities are facilitated twice daily from Monday to Sunday. Notice boards are maintained up to date to inform patients of planned activities. Notices are displayed in each of the two lounges and the dining room. A copy of the planned activities is also emailed to patients' next of kin, encouraging them come to the home if they wish. Planned activities include baking; jam making; candle making; singing; dancing; one to one aerobics; walks; fundraising and games. Outings involving up to 15 patients are arranged once every two months depending on transport. The provision of activities was observed to be commendable.

5.5.4. Documentation

There was no evidence within four records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs. This was discussed with the registered manager who confirmed that these records had recently been transferred to electronic recording. Staff are currently liaising with computer technicians to receive uploads to rectify identified deficits such as somewhere for patients and/or their representatives to confirm they have agreed assessment, planning and evaluation of care. A recommendation was made in this regard.

A review of three care records confirmed that details included specific continence products in use and patients' normal bowel pattern information was included as appropriate. However, the information provided was not located in the same area of the records. In the four records reviewed the information was included in either the continence assessment or the care plan. Continence assessments had not been fully completed in the three records reviewed. This was discussed with the registered manager and it was agreed all information should be collated within the continence assessment and the care plan. A recommendation was made.

A commendable practice noted with computerised recording was that any significant change in patients' care or need can be emailed directly to the manager in their absence which keeps them informed of the current care needs of the patients.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager, Winnie Mashumba, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

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. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** First time **To be Completed by:** 30 October 2015	The registered person should ensure evidence that patients and/or their representatives were involved in the assessment; planning and evaluation of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record. **Ref: Section 5.4, 5.6.4**
	Response by Registered Person(s) Detailing the Actions Taken: A software update has been done to allow for recording of patients/representantives involvement in the the care planning process to demonstrate that they have agreed with the assessments planning and evalution of care plans. The care plan is also agreed with the Care Manager. We will continue to upload any hand written notes submitted by the patients and their representatives as contribution to the care planning process.
Recommendation 2 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time **To be Completed by:** 30 October 2015	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. **Ref: Section 5.6.2**
	Response by Registered Person(s) Detailing the Actions Taken: The creams identified on the day of inspection were removed immediately from communal areas. Feedback was given to all care staff to remind them to take these creams back to the rooms after giving personal care in communal bathrooms. We have swopped the affected bed side lockers with the spare new ones that we held in the storage. The shelves in the housekeepers stores have been vanished. Cushions kept underneath the shelves of the housekeepers cubboard have been moved to the shed.

Recommendation 3 **Ref:** Standard 4 Criteria (1) (7) **Stated:** First time **To be Completed by:** 30 October 2015	The registered person should ensure that patients continence assessments and care plans are fully completed and include: • the specific continence products required by the patient • the patients' normal bowel pattern **Ref: Section 5.6.4**
	Response by Registered Person(s) Detailing the Actions Taken: A meeting was held with all nurses to disuss the inspection feedback. They were all reminded to record continence products being used by each resident. They were also told to record the 'normal' bowel pattern for each and every resident in the assessments as well as the care plans. Care plan audits will also focus on these.

Registered Manager Completing QIP	Winn Mashumba	**Date Completed**	29/10/15
Registered Person Approving QIP	Trevor Gage	**Date Approved**	29/10/15
RQIA Inspector Assessing Response	Dermot Walsh	**Date Approved**	2/11/15

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