Bangor – Brownlee Suite
RQIA ID: 1053
27a Manor Avenue
Bangor
BT20 3NG

Inspector: Linda Thompson
Inspection ID: IN021762

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Unannounced Care Inspection
of
Bangor Care Home – Brownlee Suite

7 July 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 7 July 2015 from 11.30 to 13.30.

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

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in 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 24 September 2014.

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	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: Four Seasons Health Care/ Dr Maureen Claire Royston	**Registered Manager:** Donna Mawhinney
Person in Charge of the Home at the Time of Inspection: Donna Mawhinney	**Date Manager Registered:** 30 December 2014
Categories of Care: NH-LD, NH-LD(E)	**Number of Registered Places:** 17
Number of Patients Accommodated on Day of Inspection: 10	**Weekly Tariff at Time of Inspection:** £593 - £637

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

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 the delivery of care and care practices were observed. An inspection of the general environment of the home was also undertaken. The inspection process allowed for discussion with 10 patients either individually or in small groups. Discussion was also undertaken with four care staff, one nursing staff and one ancillary staff. No patient representatives were available during the inspection visit.

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP
- the staff duty rota
- three patient care records
- records of accident/notifiable events
- staff training records
- staff induction records
- records of competency and capability of the registered nurse in charge of the home in the absence of the registered manager
- 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 the home was an unannounced estates inspection dated 14 October 2014. The completed QIP was returned and approved by the estates 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 (7) **Stated:** First time	The registered person must ensure that: • The malodour in the identified bedroom is actioned with all due haste. A letter separate from the retuned QIP should be sent to the inspector to outline how the malodour has been addressed in light of the finance discussions. • The equipment identified in the communal bathroom must be cleaned, repaired or replaced	**Met**
	Action taken as confirmed during the inspection: It was confirmed during inspection that the general environment of the home was very well maintained. There were no malodours evidenced and storage of equipment was in keeping with infection prevention and control best practice guidance.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Policy guidance for staff was available on communicating effectively and referred to regional guidelines on 'breaking bad news.

A sampling of communication training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives.

Is Care Effective? (Quality of Management)

An examination of three nursing care records evidenced that patient's individual needs and wishes in regards to daily living were appropriately recorded.

Recording within care records did include reference to the patient's specific communication needs. All records examined demonstrated a person centred approach to the patient's individual communication needs.

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

The registered nurse in charge of Brownlee Suite during the inspection discussed at length how she would communicate sensitively with patients when breaking bad news. Given the learning disability of the residents staff would always endeavour to give residents factual accuracy but in a simplistic format which would meet their individual needs and level of understanding. It was also advised that in the past they have sat down with the resident in a private area, held the patient's hand and using a calm voice, spoke with the patient in an empathetic manner using clear speech, offering reassurance and an opportunity for the patient to ask any questions or voice any concerns.

Is Care Compassionate? (Quality of Care)

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

The inspection allowed for consultation with four residents individually and observations with others in small groups. Resident / inspector interactions are limited due to a number of communication issues however it was confirmed that the residents appeared well cared for and were very content in Brownlee Suite.

A number of compliment cards were displayed from past family members. Comments from these cards are illustrated in section 5.4 below.

Areas for Improvement

There were no areas of improvement identified for the home in respect of communication.

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

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

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were recently updated and available for inspection. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013. The registered manager and the registered nursing team were aware of the Gain Palliative Care Guidelines November 2013 a copy of which was available in the home.

Training records evidenced that 86% of all staff were trained in the management of palliative/end of life care, death, dying and bereavement. This training was provided on the home's e-learning system and also by the palliative care nurse from the South Eastern Health and Social Care Trust (SEHSCT) on a number of occasions in recent months. The home is commended for achieving this high percentage of staff trained.

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

The home maintains one registered nurse as a palliative care link nurse. The link nurse attends the regular palliative care group meetings and minutes were available for reference in the home.

Discussion with the registered manager, four staff and a review of three 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 all registered nursing staff are trained in the use of this specialised equipment.

Is Care Effective? (Quality of Management)

There were no residents in Brownlee Suite requiring end of life care at the time of the inspection. However we were able to examine three nursing care records for residents who were considered as requiring palliative care. All records evidenced that residents' needs for palliative care were assessed and reviewed on an ongoing basis. This included a review of the management of hydration, nutrition, pain management and symptom control. Care plans were appropriately updated as required.

It was confirmed that environmental factors had been considered when a resident was considered end of life. Staff consulted confirmed 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 with their loved ones during the final days of life. A dedicated palliative care room with a bed, sofa and shower facilities was available. Meals, snacks and emotional support have been provided by the staff team.

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

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of care records evidenced that residents and/or their representatives had been consulted in respect of their cultural and spiritual preferences. Nursing staff were able to demonstrate an awareness of resident's expressed wishes and needs in respect of DNAR directives as identified in their care plan.

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

From discussion with 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 comments from recent compliment cards are detailed below;

'I want to thank you all so much for all the care you gave to ….. and the kindness you have all shown to him.'

'I was so happy that he was so very content during his time in Brownlee Suite.'

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 support through staff meetings.

Information regarding bereavement support services was available and accessible for staff, patients and their relatives. Information documents were displayed in the foyer of the home.

Areas for Improvement

No areas for improvements are identified at this time. The home is commended for their management of end of life care.

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

5.5 Additional Areas Examined

5.5.1 Consultation with patients, their representatives, staff and professional visitors

Part of the methodology in collecting data for the inspection process included speaking with staff, patients and patient's relatives asking them to give their own personal views on their impression of Brownlee Suite. Questionnaires were also given out for completion to aid data collection.

Unfortunately due to resident frailty and communication challenges it was difficult to gain the residents opinion regarding the care delivery in the home. There were no resident representatives available during the inspection visit.

Overall feedback from the staff confirmed that safe, effective and compassionate care was being delivered in the home.

Some staff comments are detailed below:

'I am very pleased with how my colleagues and I are able to provide quality care to each of the residents. For example we are able to shower everyone on a daily basis. I am also happy that despite the profound levels of disability of the residents we are still bale to ensure that everyone has a good level of independence. '

'I recently experienced death with one of our residents and I must say that the home provided me the opportunity to express my love to that resident. I feel that their family was well supported at that difficult time.'

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	DONNA MAWHINNEY	**Date Completed**	24/08/15
Registered Person	Dr M Claire Royston	**Date Approved**	28/08/2015
RQIA Inspector Assessing Response	Dermot Walsh	**Date Approved**	28/08/2015

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

***Please complete in full and returned to RQIA nursing.team@rqia.org.uk ***