Bangor – Stewart Suite
RQIA ID: 1055
27a Manor Avenue
Bangor
BT20 3NG

Inspector: Linda Thompson
Inspection ID: IN021757

Tel: 028 91273342
Email: bangor@fshc.co.uk

Unannounced Care Inspection
of
Bangor Care Home – Stewart Suite

6 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 6 July 2015 from 09.30 to 15.00.

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 31 August 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-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 30
Number of Patients Accommodated on Day of Inspection: 24	**Weekly Tariff at Time of Inspection:** £593

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 15 patients either individually or in small groups. Discussion was also undertaken with four care staff, one nursing staff and two patient's representatives.

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 (1) **Stated:** First time	The registered person must ensure that the management of wound care and associated records are maintained appropriately. The registered person must ensure the following; • The wound must be correctly identified • The prescribed interval between dressings must be adhered to unless clear reason for the change in frequency is recorded • Each individual wound should have its own wound record	**Met**
	Action taken as confirmed during the inspection: It was confirmed that wound care is appropriately managed, wounds were evidenced to be correctly identified and the intervals between dressings was accurately maintained.	
Requirement 2 **Ref**: Regulation 12 (1) **Stated:** First time	The registered person must ensure that suitable light weight china crockery is made available to meet the needs of the patients. All due consideration to patients' rights of dignity and respect must be afforded and the use of plastic crockery should be withdrawn. Plastic crockery should only be used in exceptional circumstances and only following appropriate risk assessment.	**Met**
	Action taken as confirmed during the inspection: It was confirmed that suitable crockery was available for patient use as required.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 5.7 **Stated:** First time	It is recommended that the records of patient's bowel functions are recorded in the patient's nursing care records against the Bristol Stool Chart. This will allow for a continuous professional assessment and evaluation of the effectiveness of laxative therapies.	**Met**
	Action taken as confirmed during the inspection: It was confirmed that the registered nursing staff documented that patient's bowels had moved in the patient's daily progress records. These recordings referenced the Bristol Stool Chart.	

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)

One nursing care record from a recently deceased patient and two other 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.

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.

Two registered nursing staff consulted, demonstrated their ability to communicate sensitively with patients when breaking bad news. They advised that in the past they sat down with the patient 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. Care staff were knowledgeable on how to break bad news and offered similar examples when they have supported patients when delivering bad news.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and many staff interactions with patients, it was confirmed 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 very professional way.

The inspection process allowed for consultation with 15 patients individually and with many others in small groups. In general the patients all stated that they were very happy with the quality of care delivered and with life in Stewart Suite. They confirmed that staff were polite and courteous and that they felt safe in the home.

Two patient's representatives discussed care delivery and confirmed that they were very happy with standards maintained in the home. Some patient representative comments are recorded in section 5.5.1 below.

A number of compliment cards were displayed from past family members.

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 two registered nursing staff 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 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 are commended for achieving this high percentage of staff trained.

Discussion with two registered nursing staff 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, six 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)

A review of the care records for one patient who had recently died were examined. In addition, two care records for patients who were receiving palliative care were also examined. All three care records evidenced that patients' needs for palliative or end of life care were assessed and reviewed on an ongoing basis and documented in patient care plans. This included the management of hydration, nutrition, pain management and symptom control. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

It was confirmed that environmental factors had been considered when a patient 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. 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 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 patient'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 patient's wishes, for family/friends to spend as much time as they wish with the person. Staff discussed openly a number of 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. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Some comments from recent compliment cards are detailed below;

'I want to thank everyone in Bangor Care Home who looked after my mum so well in her short stay with you. Both her and I were made to feel very welcome by everyone and I know she felt very at home with you all.'

'Thank you so much for your help and support during dad's final peaceful days.'

'This is just a short note to thank you for your thoughts and card. I much appreciated your attention and kindness that you all gave to ……, especially during his final hours; it is good to know that someone was with him at the end.'

'I am writing to offer my heartfelt thanks for all the care and attention that you showed my grandmother, who recently passed away. Knowing that granny was cared for with dignity and respect means so much.'

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 Stewart Suite. Questionnaires were also given out for completion to aid data collection.

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

A few patient comments are detailed below:
'It's just like being at home.'
'I like the company and the place is really nice.'
'I like being in my own room.'
'The nurses are lovely and very kind.'
'My daughter can come when she wants.'

One relative stated he was very happy with the care his loved one was receiving and thought that staff were always very welcoming'

Another relative stated that they were always kept informed of any changes in their loved ones health and felt that their loved one was safe in the home.

The general feeling from the staff questionnaires and conversations indicated that they took pride in delivering safe, effective and compassionate care.

A few staff comments are detailed below:

‘I’m very happy with the support and guidance that residents are given’.
‘We treat patients with dignity and respect and I feel we are sensitive to their needs especially with any dying resident and their families.’
‘I love it here.’
‘If we were worried about anything we would always be able to talk about it with Donna.’

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 ***