Belmont
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Inspector: Lyn Buckley
Inspection ID: IN021973

Unannounced Care Inspection
of
Belmont Care Home

2 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 2 September 2015 from 11:25 to 14:45 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. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in 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 12 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	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 – Responsible Person	**Registered Manager:** Victoria Lane
Person in Charge of the Home at the Time of Inspection: Victoria Lane	**Date Manager Registered:** 4 July 2012
Categories of Care: NH – I, PH, PH(E) and TI	**Number of Registered Places:** 48
Number of Patients Accommodated on Day of Inspection: 41	**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

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 by RQIA since the previous care inspection
- the returned quality improvement plans (QIP) from the last care inspection;
- the previous care inspection report
- pre-inspection assessment audit.

During the inspection the delivery of care and care practices were observed. A review of the general environment was also undertaken. The inspection process allowed for consultation with 12 patients individually and with others in small groups, two care staff, two registered nurses and three ancillary staff.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes
- duty rotas for week commencing 31 August 2015
- training records
- staff induction templates
- competency and capability assessment template for the nurse in charge of the home in the absence of the manager
- compliment records
- three patient care records
- reflective practice records referred to as 'after death care analysis'
- palliative care/end of life/grievance and bereavement resource files.

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 13 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 Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 19.1 **Stated:** First time	Care plans should be devised to manage and direct care delivery for each identified need in relation to urinary catheters and bowels.	**Met**
	Action taken as confirmed during the inspection: Examination of three patient care records evidenced that this recommendation had been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively. Guidance was also available on 'Breaking Bad News'. Discussion with staff confirmed that they were knowledgeable regarding this policy, procedure and guidance.

A sampling of training records evidenced that staff had or were required to complete training in relation to communicating effectively with patients and with families/representatives. The registered manager confirmed that additional sessions were planned to cover the inspection theme/focus.

Is Care Effective? (Quality of Management)

Care records reviewed included reference to the patient's specific communication needs and actions required to manage barriers such as, language, culture, cognitive ability or sensory impairment. There was also evidence that patients and their representatives were included in discussions regarding communication and for treatments options, where appropriate.

Staff consulted demonstrated their ability to communicate sensitively with patients and/or representatives.

Is Care Compassionate? (Quality of Care)

Observation of care delivery and interaction between patients and staff clearly demonstrated that communication was compassionate and considerate of the patient's needs. Patients were treated with dignity and respect and responded to in a timely manner.

The inspection process allowed for consultation with 12 patients individually and with others in small groups. Patients who could verbalise their feelings on life in Belmont Care Home commented positively in relation to the care they were receiving and in relation the attitude of staff. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff. One patient stated that two staff had particularly enhanced his life in the home. This was commended by the inspector and details shared with the registered manager.

Positive comments were also viewed in letters and cards received by the home from relatives.

Areas for Improvement

There were no requirements or recommendations made.

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 Standard 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 available in the home. Best practice guidance such as the Gain Palliative Care Guidelines, November 2013, was also available. The policy regarding the management of an unexpected death was under review. A resource file on palliative care/end of life/grief and bereavement was available to staff.

Training records evidenced that staff were trained in the management of serious illness/deteriorating patient and what to do when death occurred. The registered manager confirmed that she had attended training provided by the organisation on palliative and end of life care. This training was to be provided to staff in the home on 11 September 2015. Staff spoken with confirmed that they would be attending this training. Training specific to the use of syringe drivers had been delivered to registered nurses within the last year.

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

Discussion with nursing staff and a review of 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 registered nurses confirmed their knowledge of the protocol.

Is Care Effective? (Quality of Management)

A review of care records evidenced that, where required, patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. This discussion was documented in the records reviewed as taking place after the patient had settled into the home rather than on the day of admission. The discussion was usually conducted by the registered manager or a senior registered nurse.

Following discussion regarding end of life care, a care plan was developed to ensure the patient's wishes and preferences were met. The registered manager also gave an example where she had attempted to ascertain the wishes of a patient with no family and who was unable to communicate.

Discussion with the registered manager and staff evidenced that management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Staff confirmed that relatives were supported with tea, coffee, meals and advice as required.

A review of notifications of death to RQIA during the previous inspection year confirmed that any death occurring in the home was notified 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 regarding end of life care. Staff consulted demonstrated an awareness of patients' expressed wishes and needs as identified in their care plan. Staff spoken with demonstrated clearly their compassion for the patients, their relatives and friends. The inspector was impressed with how staff interacted with patients and of the detailed knowledge demonstrated to ensure patients were afforded privacy, dignity and respect.

Arrangements were in place in the home 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. All staff spoken with informed the inspector of how they could provide support to families who were 'sitting with loved ones' who were dying.

From discussion with the registered manager, 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 examples of comments made by relatives included:

'the care and understanding you showed… was fantastic and the pressure this took of me made my life a lot less stressful.'

'the care and attention given… was first class and second to none. I will always be grateful to you for this.'

'Thank you all so very much for the love and tenderness shown to our much loved…'

'It was a great comfort to the family as we knew…was being well looked after and that ...was settled.'

Referring to the expressed view of the deceased patient; 'he always said he wanted 'home' [when in hospital] *which is what he considered Belmont'.*

Discussion with the registered manager confirmed that no concerns had been raised in relation to the arrangements regarding the end of life care of patients in the home.

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

Areas for Improvement

There were no requirements or recommendations made

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

5.5 Additional Areas Examined

5.4.1 Consultation with patients, staff and patient representative/relatives

Patients

The inspector met and spoke with 12 patients individually and with others in small groups. Patients were very complimentary regarding the standard of care they received, the attitude of staff and the food provided. There were no concerns raised with the inspector. As stated in section 5.3 one patient stated that two staff had particularly enhanced his life in the home. This was commended by the inspector and the details shared with the registered manager.

Six questionnaires for patients were left with the registered manager for distribution and three were returned. Comments recorded evidenced that patient were either satisfied or very satisfied with the care they received.

Comments recorded included:

'I am happy in this home'.

In relation to pain relief – *'the nurse is always there to help'*.

Staff

In addition to speaking with staff on duty six questionnaires were provided for staff not on duty. The registered manager agreed to forward these to the staff selected. At the time of writing this report three had been returned. Comments recorded that evidenced that staff had attended training in relation to the inspection focus, safeguarding of vulnerable adults and how to report poor practice/whistleblowing. Staff were either satisfied or very satisfied that care delivered was safe, effective and compassionate.

Additional comments recorded included:

'*Good team work and good communication helps to provide good quality of care for the residents'.*

'Staff help one another to make sure that good quality of care is delivered to the patients'.
'We keep the residents' feelings and wishes in mind and base decisions on the personal needs and desires of the individual.'

Representatives/relatives

Six questionnaires were provided for patient representatives/relatives and six were returned. Comments recorded evidenced that relatives were very satisfied with the care provided for their loved ones. The respondents were complimentary regarding the staff and the care delivered.

Additional comments recorded included:

'The standard of care given to my … in Belmont is excellent and very much appreciated.'

'This care home provides superb standards of care.'

'The home not only looks after my …, but also my family when they call…'

'We find the staff all very caring and provide a homey atmosphere. They take special care at birthdays, days out and other special event stimulating memories of past times…'.

'The staff are like extended family to us. I really don't know what I would do without them. PRICELESS'.

5.4.3 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms and bathrooms on each floor. The home was found to be warm, well decorated, fresh smelling and clean.

Areas for Improvement

There were no areas of improvement for the home in respect of the additional areas examined.

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

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Mrs Tory Lane	**Date Completed**	22/09/15
Registered Person	Dr Claire Royston	**Date Approved**	20.10.15
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	22/10/2015

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

Please complete in full and returned to Nursing.Team@rqia.org.uk from the authorised email address