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Unannounced Care Inspection

Of

Carnalea

05 May 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 05 May 2015 from 09.30 to 15.00.

This inspection was underpinned by one standard and one theme. **Standard 19 - Communicating Effectively; Theme 'End of Life Care' incorporating criteria from 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.

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 20 November 2014.

1.2 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Josette Fernandez acting manager and Rosaline Morrison, Four Seasons management team, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered Manager:** See box below
Person in Charge of the Home at the Time of Inspection: Josette Fernandez acting manager	**Date Manager Registered:** Josette Fernandez Application not yet received.
Categories of Care: NH-I, NH-PH(E), NH-PH, NH-TI NH-DE x 14 in Featherstone unit	**Number of Registered Places:** 73 effectively reduced to 60 due to room changes of double rooms to single rooms.
Number of Patients Accommodated on Day of Inspection: 52	**Weekly Tariff at Time of Inspection:** £593 - £770

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 standard 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 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 40 patients either individually or in small groups. Discussion was also undertaken with six care staff, two nursing staff and one patient's visitors/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.

5.0 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 20 November 2014. The completed QIP was returned and approved by the aligned 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 15 (2)(b) **Stated:** First time	The registered manager must ensure that patient's assessment of need is updated as required plus at least annually.	**Met**
	Action taken as confirmed during the inspection: The inspector examined three sets of patient's care records and can confirm that the assessment of need is updated as required and at least annually.	
Requirement 2 **Ref**: Regulation 16(1) **Stated:** First time	The registered manager must ensure that the care plan of the identified patient is updated to reflect their current need.	**Met**
	Action taken as confirmed during the inspection: The inspector can confirm that the identified care plan was up to date at the time of inspection.	
Requirement 3 **Ref**: Regulation 18(2)(j) **Stated:** First time	The registered person must ensure that the malodour identified is removed. The carpet in the identified bedroom must be deep cleaned or replaced with urgency.	**Met**
	Action taken as confirmed during the inspection: The inspector can confirm that the identified malodour was no longer present. There were no malodours evidenced throughout the home during the inspection period.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Policy guidance for staff was available on communicating effectively. However the guidance failed to reflect regional guidelines on Breaking Bad News. The acting manager was referred to the Care Standards for Nursing Homes April 2015 for details on how to access regional guidance. Discussion with a number of care staff confirmed that they would appreciate further training regarding this policy and procedure.

A sampling of communication training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives. This training however should be developed further to include the procedure for breaking bad news as relevant to staff roles and responsibilities.

Is Care Effective? (Quality of Management)

Three care records evidenced that patient individual needs and wishes in respect of aspects of daily living were appropriately recorded. There was however limited acknowledgements that end of life issues are considered with the exception of Do Not Attempt Resuscitation (DNAR) directives.

Recording within records did include reference to the patient's specific communication needs.

The acting manager did however agree that the barrier to communication in this area rests with staff and their concerns regarding the sensitivity of the issue. It was further agreed that training on breaking bad news and communication around end of life care would be very beneficial for all grades of staff.

A review of three care records evidenced that the breaking of bad news was not discussed with patients and/or their representatives other than in respect of a DNAR.

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 by sitting down by the patient, using a calm voice, speaking clearly yet reassuringly, holding hands, allowing privacy, allowing the patient to question, and trying to display as much empathy as possible. Care staff considered the breaking of bad news to be the responsibility of the registered nursing staff and failed to initially recognise that they would do this on a regular basis and that it does not necessarily mean infirming a patient that a loved one has died. Further training will allow for greater understanding and development of these skills

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and many staff interactions with patients the inspector can confirm that communication is well maintained and patients are 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 40 patients. In general the patients all stated that they were very happy with the quality of care delivered and with life in Carnalea. They confirmed that staff are polite and courteous and that they felt safe in the home. One patient's representative discussed care delivery with the inspector and also confirmed that they were very happy with standards maintained in the home.

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

Areas for Improvement

The registered persons must review and expand the communication policy and procedure to ensure that it references regional guidance on breaking bad news. Training in communication skills including breaking bad news for all staff will further enhance the quality of life in the home. Improvements in recording communication outcomes into care records must be made.

Number of Requirements:	**0**	**Number of Recommendations:**	**2**

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 are held together in the palliative care manual which was available in the home. These documents are currently under review by the company and do not as yet reflect best practice guidance such as the Gain Palliative Care Guidelines, November 2013. The manual however did include guidance on the management of the deceased person's belongings and personal effects. A copy of the Gain Palliative Care Guidelines, November 2013 was available in draft format in the home. The acting manager arranged during the inspection for a copy of the issued guidelines to be made available for staff consultation. Registered nursing staff were aware of the Gain Palliative Care Guidelines November 2013 however a copy of the issued guidelines should be made available for staff reference.

Training records evidenced that staff were trained in the management of death, dying and bereavement. There was also evidence of training provision to guide staff on bereavement from local funeral directors. This training should be made available to all grades of staff in the home.

Training records also evidenced that three registered nursing staff had completed training in respect of palliative/ end of life care within the past three years. It is recommended that further training be made available for all staff commensurate with their responsibilities.

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

Discussion with the acting manager, eight 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 staff are trained in the use of this specialised equipment.

Is Care Effective? (Quality of Management)

A review of three care records evidenced that patients' needs for palliative and end of life care were 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. There was a lack of evidence that the patient's cultural and religious preferences were considered. As discussed in section 5.3 above further training in communication especially in 'breaking bad news' will enhance the quality of verbal and written skills of the staff team.

Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. This mostly referred to the establishment of a DNAR directive and did not wholly consider other end of life situations.

Discussion with the acting manager, eight staff and a review of three care records evidenced that environmental factors had been considered. 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 with their loved ones during the final days of life. Meals, snacks and emotional support has been provided by the staff team.

The care records reviewed were current and up to date in accordance with patients' needs.

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 three staff and a review of three care records evidenced that patients and/or their representatives had been generally consulted in respect of their cultural and spiritual preferences. However this consultation did not consider any cultural or religious wishes in respect of end of life care.

Whilst a high number of patients in the home are considered palliative care there were no patients nearing the end of life at the time of inspection. However 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.

There was however a need identified for additional training in death and dying and palliative /end of life care to ensure that staff do not avoid discussion of this important area until it is too late for the patient and their family members.

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 the acting 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.

Discussion with the 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.

From discussion with the acting 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 acting manager and support through staff meetings.

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

Areas for Improvement

Whilst staff appeared knowledgeable regarding how the home manages the end of life care of patients there is a need identified by both staff and the inspector for further formal training. This should be made available for all grades of staff. Verbal communication between patients was observed to be very compassionate however care plan records failed to reflect these interactions and there was little evidence other than DNAR directives to record that end of life issues were discussed and patient's wishes recognised and adhered to. With appropriate training and support staff should be able to improve in these areas and the quality of support for patients and their families will be greatly enhanced.

Number of Requirements:	**0**	**Number of Recommendations:** *two recommendations made are stated under Standard 19 above	*****

5.5 Additional Areas Examined

5.5.1 Pain Assessment

Examination of one identified patient's care records raised concern in regards to the assessment of pain and effectiveness of analgesia prescribed. The matter was discussed at length with the acting manager and appropriate actions were taken during inspection to address the deficits. Two other patient care records were examined and evidenced that pain risk assessments were appropriately maintained.

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

The inspector was able as part of the inspection process to meet with 20 patients individually and to most others in small groups. Comments from patients regarding the quality of care, food and in general the life in the home were very positive. A few comments received are detailed below;

'I am very happy here there is usually something to do each day'
'The food here is good and I always have enough to eat'
'The staff are all very good, I feel safe and can always tell someone if something was wrong'

Questionnaires were issued to a number of nursing, care and ancillary staff and these were returned during the inspection visit. Some comments received from staff are detailed below;

'I feel that most of the staff care and have bonded with the residents. The rapport staff has with the resident's family is proof of good care / communication.'
'The care in the home is very good and I would feel able to have my own family here if required.'

No patient representatives or professional visitors were available in the home at the time of the inspection.

6.0 Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Josette Fernandez acting manager and Rosaline Morrison representing the regional manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person 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 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 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 36 **Stated:** First time **To be Completed by:** 05 August 2015	It is recommended that the following policy guidance is updated; • Communication policy should include reference to the regional guidance for breaking bad news • The palliative care manual which incorporates palliative and end of life care, death and dying should reference the GAIN Guidelines for Palliative Care and End of Life Care in Nursing Homes and Residential Care Homes November 2013 and the regional guidance on breaking bad news. • The palliative care manual should also be updated in respect of point 12 in the policy of death which records that records are maintained for 3 years. Regulation 19(2) (4) stipulates that records should be retained for not less than 6 years from the date of the last entry. **Ref section 5.3, 5.4 , 5.5**
	Response by Registered Person Detailing the Actions Taken: Pallative Care Manual is under review, a draft was received on 25.05.15 and is in place. The pallative care manual made reference to the 2013 GAIN Guidelines for Pallative and End of Life Care.
Recommendation 2 **Ref**: Standard 39 **Stated:** First time **To be Completed by:** 05 August 2015	It is recommended that the registered person ensures that all grades of staff receive training on the following; 1. Palliative /End of life care 2. Breaking bad news communication skills **Ref section 5.3, 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Training on Pallative care and breaking bad news communication skills are now scheduled by the Training department. The Training Manager had informed me on 27.05.15 that it will be rolled out in June.

Registered Manager Completing QIP	Josette Fernandez	**Date Completed**	29.05.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	16.06.15
RQIA Inspector Assessing Response	Linda Thomps	**Date Approved**	19/6/15

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