Cedarhurst Lodge
RQIA ID: 1070
Beech Suite
Cedarhurst Road
Belfast
BT8 4RH

Inspector: Heather Sleator
Inspection ID: IN021686

Tel: 028 9049 2722
Email: cedarhurst.lodge@fshc.co.uk

Unannounced Care Inspection
of
Cedarhurst Lodge

28 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 28 July 2015 from 09:30 to 16:30.

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 8 April 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	2

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Lavina Harris, registered manager 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 Health Care Dr Maureen Claire Royston	**Registered Manager:** Lavina Ann Harris
Person in Charge of the Home at the Time of Inspection: Lavina Ann Harris	**Date Manager Registered:** 13 June 2007
Categories of Care: NH-DE	**Number of Registered Places:** 45
Number of Patients Accommodated on Day of Inspection: 41	**Weekly Tariff at Time of Inspection:** £593 - £618 per week

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 since the previous care inspection
- the returned Quality Improvement Plans (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with 12 patients, six care staff, two nursing staff and four visiting relatives. There were no visiting professionals available during the inspection.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- the staff duty rota
- four patients' care records
- accident/notifiable events records
- 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 announced Estates inspection dated 2 October 2014. The completed QIP was returned and approved by the specialist 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 18 (2) (n) **Stated:** First time	The registered person shall having regard to the size of the nursing home and the number and needs of patients – (n) where activities are provided by or on behalf of the nursing home, including training, occupation and recreation, there are arrangements to ensure that – (i) activities are planned and provided with regard to the needs of patients; and (ii) patients are consulted about the planned programme of activities The registered manager must ensure a systematic and consistent approach to the planning and provision of activities is on-going in the home. Evidence must be present in the home of the activities provided and patients' response to activities. **Ref: Section 3.1 areas inspected, activities**	**Met**
	Action taken as confirmed during the inspection: Two activities coordinators are employed. A weekly programme of activities was available however staff stated the programme is flexible and may depend on patients' preferences on any given day. A record is maintained of the activities provided, who attended and patients' response to the activity.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 31.1 **Stated:** First time	It is recommended at all times the staff on duty meet the assessed nursing care, social and recreational needs of all patients, taking into account the size and layout of the home, the statement of purpose and fire safety arrangements. The registered manager shall ensure that staffing arrangements reflect the assessed dependency levels and needs of patients. **Ref: Section 3.1 areas inspected, staffing**	**Met**
	Action taken as confirmed during the inspection: The registered manager informed that staffing levels are determined by patients' needs. Staffing arrangements are also reviewed by the regional manager during the monthly monitoring visit (Regulation 29 monitoring visit) and detailed in the report. There were no issues in respect of staffing arrangements raised with the inspector at the time of the inspection.	
Recommendation 2 **Ref:** Standard 5.4 **Stated:** First time	It is recommended re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. The registered manager shall ensure that when completing any audit of the quality of services in the home, in this instance, falls analysis, the information gained is transferred to a patient's care plan. **Ref: Section 3.1 areas inspected, care issues**	**Met**
	Action taken as confirmed during the inspection: The review of four patients care records evidenced assessment of patient need is on-going and care records were updated as and when there was a change in a patient's wellbeing.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy/reference manual had been provided by the registered manager (hereafter referred to as the manager) for staff. The manual included the regional guidelines on Breaking Bad News. The manager stated the organisation had recently updated policy information on communicating effectively and palliative and end of life care. The manager had provided staff with the updated manual. Discussion with four staff confirmed that they were knowledgeable regarding this policy and procedure.

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

Is Care Effective? (Quality of Management)

Four care records reflected patients' individual needs and wishes regarding the end of life care. Records included reference to the patient's specific communication needs.

A review of care records evidenced that the breaking of bad news was discussed with patients and/or their representatives, options and treatment plans were also discussed, where appropriate. Evidence was present in care records of how staff had supported a patient's representative and made arrangements for the representative to meet with the palliative care nurse specialist for further support.

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

Care staff were consulted and discussed their ability to communicate sensitively with patients and/or representatives. When the need for breaking of bad news was raised care staff felt this was generally undertaken by nursing staff. However, staff were aware of communication aids/cues, for example, non-verbal cues and gestures. They also felt their role was to empathise and to support patients and their representatives following sensitive or distressing news.

Is Care Compassionate? (Quality of Care)

Discussion was undertaken with staff regarding how they communicate with patients and their representatives.

All staff presented as knowledgeable and had a strong awareness of the need for sensitivity when communicating with patients and their representatives.

A number of communication events were observed throughout the inspection visit which validated that staff embedded this knowledge into daily practice. These observations included staff assisting patients with meals, and speaking to patients with a cognitive or sensory impairment. There was a calm, peaceful atmosphere in the home throughout the inspection visit.

Staff recognised the need to develop a strong, supportive relationship with patients and their representatives from admission to the home. It was appreciated by staff that this relationship would allow the delivery of bad news more sensitively and with greater empathy when required.

The inspector consulted with four visiting relatives. Relatives confirmed that staff treated patients with respect and dignity and were always welcoming to visitors.

A number of letters complimenting the care afforded to patients were viewed. Families stated their appreciation and support of staff and the care afforded in Cedarhurst Care Home.

Comments included:
"You were all so kind, it means so much."
"Thank you for the kind, compassionate care provided by the staff of Cedarhurst."
"The care and kindness given to my …. was very much appreciated."

Areas for Improvement

Following the receipt of the new policy documentation in respect of on communicating effectively and palliative and end of life care, a system should be implemented to ensure and verify staff are knowledgeable of the policy documentation and regional guidelines.

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)

As previously stated the manager had compiled a reference manual with included the management of palliative and end of life care and death and dying. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects.

Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

A review of staff training records evidenced that training had been received in the following:

- palliative care awareness — 18 staff
- syringe driver — 2 registered nurses
- palliative care (e learning in 2014) — 33 staff
- palliative/end of life care (e learning in 2015) — 42 staff

Further face to face palliative care training has been arranged by the organisation, with dates available from 11 August 2015 to 22 September 2015.

There was no identified link nurse in respect of palliative and end of life care at the time of the inspection.

A review of the new competency and capability assessments for registered nurses evidenced end of life care was included and the assessments and had been validated by the manager. The review of staff induction training records also confirmed that end of life care was included.

Discussion with nursing staff and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the manager, six 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 nursing staff confirmed their knowledge of the protocol.

Specialist equipment, for example syringe driver was in use in the home at the time of inspection. The registered nurses responsible for the patient's care had completed training and were deemed competent in the management of a syringe driver.

Is Care Effective? (Quality of Management)

A review of care records evidenced that 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 and symptom management. There was evidence that the patient's wishes and their religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. However, in discussion with a patient's representative the family expressed some concern regarding the pain management of their relative. The family felt they had to 'prompt' staff regarding the administration of pan relief. This information was discussed with the manager who agreed to discuss the concern raised with nursing staff.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals had been made to the specialist palliative care team.

Discussion with the manager, staff and a review of care records evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying, patients bedrooms are single rooms' and patients representatives were enabled to stay for extended periods of time without disturbing other patients in the home. One family informed that staff had provided a single room which was vacant so as family members could rest, refreshments were also provided.

A review of notifications of death to RQIA during the previous inspection year, evidenced they were appropriately submitted.

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 spiritual preferences regarding care. Staff gave examples from the past, of how they supported the spiritual wishes of patients and of how staff stayed and gave emotional support to patients at the end of life. Staff stated they were able to sit with patients, if family members were not available so as no patient passed away with no one present.

From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives. 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.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. From discussion with the manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included for example, bereavement support and staff meetings.

Areas for Improvement

The home manager agreed to discuss with nursing staff the need to ensure pain management is timely and in accordance with the recommendations from the palliative care specialist and/or general practitioner.

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

5.5 Additional Areas Examined

5.5.1 Questionnaires

As part of the inspection process we issued questionnaires to staff. On this occasion questionnaires were not given to patients, rather we observed care practice and spoke to patients on an individual and/or small group.

Staff Views

All comments on the two returned staff questionnaires were positive. Staff confirmed patients were afforded privacy dignity and respect at all times.

Comments included:
"The home has policies in order to provide best quality of care to the patients as well as to relatives."
"Staff can count on the support given by the person in charge as well as the manager."

Patients' Views

Comments received from patients included:
"Staff are good to me."
"I am happy enough."
"Staff are good."

Patients' Representatives' Views

There were four relatives visiting at the time of the inspection. All comments made were very positive regarding care and communication in the home. As previously stated one family raised some concerns regarding pain management however representatives were positive regarding the staff in the home.

Comments received included:
"There have been a few things but we tell staff and they do what we ask."
"Generally happy with Cedarhurst."
"I am happy with the care afforded to my …."

5.5.2 The Environment

There was a good standard of cleanliness and hygiene standards evident during the inspection. The home was spacious and communal areas were comfortable. Infection control procedures were also generally maintained to a good standard.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Lavina Harris 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.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref:** Standard 32.1 **Stated:** First time **To be Completed by:** 30 September 2015	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the orgainsation, in respect of communicating effectively and palliative and end of life care. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: All staff have signed that they have read the new policies and procedures in relation to communicating effectively and palliative and end of end of life care.
Recommendation 2 **Ref:** Standard 32.6 **Stated:** First time **To be Completed by:** 31 August 2015	Pain management should be discussed with nursing staff. Nursing staff should be informed and made aware of their responsibility regarding anticipatory prescribing to ensure that medication is available in a timely manner. **Ref: Section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Pain management has been dicussed with nursing staff during a supervision session.Nursing staff have been informed and been made aware of their responsibility regarding anticipatory prescribing to ensure that medication is available in a timely manner.

Registered Manager Completing QIP	Lavina Harris	**Date Completed**	23.10.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	23.10.15
RQIA Inspector Assessing Response	Heather Sleator	**Date Approved**	27/10/2015

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