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Unannounced Care Inspection
of
Clandeboye

8 March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 08 March 2016 from 10.00 to 16.00 hours.

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

The purpose of this inspection was to seek assurances that the care and welfare of patients was in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes, April 2015.

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

There were no further actions required to be taken following the last care inspection on 4 November 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 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 Healthcare Maureen Claire Royston	**Registered Manager:** Joanne Roy
Person in Charge of the Home at the Time of Inspection: Joanne Roy	**Date Manager Registered:** 9 December 2010
Categories of Care: NH-DE The home is approved to provide care on a day basis to 1 person	**Number of Registered Places:** 52
Number of Patients Accommodated on Day of Inspection: 49	**Weekly Tariff at Time of Inspection:** £593

3. Inspection Focus

The inspection sought 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 analysed:

- 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 (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with five patients, five care staff, three nursing staff and four patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

No requirements or recommendations were made at the last care inspection.

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The policy and procedure on communicating effectively was not available for inspection. However the regional guidelines on Breaking Bad News were available and discussion with staff confirmed that they were knowledgeable regarding the procedure. Following the inspection the registered manager submitted a copy of the policy by email, to RQIA.

The policy stated that "training in communication skills and the breaking of bad news must be provided to relevant members of staff". The registered manager confirmed that three registered nurses and two care staff had completed a six week course in palliative and end of life care, provided by the local Health and Social Care Trust. An E-learning module on palliative and end of life care was also available and this had been completed by eight registered nurses and 13 care staff. This training included the procedure for breaking bad news as relevant to staff roles and responsibilities. Four registered nurses had also received face to face training in this area. Plans were in place for all remaining staff to complete the E-learning courses. Discussion with the registered nurses and care staff confirmed that they were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication.

Is Care Effective? (Quality of Management)

Two registered nurses consulted demonstrated their ability to communicate sensitively with patients and relatives when breaking bad news and provided examples of how they had done this in the past. They also explained that there were events which would trigger sensitive conversations with patients and/or their families, for example, an increase in the number of admissions to hospital, and/or reoccurring symptoms with a poor prognosis. They emphasised the importance of building caring relationships with patients and their representatives and the importance of regular, ongoing communication regarding the patient's condition. One registered nurse stated that the registered manager was a good role model in the way she dealt with relatives who had received distressing news and identified the manager as someone they could learn from.

Care staff considered the breaking of bad news to be primarily, the responsibility of the registered nursing staff, but felt confident that, should a patient choose to talk to them about a diagnosis or prognosis of illness, they would have the necessary skills to do so. 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 with five patients individually and with the majority of patients generally, evidenced that patients were content living in the home. Observations of the delivery of care and staff interactions with patients confirmed that communication was well maintained and patients were observed to be treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time.

Staff recognised the need to develop a strong, supportive relationship with patients and relatives. It was appreciated by staff that this relationship would allow the delivery of bad news more sensitively and with greater empathy when required. One patient's representative also confirmed that they were kept informed of any changes to their relative's condition and of the outcome of visits and reviews by healthcare professionals.

Areas for Improvement

There were no areas identified for improvement.

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

5.3 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 not available in the home. Following the inspection the registered manager submitted a copy of the policy by email, to RQIA. 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.

There was no formal protocol for timely access to any specialist equipment or drugs in place. However, discussion with two registered nurses confirmed their knowledge of local arrangements for accessing palliative care teams, district nursing teams, GP out-of-hours or pharmacists, if required.

As previously discussed in section 5.2, the registered manager confirmed that three registered nurses and two care staff had completed a six week course in palliative and end of life care, provided by the local health and Social Care Trust. An E-learning module on palliative and end of life care was also available and this had been completed by eight registered nurses and 13 care staff. Four nurses had also received face to face training in this area. Plans were in place for all remaining staff to complete the E-learning courses.

Discussion with two 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
- staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken

There was no specialist equipment in use in the home on the day of inspection. However, the registered manager confirmed that five registered nurses had been trained in the use of syringe pumps.

The registered manager confirmed that there were six palliative care champions in the home. One registered nurse stated that she had been the palliative care link nurse in a previous home and was enthusiastic about continuing her involvement in this area, in Clandeboye.

Is Care Effective? (Quality of Management)

A key worker/named nurse was identified for each patient approaching end of life care. A review of two care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. There was also evidence that the patients' wishes and their social, cultural and religious preferences had been considered. Staff consulted identified the management of hydration and nutrition, pain management and symptom management as priorities for care during this period. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

Discussion with the manager and staff 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.

A review of notifications of death to RQIA during the previous inspection year identified that all deaths were appropriately notified.

Is Care Compassionate? (Quality of Care)

Discussion with the 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. All staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

From discussion with the manager and staff there was evidence that arrangements in the home were sufficient to support relatives when their loved one was receiving end of life care. 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. Staff consulted described how catering/snack arrangements would be provided to the patient's relatives. Overnight stays would be facilitated if there was a vacant bedroom.

Discussion with the manager and staff confirmed 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 manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included more experienced staff members providing support to those who were new to the role and time spent reflecting on a patient's time spent living in the home.

Information regarding support services was available and accessible for staff, patients and their relatives. This included information leaflets on palliative and end of life care.

Areas for Improvement

There were no areas identified for improvement.

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

5.4 Additional Areas Examined

Care Records

A sampling of repositioning records evidenced that patients were repositioned according to their care plans. There was also evidence that patients' total fluid intake had been monitored by the registered nurses and this had been audited on a daily basis by the registered manager. This is good practice and is commended.

Five patient care records were reviewed. Two records were maintained to a high standard. For example, all relevant risk assessments were completed and the care plans were person-centred and completed in great detail.

However, deficits were identified in three other care records which pertained to patients who had been recently admitted to the home. For example, pain assessments and nutritional risk assessments were not consistently completed; moving and handling assessments did not reflect the patient's current level of mobility; and care plans for the patients' potential for falling were not in place despite the falls risk assessment identifying a high level of risk. Care plans for the patients' risk of developing pressure damage were not developed, despite the relevant risk assessment identifying that the patient was at high risk of developing pressure damage. There was also no care plan in place for a patient who had a wound. Following the inspection, the registered manager confirmed to RQIA by email that all the assessments and care plans were in place.

Given that two care records were identified as having been completed to a high standard, the inspector was also made aware of mitigating circumstances that may have contributed to the deficits identified in the records of the new admissions. The registered manager had audited one of the identified patient care records and was aware of the deficits. The process of auditing care records was discussed with the registered manager, who stated that the records of newly admitted patients were audited during the regulation 29 monthly monitoring visits. The registered manager provided assurances that care records of patients newly admitted to the home would be monitored by herself in the future. However, there must be a robust system in place, to monitor the development of patients' assessments and care plans, following admission to the home. A recommendation has been made in this regard.

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	10	9
Patients	5	5
Patients representatives	10	5

All comments on the returned questionnaires were positive. Some comments received are detailed below:

Staff

'This place focuses on the resident, which is the most important thing.'
'It is very good here. I love it here.'
'The care is very good. I learn a lot from the manager.'
'We respect patients' dignity at all times.'
'I love it here. All the patients are treated equally.'
'I love it here. I wouldn't be here otherwise.'
'It is very important for us to make our residents feel comfortable and at home.'
'We ensure the (patients' have a good quality of life and high level of well-being, respecting their wishes.'

Two staff members consulted with stated that some patients were left in pain because there was a delay in receiving the prescribed medicine from the contracted pharmacy. Discussion with two registered nurses confirmed that anticipatory prescribing was considered to manage patients' pain. Both nurses were able to describe the arrangements for accessing medications out of hours. There were also no complaints identified regarding the administration of medicines. The staff comments were discussed with the registered manager who agreed to address communication between all grades of staff.

Patients

'They look after me well.'
'Safe as houses. (The staff) are all angels.'
'It's fine here.'
'I am cared for well here.'

One patient informed the inspector that they had made a complaint to the person in charge regarding a staff member. However, discussion with the registered manager confirmed that this had not been reported in accordance with the home's policies and procedures. The registered manager recorded this matter on the day of inspection and informed the patient's care manager. This matter is currently being investigated by the local Health and Social Care Trust. A recommendation has been made in this regard.

Patients' Representatives

'I have great peace of mind having (my relative) cared for here.'
'We are very pleased with the care.'
'Everything is fine here.'
'It's alright here.'
'Everything is grand. We have no concerns.'
'The care is very good.'
'The care and attention from all staff shown towards my (relative) and myself is exceptional.'
'We find the staff and the care of our (relative) to be of a very high standard and have no issues.'
'All the staff address the residents by name and show enormous amount of compassion.'

Environment

A general tour of the home was undertaken which included review of a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout.

One identified patient's specialist chair was torn and in need of replacement. Discussion with the registered manager confirmed that a requisition order had been submitted previously, therefore it was disappointing that this had not been actioned. Following the inspection, the registered manager confirmed that an audit of all the seating in the home had been completed and that the identified chair had been repaired/replaced.

Areas for Improvement

There should be a robust system in place to monitor the development of patients' risk assessments and care plans, to ensure that these are completed within 5 days of admission to the home. The system should also be shared with the registered nurses who have responsibility of being in charge of the home.

Staff should be provided with training on dealing with complaints to ensure that they understand that a complaint is any expression of dissatisfaction with the service provided in the home and that they know how to initially deal with complaints. A record of the training provided, in whatever format, should be retained in the home.

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

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager 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.

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 in this report do not absolve the registered provider/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 provider/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 4.1 **Stated:** First time **To be Completed by:** 05 May 2016	There should be a robust system in place to monitor the development of patients' risk assessments and care plans, to ensure that these are completed within 5 days of admission to the home. **The system should also be shared with the registered nurses who have responsibility of being in charge of the home.**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager continues to audit the care file following admission of a resident to the home, in the her absence the Deputy Manager will undertake this audit. A date for review will be diarised for the Nurse In Charge to ensure all risk assessments and care plans are completed within 5 days of admission to the home.
Recommendation 2 **Ref**: Standard 16.6 **Stated:** First time **To be Completed by:** 05 May 2016	Staff should be provided with training on dealing with complaints to ensure that they understand that a complaint is any expression of dissatisfaction with the service provided in the home and that they know how to initially deal with complaints. **A record of the training provided, in whatever format, should be retained in the home.**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager will ensure that all staff have received training on dealing with complaints in the home. Training has been scheduled for 10th May 2016 and will be based on the FSHC Management of Feedback Policy (Complaints, Concerns and Compliments).

Registered Manager Completing QIP	Joanne Roy	**Date Completed**	29.4.16
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	29.04.16
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	04/05/2016

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address