Dunlady House
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Dundonald
Belfast
BT16 1TT

Inspector: Linda Thompson
Inspection ID: IN021778

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Unannounced Care Inspection
of
Dunlady House

1 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 1 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.**

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 17 June 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	1	5

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Mr Neill Wilson registered person and Ms Lily O'Neill 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: Dunlady House Ltd/ William Hugh Wilson	**Registered Manager:** Lily O'Neill
Person in Charge of the Home at the Time of Inspection: Femy Marmeto deputy manager. The registered manager joined the inspection shortly after commencement.	**Date Manager Registered:** Before 1 April 2005
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 68
Number of Patients Accommodated on Day of Inspection: 66	**Weekly Tariff at Time of Inspection:** £593 - £618

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
- 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 30 patients either individually or in small groups. Discussion was also undertaken with six care staff, four nursing staff, two ancillary 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
- seven 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 Dunlady House was an announced finance inspection dated 24 November 2014. The completed QIP was returned and approved by the finance 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 29 (1) (2) & (3) **Stated:** Third time	It is required that a report is prepared by the registered person in respect of the monthly unannounced monitoring visits in accordance Regulation 29. **A copy of the monthly Regulation 29 report should be forwarded to the aligned inspector Linda Thompson, by the 10th of each subsequent month. This should continue until further notice.**	**Met**
	Action taken as confirmed during the inspection: Regulation 29 reports were forwarded for review by the inspector as required. The quality and comprehensiveness of the reports was evidenced to be significantly improved. The home is no longer required to submit the reports on a monthly basis. The reports must however be available for inspection at any time.	
Requirement 2 **Ref**: Regulation 15 (2) **Stated:** First time	The registered person shall ensure that the assessment of the patient's needs is (a) kept under review; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. • pain assessments must be utilised for any patient prescribed regular or occasional analgesia	**Partially Met**
	Action taken as confirmed during the inspection: A detailed review of a number of nursing care records was undertaken. From this review it was identified that pain assessments were not always maintained for patients who required regular or occasional analgesia. This requirement is discussed further in the main body of the report and is stated for a second time as a consequence of this inspection.	

<table>
<tr><th colspan="2">Last Care Inspection Statutory Requirements</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Requirement 3

Ref: Regulation 16 (2) (b)

Stated: First time</td><td>The registered person shall ensure that –

(b) The patient's plan is kept under review.

• the effectiveness of analgesia should be regularly evaluated and recorded
• wound assessment should include an evidence based classification system</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Following review of seven nursing care records it was confirmed that the effectiveness of analgesia is regularly evaluated and recorded in the patient’s daily progress notes. However a validated pain assessment tool was not always used.

It was also confirmed that wound assessments are now maintained appropriately using evidence based classification system.</td></tr>
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Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 25.12 **Stated:** Second time	It is recommended that Regulation 29 reports are further developed to also provide evidence that the registered person had: • evidenced that deficits were identified and an action plan developed to address the deficits • evidenced that previous action plans issued had been reviewed to ensure deficits previously identified were addressed or improved • evidenced that where deficits had not been addressed, in a timely manner, appropriate follow up action had been taken.	**Met**
	Action taken as confirmed during the inspection: Having examined the regular reports submitted to RQIA since the last care inspection and having examined the last two reports from April and May 2015 it is confirmed that these are now appropriately maintained in keeping with Regulation.	
Recommendation 2 **Ref**: Standard 25.6 **Stated:** Second time	The registered person should ensure that patients and their representatives are made aware of the availability of the Regulation 29 monthly monitoring report.	**Met**
	Action taken as confirmed during the inspection: Evidence was available to confirm that there is clear signposting for patients and their representatives of the availability of the Regulation 29 monthly monitoring report.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 3 **Ref**: Standard 26.1 **Stated:** First time	The 'Admission Policy' should be further developed to include the following; • The manager ensures that risk assessment and care records providing all necessary information are provided from the referring Health and Social Care Trust prior to admission, documents for the referring Trust should be dated and signed when received. • The arrangements to respond to any unplanned admission • The arrangements to respond to self-referred patients.	**Met**
	Action taken as confirmed during the inspection: It was confirmed that the admission policy has been updated accordingly.	
Recommendation 4 **Ref**: Standard 3.4 **Stated:** First time	Any documents from the referring Trust should be dated and signed when received.	**Met**
	Action taken as confirmed during the inspection: It was confirmed by review of nursing care records that documents from the referring Trust are signed and dated when received by the home.	
Recommendation 5 **Ref**: Standard 6.2 **Stated:** First time	All entries in patient's records should be dated and signed.	**Met**
	Action taken as confirmed during the inspection: It was confirmed that all entries in patient's care records are dated and signed as required.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Policy guidance for staff in respect of communication failed to refer to regional guidelines on 'breaking bad news. This was discussed at length with the registered manager and it was agreed that the policy would be reviewed and updated as required. Regional guidance on the breaking of bad news was available in the home.

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)

Seven nursing care records evidenced that patients 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.

Four 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. Training on delivering bad news was included in palliative care / end of life care training delivered in the home.

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 30 patients, many individually and with 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 Dunlady House. 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

The registered persons must review and expand the communication policy and procedure to ensure that it references regional guidance on breaking bad news.

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 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 reviewed. The registered manager should ensure that the policy documentation is drafted in line with GAIN Guidelines on Palliative Care November 2013. The policy should also reference regional guidance on breaking bad news. The registered manager and four 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 registered nursing and care staff had received recent training on palliative care and death and dying. A further training event is scheduled for August 2015. There was also evidence of a professional relationship between the home and the palliative care nurse from the Belfast Health and Social Care Trust (BHSCT). This input from the palliative care nurse is commended.

Discussion with four 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, four registered nursing staff, seven care staff and a review of seven patient 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 four 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 seven patients who were considered as requiring palliative care was undertaken. All three care records evidenced that patients' needs for palliative or end of life care were reviewed on an ongoing basis and documented in patient care plans. This included the management of hydration, nutrition, pain management and symptom control.

However not all patient care records were well maintained. Deficits were identified in the following areas;

- The assessment of need in respect of daily living activities was not always updated as required despite a change in the patient's health
- care plans were not always updated to reflect the patient need. This was especially noted following review and changes prescribed by the multiprofessional team
- pain assessments were not evidenced to be consistently used for those requiring regular or occasional analgesia (this issue was raised as a requirement at the previous inspection of June 2014 and is stated for a second time as a consequence of this inspection findings)
- monthly vital signs observations were not maintained monthly as per the home's policy
- risk assessments for nutrition and falls were not updated monthly as per the home's policy

It proved challenging to audit the nursing care records as each patient's records were located in four separate folders e.g. the care plans in one folder, the daily progress/pain records/communication records in another, the palliative register containing end of life directions / Do Not Resuscitate Directives in another folder and bowel records in a final folder. This lack of centralisation in the inspector's professional opinion increased the risk of errors or gaps in recording such as have been identified by this inspection.

Concern was raised in respect of the deficits in quality assurance of patient care records. The registered manager must review the current governance of nursing care records and ensure that an effective quality assurance process is established with all due haste.

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;

'Thank you so much for looking after our uncle. You were all brilliant to him.'

'We would like as a family to thank you all for the care and kindness shown to dad during his stay in Dunlady. Everyone was very kind and supportive to him and to the wider family circle.'

'I would like to take this opportunity to thank the entire team in Dunlady House for their care and devotion to mum in the last few months of her life. I am certain we would not have had her with us so long were it not for the care that she was shown in the home. I cannot thank you enough. '

'Your professionalism, care and devotion was amazing. Thank you so much'

'We as a family would like to thank you so much for the care you gave to mum'

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

Whilst the actual delivery of end of life care was considered to be good the registered manager must ensure that the nursing care records are appropriately maintained to validate the delivery of high quality care.

Number of Requirements:	**0**	**Number of Recommendations: *one recommendation was raised previously under section 5.3.**	**3***

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 Dunlady House. Questionnaires were also given out for completion to aid data collection.

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

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 the place was "fantastic".
One relative stated that she was very happy with the home and always felt very welcomed when visiting.

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'.

5.5.2 Staffing skill mix

Given the deficits identified in nursing care records we reviewed the staffing levels provided in the home to seek an assurance that there were sufficient registered nursing staff deployed to effectively maintain the nursing care records required.

Analysis of the staff duty rota confirmed that there were sufficient numbers of staff (registered nurses and care assistants) available however the ratio of registered nurses to care staff fell significantly below that recommended in the Care Standards for Nursing Homes April 2015. It is recommended that a minimum skill mix of at least 35% registered nurses and up to 65% care assistants should be maintained over 24 hours.

It is anticipated that a review of the staff skill mix and appropriate increase in the number of registered nurses deployed will allow for an improvement in the quality of records maintained and for increased supervision of care delivery.

A recommendation is stated.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr Neill Wilson, registered person and Ms Lily O'Neill, 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 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	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 15 (2) **Stated:** Second time **To be Completed by:** **1 July 2015 and on going**	The registered person shall ensure that the assessment of the patient's needs is (a) kept under review; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. • pain assessments must be utilised for any patient prescribed regular or occasional analgesia **Ref section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Discussed with all RGN. All Pain Assessments reviewed and updated where necessary. Appropriate tools in place and review and update of Care Pan Audit tool and Peer Audit to commence.
Recommendations	
Recommendation 1 **Ref**: Standard 36 **Stated:** First time **To be Completed by:** **30 September 2015**	It is recommended that the registered manager review and update the following policies; • the communication policy should reference the regional guidance on 'breaking bad news' • the palliative care / end of life care policy should be expanded to include reference to the GAIN Palliative Care Guidelines November 2013, regional guidance on breaking of bad news and the use of a palliative care link nurse. **Ref section 5.3, 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Updated and referenced made to the Regional gusidance on 'breaking bad news'. Palliative care/end of life care policy expanded to include reference to GAIN Palliative CAre Guidelines Nov 2013.

Recommendation 2 **Ref:** Standard 21 **Stated:** First time **To be Completed by:** **1 August 2015**	It is recommended that the registered manager ensures that; • care plans are updated appropriately following directions from the multiprofessional team • risk assessments should be updated monthly in line with the home's policy • the assessment of daily living should be updated as the patient's health changes and at least annually • patient's vital signs observations should be maintained monthly in line with the home's policy. **Ref section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Reviewed and updated care plans, risk assessments where necessary All documents including activities of living, directions from multidisciplinary team to be cross reference with other documents. All observations updated monthly, bowels and fluids now recorded in daily nursing notes. All Primary nurses aware to ensure 100% compliance.
Recommendation 3 **Ref**: Standard 37 **Stated:** First time **To be Completed by:** **1 August 2015**	It is recommended that the registered manager ensures that; The patients nursing care records are maintained centrally in an accessible format which enables easy retrieval of information. **Ref section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: All documents now kept in Residents individual files which include Rsidents profile, risk assessments, pain assessments, records pertaining to palliative care/end of life, DNACPR,Nursing and Medical Care plans, wound assessments, Residents-Relative communication, etc.
Recommendation 4 **Ref**: Standard 35 **Stated:** First time **To be Completed by:** **1 September 2015**	It is recommended that the registered manager ensures that; An effective file audit is developed and maintained in respect of the patient's nursing care records. **Ref section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: File Audits expanded and updated. Primary nurses to undertake peer reviews to enhance audit system.

Recommendation 5 **Ref**: Standard 41 **Stated:** First time **To be Completed by:** **1 August 2015**	It is recommended that the registered manager ensures that; A minimum skill mix of at least 35% registered nurses and up to 65% care assistants is maintained over 24 hours. **Ref section 5.5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Dunlady House currently employs extra care staff above the industry norm which provides a high level of care by which we recognise affects the appearance of the skill mix. Given the issues raised however management will undertake a review of staffing levels.

Registered Manager Completing QIP	Lillian Jane O'Neill	**Date Completed**	24/7/15
Registered Person Approving QIP	William Neil Wilson	**Date Approved**	24/7/15
RQIA Inspector Assessing Response	Heather Sleator	**Date Approved**	29/07/15

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