Bannview House Care Home
RQIA ID: 11103
23 Bannview Road
Banbridge
BT32 3RL

Inspector: Donna Rogan
Inspection ID: IN022021

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Unannounced Care Inspection of Bannview House Care Home

06 May 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 06 May 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. There were no requirements or recommendations made as a result of this inspection.

For the purposes of this report the term 'patients' will be used to described those living in Bannview Care Home which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Inspection

There were no further actions required to be taken following the last care inspection on 20 November 2014.

1.2 Actions/Enforcement Resulting from this Inspection

Urgent actions or enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

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

2. Service Details

Registered Organisation/Registered Person: Bannview House Care Home Mrs Caroline Denny	Registered Manager: Roberta Wilson, (registration pending)
Person in Charge of the Home at the Time of Inspection: Roberta Wilson Manager, (registration pending)	**Date Manager Registered:** 06 April 2015
Categories of Care: NH-PH, NH-I, RC-I, NH-DE	**Number of Registered Places:** 80
Number of Patients Accommodated on Day of Inspection: Total 77 Nursing 17 Dementia 40 Residential 20	**Weekly Tariff at Time of Inspection:** Nursing £593 & £25 top up Dementia Nursing £593 & £25 top up Residential £593 & £25 top up

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 have been met:

Standard 19: Communicating Effectively
Standard 20: Death and Dying
Standard 32: Palliative and End of Life Care

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; and
- 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 35 patients both individually and in small groups. Discussion was also undertaken with 12 care staff, four nursing staff and three patient's representatives.

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP;
- the staff duty rota;
- four 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 manager; and
- policies for communication, death and dying, and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from 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 inspector. The findings of this inspection are outlined in section 5.2, 5.3, 5.4 and 5.5.

5.2 Review of Requirements and Recommendations from the last care inspection

Previous Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref: Regulation 29 (4)**	Ensure the Regulation 29 reports are anonymised to maintain patients/residents' and staffs' confidentially.	**Met**
	Action taken as confirmed during the inspection: Reviews of the most recent Regulation 29 reports were observed to be anonymised. Confidentiality was being maintained.	
Requirement 2 **Ref: Regulation 32 (h)**	Ensure that notice is provided in writing of any changes or alterations, extensions or changes in categories of care are proposed to the RQIA prior to the changes being made.	**Met**
	Action taken as confirmed during the inspection: RQIA confirms that since the previous inspection that all changes/alterations were forwarded to RQIA. Following discussion with the manager the inspector was assured that she was aware of her duty to process an application to RQIA regarding any proposed changes/alterations prior to the works commencing.	
Requirement 3 **Ref: Regulation 18 (2) (n)**	Ensure activities are planned and provided on a Monday and Tuesday in keeping with the needs and choices of patients/residents.	**Met**
	Action taken as confirmed during the inspection: Following discussion with staff and patients and a review of the activity programme it was evident that activities have been organised on a Monday and Tuesday on a weekly basis. The planned activity programme evidenced that hairdressing and implementation of the creative minds programme were organised on both days.	

Requirement 4 Ref: Regulation 27	Ensure the following issues are addressed in relation to the environment. Ensure an application regarding the change of use of the treatment room on the ground floor is forwarded to RQIA without delay. Ensure the foul odour is eradicated in the identified bathroom. Ensure the temperature in the residential unit dining room is maintained comfortable and warm. Ensure the items stored in the staff shower room is removed, this shower room is required to be thoroughly cleaned. Ensure that the identified toilet is regularly flushed and the water in the identified sink is also run regularly in the interests of legionella management. Records should be maintained. The use of signage and use of memory boxes should be reviewed in the dementia units.	**Met**
	Action taken as confirmed during the inspection: RQIA can confirm that they have received an approved the application of the change of use of the treatment room on the ground floor. There were no foul odours detected during the inspection. The temperature in the residential unit was maintained comfortable and warm. Records were being maintained of the checks made. There was no inappropriate storage observed in the staff shower room. It was observed to be clean. The identified toilet and sink are regularly flushed in the interests of legionella. Records are maintained of the checks completed. The use of the memory boxes are currently being reviewed in the dementia units.	

Requirement 5 **Ref: Regulation 12 (1) (b)**	Ensure the microwaves in the serveries are thoroughly cleaned following their use. Menus should be appropriately displayed in a suitable format to meet the needs of patients/residents.	**Met**
	Action taken as confirmed during the inspection: The microwaves in the serveries were observed to be clean. Pictorial menus were displayed in each of the dining areas.	
Requirement 6 **Ref: Regulation 13 (7)**	Ensure the following issues are addressed regarding the management and control of infection. Ensure all creams and lotions are appropriately labelled. Ensure toiletries are individualised and only used by the person who own them. Ensure the management of patients' oral hygiene is reviewed and that toothbrushes and tooth mugs are appropriately cleaned and stored after use.	**Met**
	Action taken as confirmed during the inspection: All creams and lotions were observed to be appropriately labelled and were appropriately stored. The inspector observed all toothbrushes and tooth mugs to be cleaned and appropriately stored after use. Care records evidenced that oral hygiene was implemented where needed.	

<table>
<tr><td rowspan="2">Requirement 7

Ref: Regulation 12 (1) (b)</td><td>The registered manager shall ensure the following issues are addressed regarding care records as follows;

Ensure fluid balance charts are competed in sufficient detail. This should include the intake and output amount.

Ensure that the consistency of fluids to be given is included on the fluid balance charts.

Ensure details of mouth care delivered are sufficiently recorded.

Ensure the exact time that fluids are given/offered is recorded.

Ensure patients' weights are appropriately carried out in keeping with their needs and records are maintained.

Ensure that when patients/residents needs change that the care plan is updated in a clear and concise manner.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

A review of the fluid balance charts were observed to be to be completed in sufficient detail and included the input and output amount.

The consistency of fluids, the exact time fluids are given and the details of mouth care delivered were included in the care records.

Details of patients' weights were recorded in keeping with their needs in their care records.

Of the four care plans reviewed, all were observed to be updated in a clear and concise manner.</td></tr>
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5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on breaking bad news. Discussion with four registered nursing 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.

A palliative link nurse has been appointed in the home and has received formal training from the local Healthcare Trust. It is planned that this training will be cascaded to all registered nursing staff in the home. Four registered nurses spoken with were knowledgeable about the important aspects to consider when communicating sensitively with their patients. The importance of good effective communication was included in all staff inductions to the home. It is also included in the competency and capability assessments of all registered nurses taking charge of the home in the manager's absence.

A review of one care record examined evidenced that consultation patients were conducted in regards to consultation with relatives or their representatives.

Is Care Effective? (Quality of Management)

The care records examined evidenced that, patients' individual needs and wishes regarding end of life care had been discussed with their General Practitioner (G.P). The care plans included reference to the patient's specific communication needs, including sensory impairment and cognitive ability.

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. The records evidenced that with patients and/or their representative's consent, information had been shared with the relevant health care professionals.

Four nursing staff consulted with demonstrated their ability to communicate sensitively with patients and/or representatives when breaking bad news by emphasising the need for privacy, have sufficient time and emphasised the importance of good relationships with their patients. Two registered nursing staff consulted demonstrated their ability to communicate sensitively with patients and described to the inspector that when they are breaking bad news that they would sit down by the patient, use a calm voice, speak clearly yet reassuringly, would hold their hands, allow privacy, allow the patient to ask questions, and try to display as much empathy as possible.

There was evidence within two of 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.

There was evidence in the training records that staff had received grief management training.

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 sensitive way.

The inspection process allowed for consultation with 35 patients. In general patients all stated that they were very happy with the quality of care delivered and with life in Bannview Care Home. They confirmed that staff are polite and courteous and that they felt safe in the home. Three patient's representatives discussed care delivery with the inspector and also confirmed that they were very happy with standards maintained in the home and the level of communication with all grades of staff.

A number of compliment cards were reviewed from past family members. All detailed a positive response in relation to their experiences of how staff communicated in a compassionate and thoughtful way throughout the end of life or palliative care process.

Discussion with ancillary staff such as those in the laundry, domestic and kitchen staff stated that nursing staff communicated regularly with them where needed regarding patients' needs. All stated that they were kept informed where required if patients' conditions were deteriorating. All staff spoken with felt that communication was exceptional regarding the theme of this inspection.

Areas for Improvement

There were no requirements or recommendations made regarding this theme.

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

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and 32)

Is Care Safe? (Quality of Life)

House Manager Sharon Clegg has been identified as the link nurse in palliative care. Ms Clegg has had recent up to date training in palliative care link nurse training provided by the local Healthcare Trust. Guidance documents on the management of palliative and end of life care and death and dying are held together in the palliative care manual. These documents are currently under review and it is intended to ensure that the homes policies and procedures are updated to reflect best practice guidance such as the Gain Palliative Care Guidelines, November 2013. The manual included guidance on the management of deceased person's belongings and personal effects. The registered manager and two registered nursing staff were aware of the Gain Palliative Care Guidelines November 2013 and a copy of the Guidelines, were available in the home and all registered nursing staff spoken with were aware of the guidelines and where they were retained in the home.

The palliative link nurse, Sharon Clegg was able to present her own training file on end of life/palliative care. The training in end of life care undertaken by Ms Clegg is commended. The inspector evidenced that registered nursing staff were trained in palliative care model and treatment of pain in nursing home patients and grief awareness training.

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 registered 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 all registered nursing staff are trained in the use of this specialised equipment.

Is Care Effective?

There were no patients considered as being at end of life in the home during the inspection, however a number of patients were recognised as requiring palliative care. A review of three care records evidenced that patients' needs for palliative 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. The inspector reviewed the care records of one recently deceased patient who had received end of life care in the home. The care record was commendable and evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. The record included in detail families wishes and involvement and there was obvious consultation with the patient regarding their wishes and feelings. The record was maintained in a sensitive manner and provided clear information regarding consultations with allied professionals, disciplinary team, relatives and clergy. The care plan had been updated as the patient's needs and wishes changed.

Discussion with the registered manager, three registered nurses, four care staff and a review of care records evidenced that environmental factors had been considered when a patient was at the end of life. 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 had been provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that all had been appropriately reported.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of three 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 Do Not Attempt Resuscitation (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 the 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.

No concerns were raised by relatives 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 1:1 support from the manager and support through staff meetings.

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

Areas for Improvement

There were no requirements or recommendations made regarding this theme.

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

5.5 Additional Areas Examined

5.5.1 Comments by staff, patients and patient representatives

As part of the inspection process patients, their representatives and staff were consulted and questionnaires issued. All comments were positive. Some comments received are detailed below:

Staff

Staff spoken with were positive regarding services the home and the management. They raised no concerns in discussion. Eight staff members completed questionnaires and all were satisfied with the training and services provided in the home in relation to end of life and palliative care. The following comments were made;

"Dignity and respect are at the heart of our practice and is reflected in our care plans and our daily practice."
"Overall I am very satisfied with the care. Management procedures are put in place when palliative care is required."
"Families are encouraged to visit regularly throughout end stages of care, there are no visiting restrictions in place at this time."
"We are well supported by the palliative care team in the local Healthcare Trust."

Patients

Six patients were able to complete the questionnaires. The following comments were detailed in the questionnaires returned and discussions with patients;

"Very satisfied that I am treated with dignity and respect."
"I am able to make choices on a day to day basis."
"Staff have helped me to settle in and to come to terms with my illness, my dignity is kept at all times."
"I am very satisfied with my care, I get all my needs met."
"I have been here for over two years and I am very happy here."
"You will not get any better than here."

Patients' representatives

Three visiting relatives/representatives stated in discussion that they could not ask for better and that staff were always available. They felt they had made the right decision choosing the home for their relative. Another visitor commented that they found staff to be very good and that they were full of care and compassion.

The following comments were made by relatives/representatives in six returned questionnaires;

"Staff are courteous and respectful, top quality care home."
"Very satisfied that staff listen to me about the needs of my relative."
"Very friendly and cooperative staff, it's a pleasure to come in here."
"My father moved here 16 months ago and I or he have never had to complain. An excellent home."

"We have been very pleased with the care our mother has been given, when she is not feeling well it is dealt with immediately."
"Very satisfied that my relative has privacy in the home."

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Roberta Wilson	**Date Completed**	18/05/2015
Registered Person	Caroline Denny	**Date Approved**	18/05/2015
RQIA Inspector Assessing Response	Donna Rogan	**Date Approved**	26/05/2015

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

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

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.