Bohill House
RQIA ID: 11142
69 Cloyfin Road
Coleraine
BT52 2NY

Inspector: Lyn Buckley
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Unannounced Care Inspection
of
Bohill House

17 August 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 17 August 2015 from 11:55 to 16:45 hours.

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 areas of concern. A Quality Improvement Plan (QIP) is not included in 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.

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

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 11 March 2015.

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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Priory care Homes Number 2 Ltd Caroline Denny – Responsible Individual	Registered Manager: Tracey Henry
Person in Charge of the Home at the Time of Inspection: Tracey Henry – registered manager	**Date Manager Registered:** 15 August 2011
Categories of Care: NH – I, PH (one identified person) and De (maximum of 36 persons) RC – DE (maximum of 18 persons)	**Number of Registered Places:** 80
Number of Patients/Residents Accommodated on Day of Inspection: 77	**Weekly Tariff at Time of Inspection:** Nursing - £616 - £671 Residential - £486

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:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received by RQIA 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 the delivery of care and care practices were observed. A review of the general environment was also undertaken. The inspection process allowed for consultation/interaction with eight patients individually and with others in small groups, six care staff, two registered nurses and one relative/visitor.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes
- duty rotas from 10 – 28 August 2015
- training records
- staff induction templates
- competency and capability assessment template for the nurse in charge of the home in the absence of the manager
- complaints record.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 11 March 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last care inspection.

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 14(2)(c) **Stated:** First time	The registered manager must ensure that staff are aware of the importance of checking sluice room doors are locked, as required, to eliminate risks to patients.	**Met**
	Action taken as confirmed during the inspection: Discussion the registered manager and staff; and observations of the environment confirmed that this requirement had been met.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 19.1 **Stated:** First time	Care plans should be devised for each identified need in relation to the management of bladder and/or bowels and contain specific details regarding the care and management of urinary catheters if required.	**Met**
	Action taken as confirmed during the inspection: Review of two care records evidenced that this recommendation had been met.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice. Guidance was also available on ‘Breaking Bad News’. Discussion with staff confirmed that they were knowledgeable regarding this policy, procedure and guidance.

A sampling of training records evidenced that staff had or were required to complete training in relation to communicating effectively with patients and with families/representatives. The registered manager confirmed that additional e-learning sessions were planned to cover the inspection theme/focus.

Is Care Effective? (Quality of Management)

Care records reviewed included reference to the patient’s specific communication needs and actions required to manage barriers such as, language, culture, cognitive ability or sensory impairment. There was also evidence that patients and their representatives were included in discussions regarding communication and for treatments options, where appropriate.

Staff consulted demonstrated their ability to communicate sensitively with patients and/or representatives.

Is Care Compassionate? (Quality of Care)

Observation of care delivery and interaction between patients and staff clearly demonstrated that communication was compassionate and considerate of the patient’s needs. Patients were treated with dignity and respect and responded to in a timely manner.

The inspection process allowed for interaction with eight patients individually and with others in small groups. Patients who could verbalise their feelings on life in Bohill House commented positively in relation to the care they were receiving. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

Discussion with one relative confirmed that staff were professional, caring, and attentive and kept them informed of any and all changes in the care of their loved one. Positive comments were also viewed in letters and cards received by the home from relatives.

Areas for Improvement

There were no requirements or recommendations made.

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 available in the home. 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 was also available.

Training records evidenced that staff were trained in the management of serious illness/deteriorating patient and what to do when death occurred. The registered manager confirmed that the organisation was developing a foundation for growth (FFG) e- learning session relating to palliative and end of life care. Training specific to the use of syringe drivers had been delivered to registered nurses within the last year.

Staff spoken with were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013. A resource file was available to staff.

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

Discussion with nursing 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 registered nurses confirmed their knowledge of the protocol.

Is Care Effective? (Quality of Management)

A review of care records evidenced that where required 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, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A document entitled 'end of life wishes' had been developed and recently introduced to assist staff when discussing and care planning for end of life care. The registered manager confirmed that this document was to be discussed within the next days with nursing and senior care staff.

Discussion with the registered manager and staff evidenced that management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Staff confirmed that relatives were supported with tea, coffee, meals and advice as required.

A review of notifications of death to RQIA during the previous inspection year confirmed that any death occurring in the home was notified 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 regarding end of life care. Staff consulted demonstrated an awareness of patients' expressed wishes and needs as identified in their care plan.

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. The registered manager informed the inspector that a 'comfort box' had been developed by one of the activity therapist for use in the bedroom of a patient who was seriously ill or dying. This box included items such as a New Testament, face cloths, wipes, hand cream. This enabled staff and/or relatives to read, massage the patient's hands or to wipe someone's face with a 'cool cloth' as wished. This is commendable.

From discussion with the registered manager, 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 examples of comments made by relatives included:

'I would like to write to you to let you know of the very high level of care my….received.'
'A sincere thank you for all your care, help and support…'
'Thank you so much for your kindness and devotion.'
'…like to thank you for all the great care and attention you gave…'

Discussion with the registered 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.

Areas for Improvement

There were no requirements or recommendations made.

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

5.4 Additional Areas Examined

5.4.1Consultation with patients, staff and patient representative/relatives

Patients

The inspector met and spoke with eight patients individually and with others in small groups. Patients were complimentary regarding the standard of care they received, the attitude of staff and the food provided. There were no concerns raised with the inspector.

Six questionnaires for patient were left with the registered manager for distribution and five were returned. Comments recorded evidenced that patient were either satisfied or very satisfied with the care they received.

Comments recorded included:

‘nice grounds to go outside in good weather and food good.’
‘I feel safe here and have no issues at all.’
‘Always get my medications…’
‘I like living here.’
‘Good company and range of activities, i.e. painting.’
‘Home is kept clean and tidy and is spacious. Staff are mostly jolly and keep me in good form.’

Staff

In addition to speaking with staff on duty six questionnaires were provided for staff not on duty. The registered manager agreed to forward these to the staff selected. At the time of writing this report four had been returned. Comments recorded that evidenced that staff had attended training in relation to the inspection focus, safeguarding of vulnerable adults and how to report poor practice/whistleblowing. Staff were either satisfied or very satisfied that care delivered was safe, effective and compassionate.

Additional comments recorded included:

‘each member of staff is hard working offering 110% to ensure residents receive the best care possible.’
‘…we pride ourselves in being able to care for the elderly and making their experience of a nursing home enjoyable.’
‘We use end of life care to provide a peaceful, pain free death, providing compassion and support to loved ones.’

Representatives/relatives

Six questionnaires were provided for patient representatives/relatives. At the time of writing this report four had been returned. Comments recorded evidenced that relatives were either satisfied or very satisfied with the care provided for their loved ones. The respondents were complimentary regarding the staff and the care delivered. One relative raised the concern that it was difficult for the home to arrange visits by clergy from a particular faith but that it had been arranged when the relative became involved.

Additional comments made included:

'Everyone very helpful and kind.' This relative named a member of staff as being *'great with activities and sewing etc.'*
'I have always been greatly impressed with the staff…their friendliness and good humour makes visiting a pleasure…'
'I am very satisfied with … care and the senior staff's approachability at all times and to the carers who I trust with my … care.'

5.4.3 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms and bathrooms on each floor. The home was found to be warm, well decorated, fresh smelling and clean.

Since the last inspection the enclosed garden to the rear of the home had been developed further to enable and stimulate patients' sensory perception and enjoyment. The ongoing plans for this area will further enhance what is already a restful and relaxing space.

Areas for Improvement

There were no areas of improvement for the home in respect of the additional areas examined.

Number of Requirements:	0	Number of Recommendations:	0

6. Quality Improvement Plan

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Tracey Henry	**Date Completed**	03/09/15
Registered Person	Caroline Denny	**Date Approved**	4/9/2015
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	04/09/15

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

***Please complete in full and return to RQIA nursing.team@rqia.org.uk ***