



The Regulation and
Quality Improvement
Authority

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**Unannounced Care Inspection
of
Brooklands Private Nursing Home**

02 June 2015

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 02 June 2015 from 10.30 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.**

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; 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 02 April 2014

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

1.4

	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 Mrs Christine Donnell, 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: Brooklands Nursing Homes Ltd Ms Therese Conway	Registered Manager: Mrs Christine Donnell
Person in Charge of the Home at the Time of Inspection: Mrs Christine Donnell	Date Manager Registered: 1 April 2005
Categories of Care: NH – I & PH	Number of Registered Places: 45
Number of Patients Accommodated on Day of Inspection: 43	Weekly Tariff at Time of Inspection: £567.00 - £609.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively

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

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to inspection the following records were examined:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report.

During the inspection, the inspector met with 20 patients, two nursing, four care staff, two ancillary staff and two patient's visitors/representatives.

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP
- three patient care records
- records of accident/notifiable events
- staff training records
- staff induction records
- policies for communication, death and dying, and palliative and end of life care
- complaints and compliments records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced estates inspection dated 15/5/15. The completed QIP had not been returned at the time of this inspection. An unannounced pharmacy inspection was conducted on 11/11/14. The completed QIP was returned and approved by the specialist inspector.

Review of Requirements and Recommendations from the last care Inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 Ref: Regulation 20 (1) (c) (i) Stated: First time	It is required that the activity therapist and care staff be trained in the provision of activities to the elderly. Action taken as confirmed during the inspection: Discussion with the registered manager and review of training records evidenced that this requirement had been met.	Met
Requirement 2 Ref: Regulation 18 (2) (c) Stated: Second time	The registered person shall having regard to the size of the nursing home and the number and needs of patients provide in rooms occupied by patients adequate furniture, bedding and other furnishings, including curtains and floor coverings, and equipment suitable to the needs of patients and <u>screens</u> where necessary. Action taken as confirmed during the inspection: Discussion with the registered manager and review of the internal environment confirmed that new screens for double rooms had been purchased and were in place.	Met
Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 Ref: Standard 5.2 Stated: First time	It is recommended that patients' individual activity assessments be reviewed and updated. All sections in these assessments should be completed. Action taken as confirmed during the inspection: Discussion with the activity therapist and review of activities records evidenced that this recommendation had been met.	Met

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 six staff confirmed that they were knowledgeable regarding this policy and procedure.

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

Is Care Effective? (Quality of Management)

Three care records reflected patients' individual needs and wishes regarding the end of life care. Reference had been made to patients' specific communication needs. Discussion with the registered manager and nursing staff evidenced that they were aware of patients religious preferences/spiritual needs, however these had not been documented in the patients end of life care plans.

A review of three 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.

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

The registered manager and two registered nurses 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.

Is Care Compassionate? (Quality of Care)

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.

Discussion with 20 patients individually and with the majority of patients generally evidenced that patients were happy living in the home. One patient expressed some dissatisfaction regarding the timing of breakfast and medications. This was discussed with the registered manager who agreed to follow up and address the issue. Comments received included:

- "We're well looked after."
- "I'm happy here."

Two patient's representatives also confirmed that they were happy with standards maintained in the home.

Areas for Improvement

It is recommended that patients religious preferences/spiritual needs are documented in end of life care plans.

Number of Requirements:	0	Number of Recommendations:	1
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5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home. 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.

Training records evidenced that eight nursing staff had received palliative care training in 2013. It is recommended that all nursing staff receive an update in palliative care training. The majority of care assistants had completed an e learning module on care of the dying and palliative care. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

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

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

A palliative care link nurse had been identified.

Is Care Effective? (Quality of Management)

A review of three care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social and cultural preferences were also considered. As previously stated, a recommendation has been made for patients religious preferences to be included in care records. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Discussion with the manager, two nursing staff and a review of three care records evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. 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 has 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 two nursing staff and a review of three care records evidenced that patients and/or their representatives had been generally consulted in respect of their cultural and spiritual preferences. However patients' spiritual/religious preferences had not been documented in respect of end of life care.

Arrangements were in place in the home to facilitate family and friends to spend as much time as they wish with the patient. Staff discussed openly a number of deaths in the home and how the home had been able to support the family members in providing refreshments and facilitating staying overnight with their loved ones.

From discussion with the registered manager, eight staff and a review of the compliments records 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.

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.

Eight 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.

Areas for Improvement

It is recommended that update training for registered nurses in relation to end of life/palliative care needs is provided.

As previously identified under standard 19 a recommendation is made that care plans document patients religious preferences/spiritual needs.

Number of Requirements:	0	Number of Recommendations: *1 recommendation made has been stated under Standard 19 above.	*2
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5.5 Additional Areas Examined

5.5.1 Consultation with patients, their representatives and staff

Discussion took place with 20 patients individually and with the majority of others in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were very positive. One patient informed the inspector that they were not entirely happy with the timing of breakfasts and medications. This was brought to the attention of the registered manager who agreed to address this. A few comments received are detailed below:

- “We’re well looked after.”
- “I’m happy here.”
- “No one has ever refused a request.”

Two patients’ representatives confirmed that they were happy with standards maintained in the home. Relatives commented;

- “We are completely satisfied.”
- “Staff are top class.”

Staff commented positively with regard to staffing and the delivery of care. No issues were raised by staff.

Six questionnaires were issued to nursing, care and ancillary staff and six were returned at the conclusion of the inspection. Staff indicated that they were satisfied or very satisfied that care was safe, effective and compassionate.

Some comments received from staff are detailed below:

- “There is great teamwork. All staff are very approachable.”
- “We get an opportunity to attend wakes and funerals.”
- “There is a peaceful, quiet and respectful atmosphere in the home.”

No professional visitors were available in the home at the time of the inspection.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Christine Donnell, 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 (non-paperlite) 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			
Recommendations			
Recommendation 1 Ref: Standard 32 Stated: First time To be Completed by: 30 September 2015	The registered manager should ensure that all nursing staff are provided with an update in the palliative care.		
	Response by Registered Person(s) Detailing the Actions Taken: Palliative Care training has been arranged for 8 th July 2015 for all nursing and care staff.		
Recommendation 2 Ref: Standard 19 Stated: First time To be Completed by: 09 June 2015	The registered manager should ensure that patients religious preferences/spiritual needs are documented in end of life care plans.		
	Response by Registered Person(s) Detailing the Actions Taken: A specific care plan for all patients religious preferences / spiritual needs has now been implemented.		
Registered Manager Completing QIP	Christine Donnell	Date Completed	18.06.15
Registered Person Approving QIP	Therese Conway	Date Approved	18.06.15
RQIA Inspector Assessing Response	Sharon Loane	Date Approved	27/07/2015

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