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Unannounced Care Inspection
of
Meadowbank

30 September 2015

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1. Summary of Inspection

An unannounced care inspection took place on 30 September 2015 from 11.30 to 15.30 hours.

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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Please also refer to sections 5.2 and 6.2 of 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 10 February 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	1

The details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Louisa Rea, regional manager and Ms Claire Wilkinson, acting 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 Health Care Dr Maureen Claire Royston	**Registered Manager:** No manager registered
Person in Charge of the Home at the Time of Inspection: Claire Wilkinson	**Date Manager Registered:** Claire Wilkinson – application not yet submitted
Categories of Care: NH-LD, NH-LD (E)	**Number of Registered Places:** 35
Number of Patients Accommodated on Day of Inspection: 32	**Weekly Tariff at Time of Inspection:** £637.00

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 analysed:

- 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 the last care inspection;
- the previous care inspection report
- pre-inspection assessment.

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 with four patients individually and with others in small groups, three care staff, one registered nurse and the deputy manager and one patient's representative.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes
- duty rotas for weeks commencing 21 & 28 September 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
- compliment records
- three patient care records
- palliative care/end of life/grievance and bereavement resource files.

5. The Inspection

6. Review of Requirements and Recommendations from the Previous Care Inspection10 February 2015

The previous inspection of the home was an announced estates inspection dated 24 February 2015. The completed QIP was returned and approved by the estates inspector.

6.1 Review of Requirements and Recommendations from the Last Care Inspection 10 February 2015

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 19.1 **Stated:** First time	The responsible individual should ensure that patients bowel functions referencing Bristol Stool should be recorded and effectively monitored.	**Met**
	Action taken as confirmed during the inspection: A review of bowel management records for the Oakwood unit for September 2015 evidenced that the Bristol Stool guidance was being implemented.	

6.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively. Guidance was also available on 'Breaking Bad News'. Discussion with staff confirmed that they were knowledgeable regarding this policy, procedure and guidance. Staff confirmed that the training they had completed included "breaking bad news". Staff advised of how they approached breaking bad news and examples were provided.

A sampling of training records evidenced that staff had completed training in relation to communicating effectively with patients and with families/representatives. Twenty six staff had completed training in communication provided by the Speech and Language Therapy department within the Trust. The content of the training included; aids to communication, verbal and non-verbal communication and how patients' individual needs can be communicated by challenging behaviours. Some staff had also completed "person centred" training which referred to the different ways to communicate. The training provided in this regard is commended. The manager confirmed that additional sessions were planned to cover the inspection theme.

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 detailed interventions for staff as to how to respond to patients challenging and/ or distressed behaviours. There was 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. It was clear from the observations made that the patients knew the staff and the manager very well. All areas of the home were accessible to the patients' including the manager's office, were patients were observed to visit often during the inspection process, this was observed as a very relaxed homely environment.

The inspection process allowed for interaction with some patients individually and for the majority of others in small groups. Patients who could verbalise their feelings on life in Meadowbank Care Home commented positively in relation to the care they were receiving and their affection and fondness for the staff. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

Positive comments were also viewed in letters and cards received by the home from relatives. A copy of an acknowledgement from the Trust was also reviewed.

Areas for Improvement

No areas for improvement were identified in relation to this standard.

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

6.3 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 have been recently reviewed and the draft copies 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. A resource file on palliative care/end of life/grief and bereavement was available to staff. Staff were knowledgeable of the policies and information held in the resource file.

Training records evidenced that staff were trained in the management of palliative and end of life care, death and dying. The link nurse for palliative and end of life care had facilitated an information session during July 2015 and 14 staff attended. The manager advised that additional palliative and end of life care training was scheduled and was being provided by FSHC. In addition, some staff were scheduled to attend the Final Journeys training provided by the Foyle Hospice.

The palliative care link nurse had completed the Palliative Care Awareness training course for registered nurses at the clinical education centre. The manager and the link nurse had completed supervision with 17 staff in regards to palliative and end of life care. This supervision included the completion of a learning booklet of which a sample was reviewed at this inspection. This is commended.

Discussion with the 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 not in place and the manager agreed to develop and or contact the Western Health and Social Care Trust to access a copy of the protocol that has been issued to Nursing homes within this Trust area.

Is Care Effective? (Quality of Management)

A review of three care records evidenced that, where required, patients' needs for palliative and end of life care were assessed and reviewed as appropriate to the needs of the patient. This included the management of hydration and nutrition, pain management and symptom management. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements were appropriate.

The review of care records evidenced that the individual needs and wishes of patients regarding the end of life care was being addressed through the completion of a booklet entitled, 'When I Die'. The booklet refers to all aspects of death and dying and recorded the patient's and /or their representative's wishes and requests which were to be actioned in the event of their death. The manager confirmed that the use of the booklet was recently implemented and careful consideration is given as to when and how this is approached and completed. This is in most circumstances completed after the patient had settled into the home rather than on the day of admission. The discussion was usually conducted by the manager, deputy manager and or the registered nurse. This innovative practice is to be commended.

Following discussion regarding end of life care, a care plan was developed to ensure the patient's wishes and preferences were met.

Discussion with the 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. Staff advised that a lot of the patients do not have family and staff referred to "themselves as the patients' family at this time". Arrangements are made in these circumstances for a member of staff to be present with the patient. This is commended.

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 where appropriate 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. Staff spoken with demonstrated clearly their compassion for the patients, their relatives and friends.

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.

From discussion with the 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:

Discussion with the manager confirmed that no concerns had been 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. Other patients if it is deemed appropriate are also given the opportunity to pay their respects.

Areas for Improvement

A system should be implemented to ensure that staff are knowledgeable of the updated policy and procedure in respect of palliative and end of life care.

Number of Requirements:	**0**	**Number of Recommendations:**	**1**

6.4 Additional Areas Examined

6.4.1 Consultation with patients, staff and representatives/relatives

Patients

The inspector met and spoke with four patients individually and with others in small groups. There were no concerns raised.

Two questionnaires were completed and returned by patients. Comments recorded evidenced that patients were either satisfied or very satisfied with the care they received. Comments included:

- "Very content in the home and encouraged to do all I can."
- "I like Meadowbank and the food is good. All the staff are my friends."

Staff

In addition to speaking with staff on duty, five questionnaires were provided for staff not on duty. The manager agreed to forward these to the staff selected. All questionnaires issued were completed and returned either during or post inspection. Comments recorded 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. No concerns were raised.

Additional comments recorded included:

- “Has a great system of care in place the staff training opportunities are very good, residents are very well cared for.”
- “We have lost a few dear residents and I can honestly say every one of them were treated with dignity and respect.”
- “We encourage everyone to be as independent as possible, treat everyone as an individual.”
- “I feel that staff are compassionate and always have taken time out to sit with and comfort our residents who were receiving palliative care.”
- “Staff are very respectful to residents and relatives in the palliative care period.”
- “I love working in Meadowbank, when you get a positive reaction out of a resident you know it’s because all staff have put time and effort into individuals.”
- “Good support from manager and is very approachable at all times, teamwork is good.”

Representatives/relatives

Five questionnaires were provided for patient representatives/relatives and two were returned. Responses indicated that relatives were very satisfied with the care provided for their loved ones. The respondents were complimentary regarding the staff and the care delivered. No concerns were raised.

6.4.2 Environment

A general inspection of the home was undertaken which included inspection of a random sample of bedrooms and bathrooms. The home was found to be warm and decorated to reflect each patient’s personhood. Staff are commended for their efforts. The manager advised of a number of environmental improvements completed since the last care inspection and an ongoing programme of refurbishment / improvements. The following issues were identified:

- an extension lead in an identified bedroom needed to be secured safely
- a clinical waste bin was rusted
- a mattress was “bottomed out”
- a radiator cover was damage
- an identified bedroom needed to be re-decorated.

These matters were discussed during feedback and the manager gave assurances that these would be addressed immediately. Post inspection the manager confirmed by an email correspondence that all of the above issues had been actioned satisfactorily. The manager advised that the identified bedroom was scheduled to be redecorated and that the home were awaiting confirmation of the chosen colour scheme from the patient’s representatives.

7. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with management representatives 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.

7.1 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.

7.2 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.

7.3 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 any 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

No Requirements were made at this inspection.

Recommendations

Recommendation 1 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 30 November 2015	The registered manager should ensure staff are knowledgeable of the reviewed policy and procedures in respect of palliative and end of life care, death and dying. **Response by Registered Person(s) Detailing the Actions Taken:** Ratified Palliative Care and End of Life Policy received 26/10/15 Policy has been cascaded to staff, acknowledgement form attached for all staff to sign once read and understood. supervisions will be completed to ensure understanding and to provide additional support and guidance. draft policy removed and replaced. link nurse advised

Registered Manager Completing QIP	Claire Wilkinson	**Date Completed**	28/10/15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	28.10.15
RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	02.11.15

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