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Unannounced Care Inspection
of
Woodmount

02 November 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 02 November 2015 from 10.15 to 16.45.

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. 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.

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 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	8

The total number of requirements and recommendations above includes both new and those that have been ‘restated’.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the 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: Woodmount Alfred Linsay Woods and Roberta Jillian Woods - responsible persons	**Registered Manager:** Thomas Monteith
Person in Charge of the Home at the Time of Inspection: Thomas Monteith	**Date Manager Registered:** 7 April 2014
Categories of Care: NH-I, NH-PH, NH-PH (E)	**Number of Registered Places:** 32
Number of Patients Accommodated on Day of Inspection: 31	**Weekly Tariff at Time of Inspection:** £593

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 since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with six patients, four care staff, two nursing staff and three patient's representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death 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 the home was an unannounced care inspection dated 19 October 2015. The completed QIP is to be returned and approved by the estates inspector by 14 December 2015.

5.2 Review of Requirements and Recommendations from the Last Care inspection on 11 February 2015

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 16 (2) **Stated:** Second time	The registered person shall ensure that patients care plans are reviewed monthly or more often if deemed appropriate.	**Partially Met**
	Action taken as confirmed during the inspection: Inspector confirmed that patients' care plans were generally reviewed on a monthly basis. However, a review of three patients' care records evidenced that a small number had not been updated. Further detail regarding the care file auditing is discussed under section 5.5., where a new recommendation was made in this regard.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 5.3 **Stated:** First time	It is recommended that patients repositioning charts are recorded and completed appropriately.	**Not Met**
	Action taken as confirmed during the inspection: Inspector confirmed that repositioning records were generally completed. However, a review of five patients repositioning records evidenced that two patients had not been repositioned as indicated in their care plans. This was discussed with the registered manager, who agreed to address this matter with the staff. This recommendation was not fully met and is stated for the second time.	
Recommendation 2 **Ref**: Standard 5.3 **Stated:** First time	It is recommended that the Malnutrition Universal Screening Tool (MUST) is recorded monthly or more often if deemed appropriate.	**Not Met**
	Action taken as confirmed during the inspection: Two out of three patient care records evidenced that MUST score was regularly updated. However, one patient's care record evidenced that only the patient's weight had been entered on the MUST assessment tool and had not been fully completed. This was evident on two consecutive months. Considering that the identified patient was receiving enteral feeding, it was concerning that this MUST score had not been completed. This recommendation was not met and is stated for the second time.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The home's policies and procedures on palliative and end of life care were reviewed. Advice was given regarding the deficits in content and a recommendation was made. However, regional guidance on Breaking Bad News was available in the home and discussion with staff confirmed that they were knowledgeable regarding the procedure to follow when they needed to share sensitive or distressing news. Communication with patients' relatives was also included in the competency assessment for registered nurses who have the responsibility of being in charge of the home.

Training had not been provided in relation to communicating effectively with patients and their families/representatives. However, there were plans in place for training to be delivered to all staff. The content of the proposed training was reviewed and included communication with patients' and their family members. Further detail regarding training is discussed in section 5.4.

Is Care Effective? (Quality of Management)

Discussion with one registered nurse 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. Two registered nurses consulted explained that there were events which would trigger sensitive conversations with patients and/or their families, for example, an increase in the number of admissions to hospital, and/or reoccurring symptom with a poor prognosis. They emphasised the importance of building caring relationships with patients and their representatives and the importance of regular, ongoing communication regarding the patient's condition.

Generally, the care staff consulted, considered the breaking of bad news to be primarily, the responsibility of the registered nursing staff. However, one carer commented to the inspector that the nursing staff 'take over' when a patient is nearing end of life and felt confident that, should a patient choose to talk to them about a diagnosis or prognosis of illness, that they would have the necessary skills to do so. All staff consulted felt their role was to empathise and to support patients and their representatives following sensitive or distressing news.

Is Care Compassionate? (Quality of Care)

Discussion with six patients individually and with the majority of patients generally, evidenced that patients were content living in the home. 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 taking time to reassure patients as was required from time to time.

Staff recognised the need to develop a strong, supportive relationship with patients and relatives. It was appreciated by staff that this relationship would allow the delivery of bad news more sensitively and with greater empathy when required.

One patient's representative also confirmed that they were kept informed of any changes to their relative's condition and of the outcome of visits and reviews by healthcare professionals. There were several cards and letters on display complimenting the care that was afforded to patients when they were receiving end of life care.

Areas for Improvement

A policy on communicating effectively should be developed in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.*

Number of Requirements:	0	Number of Recommendations: *1 recommendation made is	*1

		stated under Standard 32 above	

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)

As previously discussed, policies regarding the management of palliative and end of life care were reviewed. Advice was given regarding the deficits in content and a recommendation was made. There was no formal protocol for timely access to any specialist equipment or drugs in place. However, discussion with two registered nurse confirmed their knowledge of local arrangements for accessing palliative care teams, district nursing teams, GP out-of-hours or pharmacists, if required.

There was no evidence that training had been provided. However, the registered manager confirmed that plans were in place for palliative and end of life care training to be provided. The content of the proposed training was reviewed and did include palliative and end of life care principles, providing care in the last 48/72 hours of life and symptom management. Palliative care was also included in competency assessment for registered nurses who have the responsibility of being in charge of the home.

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
- staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken

There was no specialist equipment in use in the home on the day of inspection. The training needs of staff were discussed with the registered manager who provided assurances that update training in the use of syringe drivers would be accessed through the local healthcare trust nurse, if required.

There was no palliative care link nurse identified in the home. The registered manager stated that a registered nurse would be appointed, when such training becomes available from the local healthcare trust.

Is Care Effective? (Quality of Management)

A key worker/named nurse was identified for each patient approaching end of life care. A review of three care records evidenced that patients' needs for palliative and end of life care were generally assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered.

However, two care records did not evidence discussion between the patient, their representatives and staff in respect of death and dying arrangements and care plans had not been developed regarding end of life care. A recommendation was made.

The registered manager discussed the difficulties experienced when family members were not in agreement with medical assessment of the patients' prognosis. However, one patient who

was recently deceased did not have a care plan developed, despite the patient's death being expected. A review of this patient's progress notes did however reflect that their relatives/representatives were involved and present when the patient deceased.

Discussion with the registered manager, 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. Through discussion there was evidence that staff had managed shared rooms sensitively.

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

Is Care Compassionate? (Quality of Care)

Discussion with the staff and a review of three patients' 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.

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. Overnight stays were facilitated if there was a vacant bedroom available. Staff consulted with described how catering/snack arrangements would be provided when family members were present for long periods. They also emphasised the need for patients' relatives to have a break during this period.

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.

Discussion with the 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.

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 more experienced staff supporting those that were new to the caring role and time spent reflecting on the patients time spent living in the home.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included leaflets providing advice on palliative and hospice care. Advice was given regarding additional sources of support services.

Areas for Improvement

As previously discussed in section 5.3, a policy on communicating effectively should be developed in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* This recommendation also extends to palliative and end of life care.

Registered nursing staff should record efforts made to establish patients' preferences in respect of end of life care and that for patients who do not wish to discuss this, a record should be also be maintained in line with the policy on end of life care. Where a decision is made regarding end of life care, a care plan should be developed and should include identified religious, spiritual and cultural needs.

Number of Requirements:	0	Number of Recommendations:	2

5.5 Additional Areas Examined

Care Records

A review of three patient care record evidenced that care plans had not been developed in respect of do not resuscitate decisions. A recommendation was made to address this.

As previously discussed in section 5.2, a small number of care plans were not updated on a regular basis. Discussion was held with the registered manager regarding care file auditing, who confirmed that although care plans were audited informally, there was no formal process that would provide traceability of audit or subsequent follow up of actions taken. A new recommendation was made in this regard.

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	7	6
Patients	5	5
Patients representatives	3	3

All comments on the returned questionnaires were in general positive. Some comments received are detailed below:

Patients

'The care is excellent'
'I am very happy with everything so far'
'They go above and beyond the call of duty. They manage my pain before moving me and massage my legs to help with the pain'
'It's great here'
'They are very attentive, kind and caring'
'They are very patient. I like it here'
'I get treated with 100 percent respect, but extra hands are needed'

Three patients informed the inspector that there were delays in having their call bells answered. One patient described how they would often have to wait half an hour for assistance getting to the toilet and another patient described how other patients could be heard calling for assistance. A review of the complaints records also evidenced that this matter had previously been raised by patients' relatives on two previous occasions. The process for auditing call bell response times was discussed with the registered manager and a recommendation was made in this regard.

Staff

'This is a happy home and (is made) to be like a home from home'
'Care assistants work hard and are praised often by family members'

Three staff members commented to the inspector regarding staffing levels, as follows:

'We need extra (staff) in the middle to help. We don't have enough time to spend with the residents'
'I sometimes feel we are overworked and understaffed and the nurses aren't able to help with the workload. It would be easier if we could all work together in the mornings and at meal times'
'Not enough staff. We cannot spend time with the residents. There is not enough time to carry out activities'

These comments were discussed with the registered manager. A review of duty rotas for nursing and care staff confirmed that staffing levels were generally in keeping with the planned staffing levels discussed with inspector. Staff spoken with confirmed that short notice absences were being managed as per the home's protocol. The inspector did not observe any impact on patient care. However, given the concerns expressed by patients and staff, a recommendation was made to ensure that the work practices on the morning shift are reviewed, taking into account the dependency levels of the patients accommodated in the home. This refers specifically to the period in the morning, when the registered nurse is administering medicines.

Patients' Representatives

'My (relative) is happy and well looked after in Woodmount'
'Each and every one of the staff have been very approachable and very caring towards my (relative)'
'I know that if any problems arise with (my relative's) health, we are notified right away'
'We are delighted that we got our (relative) in here. The nurses are on the ball'
'It's alright. The nurses are good'
'We have no concerns whatsoever'

Environment

A general tour of the home was undertaken which included review of a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Thomas Monteith, registered manager and Kay Hardy, staff nurse, 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 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	
Recommendations	
Recommendation 1 **Ref**: Standard 5.3 **Stated:** Second time **To be Completed by:** 30 December 2015	It is recommended that patients repositioning charts are recorded and completed appropriately. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: All staff advised to complete repositioning charts immediately following each care intervention. Manager to monitor compliance on a random/regular basis and address any issues of non compliance directly with appropriate staff
Recommendation 2 **Ref**: Standard 5.3 **Stated:** Second time **To be Completed by:** 30 December 2015	It is recommended that the Malnutrition Universal Screening Tool (MUST) is recorded monthly or more often if deemed appropriate. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Registered Nurses have been reminded of importance of completing (MUST) on a monthly or more frequent basis where deemed necessary. Manager to monitor compliance within Care plan audits
Recommendation 3 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 30 December 2015	The following policies and guidance documents should be developed and made readily available to staff: A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the: • referral procedure for specialist palliative care nurses; • procedure for managing shared rooms; • process for notifying RQIA in the event of a death; • management of patients' belongings; and • management of a sudden or unexpected death **Ref: Section 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: A Policy on palliative and end of life care which incorporates recommended issues as detailed above has been developed

Recommendation 4 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 30 December 2015	It is recommended that registered nursing staff should record efforts made to establish patients' preferences in respect of end of life care and that for patients who do not wish to discuss this, a record should be also be maintained in line with the policy on end of life care. Where a decision is made regarding end of life care, a care plan should be developed and should include identified religious, spiritual and cultural needs. **Ref: Section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Registered Nurses have been advised to record end of life preferences in patients care plans, or evidence that the patient does not wish to discuss/record same. Care plans will reflect religious/spiritual and cultural needs.
Recommendation 5 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:** 30 December 2015	It is recommended that decisions regarding patient's resuscitation status (DNAR) are recorded a care plan, in keeping with good practice guidelines. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Registered Nurses have been advised that patients with DNAR status require this important issue to be detailed within a care plan
Recommendation 6 **Ref**: Standard 17.1 **Stated:** First time **To be Completed by:** 30 December 2015	The registered manager must ensure that care records are audited, using a robust system that provides traceability of audit. **Ref: Section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: A care plan audit proforma has been developed and will be completed for each resident on alternate months by the Registered Manager or a delegated Registered Nurse
Recommendation 7 **Ref**: Standard 35.16 **Stated:** First time **To be Completed by:** 30 December 2015	The registered manager should audit the call bell response times on a regular basis. This audit should include response times at or nearing change of shifts. **Ref: Section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager will audit and record call bell response times on a regular basis and take appropriate action where issues have been identified

Recommendation 8 **Ref**: Standard 41.1 **Stated:** First time **To be Completed by:** 30 December 2015	The registered manager should review the work practices on the morning shift, taking into account the dependency levels of the patients accommodated in the home. This refers specifically to the period in the morning, when the registered nurse is administering medicines. **Ref: Section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager has discussed with staff current work practices. Agreement has been reached to delegate the care interventions (Work Load) so that all available staff including Registered Nurses can work more efficiently, particularly over the very busy morning period. This will need to be kept under regular review in line with the changing dependency levels within the home

Registered Manager Completing QIP	Thomas Monteith	**Date Completed**	09/12/2015
Registered Person Approving QIP	Jill Woods	**Date Approved**	10/12/2015
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	10/12/2015

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