Oakmont Lodge Care Home
RQIA ID: 11966
267 - 271 Old Belfast Road
BT19 1LU
Bangor

Inspector: Karen Scarlett
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Unannounced Care Inspection
of
Oakmont Lodge Care Home

19 January 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 19 January 2016 from 09.40 to 16.15 hours.

This inspection was underpinned by one standard and one theme from the DHSSPSNI Care Standards for Nursing Homes (2015). **Standard 19 - Communicating Effectively; Theme 'End of Life Care' incorporating criteria from 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.

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 19 June 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	**2***	**5***

*The total number of requirements and recommendations includes two requirements and one recommendation which have each been stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Lyndsey Paul, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Maria Mallaband (9) Limited	**Registered Manager:** Lyndsey Paul
Person in Charge of the Home at the Time of Inspection: Lyndsey Paul	**Date Manager Registered:** 4 December 2015
Categories of Care: NH-DE, NH-I, NH-PH, NH-PH(E) A maximum of 27 patients in category NH-DE and a maximum of 29 patients in categories NH-I, NH-PH, NH-PH(E)	**Number of Registered Places:** 56
Number of Patients Accommodated on Day of Inspection: 33	**Weekly Tariff at Time of Inspection:** £593 - £800

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:

- discussion with the registered manager
- discussion with patients
- discussion with staff
- observation during an inspection of the premises
- evaluation and feedback

The inspector met with seven patients individually and with the majority of others in groups, three care staff, two registered nurses and two patient's visitors/representatives.

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 plan (QIP) from the care inspection undertaken in this inspection year
- the previous care inspection report

The following records were examined during the inspection:

- three care records and a selection of daily charts
- staff duty rotas from 4 January to 24 January 2016
- palliative care resource file for staff
- a selection of policies and procedures
- complaints records
- staff meeting minutes
- staff induction records
- competency and capability assessments for registered nurses
- care record audits
- cleaning schedules
- medication administration charts

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced medicines management inspection on 1 July 2015. The completed QIP was returned and approved by the pharmacy inspector. On review of the notifications sent to RQIA a number of medication related errors and omissions were noted. On discussion with the aligned pharmacy inspector it was agreed to follow this up at this inspection.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref:** 13 (4) (b) **Stated:** Second time	The registered manager must ensure that all prescribed creams are individually labelled and administered only to the patient for whom they were prescribed.	**Met**
	Action taken as confirmed during the inspection: No unlabelled creams or medications were found on an inspection of patients' bedrooms and en-suite bathrooms. On out of date emollient cream was found and this was reported to the manager who promptly discarded this. This requirement has been met.	
Requirement 2 **Ref:** Regulation 13 (4) (a) **Stated:** First time	The registered person shall make suitable arrangements for the ordering, storage, stock control, recording, handling, safe keeping, safe administration and disposal of medicines. Any medicine which is kept in the nursing home is stored in a secure place and at the recommended temperature.	**Met**
	Action taken as confirmed during the inspection: Air conditioning units had been fitted in the treatment rooms in both units. The temperature records for January 2016 evidenced that temperatures had remained within the recommended temperatures for medicines storage. This requirement has been met.	

Requirement 3 **Ref:** Regulation 15 (2) (a) (b) **Stated:** First time	The registered person shall ensure that the assessment of patient's needs is kept under review and revised as necessary. **Action taken as confirmed during the inspection**: Three patients' care records were reviewed. One record was found to have assessments in place and these were reviewed appropriately. In another record the bed rails assessment had not been completed and there was no indication as to whether bed rails were in use or not. In another record the patient had no annual activities of living assessment in place. This requirement has not been met and has been stated for a second time.	**Not Met**
Requirement 4 **Ref:** Regulation 16 (2) (a) **Stated:** First time	The registered person shall ensure that the patient's plan is kept under review. **Action taken as confirmed during the inspection**: A review of three patients' care records evidenced that not all care plans were in place to identify their assessed needs. Care plans were not being consistently reviewed on a monthly basis or as the patients' condition deteriorated. This requirement has not been met and has been stated for a second time.	**Not Met**

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 12, 12.8 **Stated:** Third time	When returning the quality improvement plan (QIP), the registered person is requested to confirm how: • patients / relatives are informed regarding the home's policy on external food provision and the use of personal fridges.	**Met**
	Action taken as confirmed during the inspection: The manager explained that the patients' personal fridges had been put out of use as they had been unable to maintain the temperatures within recommended limits. The fridges were still in the rooms but were turned off. The manager assured RQIA that she would remove these on the day following the inspection. Confirmation of this is to be returned along with the QIP. Suitable alternative arrangements had been made to store patients' food items requiring refrigeration. No complaints had been received from patients or their representatives in regards to the use of fridges. The homes' policy had been updated in this regard. This recommendation has been met.	
Recommendation 2 **Ref:** Standard 5, 5.4 **Stated:** Second time	Re-assessment of patients' needs should be an ongoing process and be carried out daily and at agreed time intervals. This is in relation to: • Pain assessments must be carried out and documented and kept under regular review to ensure that these needs are met and the effectiveness of any analgesia is documented.	**Met**
	Action taken as confirmed during the inspection: Pain assessments were completed in the three records reviewed. Pain assessments were also kept with the medication records on the medicine trolley and these were completed as required. This recommendation has been met.	

Recommendation 3 **Ref:** Standard 41 criterion 1 **Stated:** Second time	It is recommended that the frequency with which patient dependency levels are reviewed is increased and staffing levels adjusted accordingly.	**Met**
	Action taken as confirmed during the inspection: The most recent dependency levels for January were reviewed and the home was staffed accordingly. These were completed monthly. There were concerns raised by staff and one complaint had been received from a patient's representative regarding staffing levels. Please refer to section 5.5.1 for further information. This recommendation has been met.	
Recommendation 4 **Ref:** Standard 46 criterion 2 **Stated:** First time	It is recommended that a system should be established to ensure that deep cleaning of the home environment is carried out to ensure compliance with best practice in infection prevention and control.	**Not Met**
	Action taken as confirmed during the inspection: The home was found to be clean and well presented. Daily cleaning schedules were reviewed in discussion with a domestic assistant and they confirmed that all duties were signed once they had been carried out. However, following discussion with the domestic supervisor, it was apparent that no deep cleaning schedules had been put in place. They confirmed that deep cleaning duties tended to be carried out on an "ad-hoc" basis as staffing numbers allowed. They confirmed that new staff were starting and they would be better able to initiate deep cleaning on a planned basis. This recommendation has not been met and has been stated for a second time.	
Recommendation 5 **Ref:** Standard 47 criterion1 **Stated:** First time	It is recommended that procedures should be introduced to ensure that patients' fridges are kept clean and the temperatures monitored and documented on a daily basis.	**Met**
	Action taken as confirmed during the inspection: As previously stated, patients' personal fridges had been put out of use and are to be removed. This recommendation has been met.	

Recommendation 6 **Ref:** Standard 35 criterion 3 **Stated:** First time	It is recommended that care plan audits are conducted on a monthly basis and the outcomes shared with staff; the audit process should be further developed to include a re-audit of any deficits identified to ensure the required improvements are actioned.	
	Action taken as confirmed during the inspection: The manager had introduced a robust system of care record audits and these were reviewed for January 2016. Any deficits were brought to the attention of the named nurse and once amendments had been made the named nurse signed and returned the audit. It was evident that not all records had yet been audited and the manager confirmed that this work was ongoing to drive improvement in the standards of record keeping. This recommendation has been met.	**Met**
Recommendation 7 **Ref:** Standard 23 **Stated:** First time	It is recommended that repositioning charts are consistently completed and reflective of the time frames for repositioning in the care plan. Entries should reflect the actual position of the patient. The condition of the patients' skin should be documented using a validated grading tool.	
	Action taken as confirmed during the inspection: A selection of repositioning charts were reviewed and these were found to be consistently well completed. Time frames for repositioning were included on the charts along with the actual position of the patient. Registered nurses were using a validated tool to grade pressure ulcers. This recommendation has been met.	**Met**

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A draft policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. This was awaiting final approval. A recommendation has been made that this policy is shared with staff on completion.

Staff had not had formal training on communicating effectively but, in discussion, they were knowledgeable regarding this aspect of care.

Is Care Effective? (Quality of Management)

Care records reflected patients' specific communication needs including sensory and cognitive impairments.

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.

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

Registered nurses talked confidently about communicating with patients and their representatives and emphasised the value of building effective, professional relationships with them.

Is Care Compassionate? (Quality of Care)

Staff were observed to be communicating in a dignified manner with patients. Relationships were observed to be relaxed and friendly. Staff demonstrated knowledge regarding individual patients and were responding promptly to patients' requests and needs.

Patients and patients' representatives confirmed that staff were very kind and attentive. There were no concerns raised.

Areas for Improvement

A recommendation has been made that draft policies in relation to this theme and standard are shared with staff upon completion.

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

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)

A draft policy and on the management of palliative and end of life care, including death and dying, was available in the home. This document reflected best practice guidance such as the Gain Palliative Care Guidelines (2013) and included guidance on the management of the deceased person's belongings and personal effects. A recommendation has been made that this policy is shared with staff on completion.

Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines (2013).

A review of training records evidenced that a training session on palliative care with the palliative care specialist nurse of the local Trust was planned for January. The manager confirmed that further sessions were to be arranged.

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

Discussion with the manager, 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. However, although appropriate referrals and actions had been taken, the care plans had not been updated to reflect the deterioration in one patient's condition. A previous requirement made in regards to care planning has been stated for a second time. Please refer to section 5.2 for further information.

A protocol for timely access to any specialist equipment or drugs was in place and discussion with staff confirmed their knowledge of the protocol. One registered nurse confirmed that she had received syringe driver training and was supported by the local community nursing team as required.

Is Care Effective? (Quality of Management)

A review of 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 no evidence that the patient's wishes and their social, cultural and religious preferences had been considered. Care records did not evidence discussion between the patient, their representatives and staff in respect of death and dying arrangements. A recommendation has been made in this regard.

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

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

Is Care Compassionate? (Quality of Care)

Although staff demonstrated knowledge of patients' cultural and spiritual preferences these were not evident in the care records reviewed. Patient's expressed wishes and needs in relation to end of life were not identified in their care plan. As previously stated, a recommendation has been made.

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 wished with the person. Staff confirmed that relatives were always welcome to visit and sit with their loved ones at this time. Regular drinks and snacks were offered. If relatives wished to stay overnight they were accommodated appropriately. Staff emphasised the importance of caring for the relatives as well as the 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.

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 including the support of the team and the manager.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included information provided by the Trust and the bereavement network.

Areas for Improvement

As previously stated, a recommendation has been made that draft policies in relation to this theme and standard are shared with staff upon completion.

A recommendation has been made that end of life care and death arrangements should be discussed with the patient and their representatives and documented in a personalised care plan as appropriate. This should include the patient's wishes, cultural and spiritual preferences and their preferred place of care/ death.

Number of Requirements:	0	Number of Recommendations:	2*

*1 recommendation made is stated under Standard 19 above

5.5 Additional Areas Examined – records audits and some progress

5.5.1. Comment of patients, patients' representatives and staff

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

Patients

Patients' comments were positive regarding the care provided and the staff. No concerns were raised.

Comments included:
'I have no complaints.'
'The staff are very good.'
'Staff good, food good! I have no complaints.'

Patients' representatives

Questionnaires were left at reception for patients' representatives but none were returned. Patients' representatives spoken with raised no concerns regarding the care provided in the home and they commented on the kindness and attentiveness of the staff.

One representative commented that their loved one was resistive to personal care but that the staff did encourage the patient as much as possible. Another commented that their loved one had been in two other homes and this was the best one they had been in. One representative, although satisfied with the care, commented regarding the staff turnover and that the use of agency nurses, which meant that they were not always aware of their loved one's needs in the same way as the permanent staff. These comments were discussed with the manager for her attention and action as required.

Staff

Ten questionnaires were issued to staff and none were returned. In general staff were happy working in the home. They were positive about the change of manager and commented that they found her approachable and supportive. One care assistant was undergoing induction and commented that they had received training and support.

Staff stated that agency registered nurses were working in the home but that these were usually the same members of staff. They were of the opinion that agency use had reduced and this was confirmed on review of the duty rota.

Some care staff commented that staffing levels had recently been reduced on night duty in the dementia unit to one nurse and one care assistant. They stated that they found it a challenge to appropriately supervise residents at busy times. This was discussed with the manager who stated that there had also been a recent complaint from a patients' representative in this regard. Following discussion a recommendation has been made that staffing levels are reviewed to ensure patients' needs are appropriately met at all times. The manager stated that staffing levels would be kept under continuous review, particularly as patient numbers increased.

5.5.2. Medicines management

On review of the notifications sent to RQIA it was noted that there had been a number of medication errors and omissions. This was discussed with the pharmacy inspector prior to the inspection and it was agreed that this would be addressed at this inspection. This was discussed with the manager and it was reassuring that regular medication audits were being carried out to identify issues. Supervision had been planned for all registered nurses and the date was noted on the rota. In addition, the manager has initiated a new system for medicines management with a local pharmacy who have agreed to assist with auditing and to offer support and training to staff. The manager confirmed that registered nurses were being performance managed in relation to medication incidents. This will continue to be monitored as part of ongoing inspection activity.

5.5.3. Completion of daily charts

It was noted that three gentlemen had not been shaved. This was discussed with the manager who stated that these patients would often refuse when offered. Personal care charts were reviewed and it was noted that shaving was not included as one of the personal care activities on the chart. It was recommended that a column be added to this chart to indicate when shaving had been offered but refused. Similarly, one patient who was assessed as high risk of pressure ulcers was not on a repositioning chart. The manager stated that she was offered but frequently refused to be repositioned.

It was advised and agreed that a repositioning chart would be put in place to enable staff to evidence that repositioning was offered but refused by the patient. A recommendation has been made that instances in which personal care or repositioning is refused should be appropriately documented.

Areas for Improvement

Number of Requirements:	**0**	**Number of Recommendations:**	**2**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Lyndsey Paul, 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 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 in this report do not absolve the registered provider/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 provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 15 (2) (a) (b) **Stated:** Second time **To be Completed by:** 19 February 2016	The registered person shall ensure that the assessment of patient's needs is kept under review and revised as necessary. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: From the 1st March the Manager has introduced a "resident of the day" system. This ensures that on a monthly basis each resident will have an hollistic review of their care needs and living environment, the manager will review the paper work for this system daily . The manager will also review at least 8 care files on a monthly basis and produce an action plan for RGNS as required.
Requirement 2 **Ref:** Regulation 16 (2) (a) **Stated:** Second time **To be Completed by:** 19 February 2016	The registered person shall ensure that the patient's plan is kept under review. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: As stated above the manager will audit a minimum of 8 care files each month to ensure resident care is being reviewed and documented appropriately .An action plan will be drawn up with achievable deadlines for Nurses to adhere to.
Recommendations	
Recommendation 1 **Ref**: Standard 46, criterion 2 **Stated:** Second time **To be Completed by:** 1 March 2016	It is recommended that a system should be established to ensure that deep cleaning of the home environment is carried out to ensure compliance with best practice in infection prevention and control. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: All rooms in the home are currently being Deep cleaned. A system will then be in place for the 1st March where by one room each day will be deep cleaned.
Recommendation 2 **Ref**: Standard 19 and Standard 20 **Stated:** First time **To be Completed by:** 19 April 2016	Staff should receive training/supervision on the content of the policies in relation to breaking bad news and end of life care once completed to ensure they are knowledgeable regarding best practice in this aspect of care. **Ref: Section 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: A group supervision for RGNS has been organised for 16th March , at this session we will review breaking bad news / palliative care. A link nurse for Palliative care was appointed on the 1st February and she will carry out a training session with the carers in April/ May.

Recommendation 3 **Ref**: Standard 20, criterion 2 **Stated:** First time **To be Completed by:** 19 February 2016	End of life care and death arrangements should be discussed with the patient and their representatives and documented in a personalised care plan as appropriate. This should include the patient's wishes, cultural and spiritual preferences and their preferred place of care/ death. **Ref: Section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Following on from the training/ supervision it would be expected that the nurses can undertake care planning in an hollistic manner with residents regarding Palliative/ end of life care.
Recommendation 4 **Ref**: Standard 41, criterion 2 **Stated:** First time **To be Completed by:** 19 February 2016	The registered manager should ensure that at all times suitably qualified, competent and experienced staff are working at the nursing home in such numbers as are appropriate for the health and welfare of patients. **Ref: Section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: The resident dependancies / staff levels have been reviewed by the nurse manager and will be continually reviewed as the admissions change. There is on going recruitment by the home with the aim of always keeping agency use to a minimum. Rotas are always completed to ensure a good skill mix on each suite.
Recommendation 5 **Ref**: Standard 4, criterion 9 **Stated:** First time **To be Completed by:** 19 February 2016	Contemporaneous nursing records should be kept of all nursing interventions and procedures carried out in relation to each resident. The outcome of these actions should be recorded and any variance from the care plan should be documented. In particular, instances in which personal care or repositioning is refused should be appropriately documented. **Ref: Section 5.5.3**
	Response by Registered Person(s) Detailing the Actions Taken: There will be group supervisions carried out early March for all carers in the home with regards to record keeping and documentation. The RGNS are taking part in a documentation/ record keeping workshop with the quality manager on the 26th February. The manager during care plan audits will review documentation.

Registered Manager Completing QIP	Lyndsey Paul	**Date Completed**	17.02.16
Registered Person Approving QIP	V.Craddock	**Date Approved**	17/02/16
RQIA Inspector Assessing Response	Karen Scarlett	**Date Approved**	22/02/16

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