The **Regulation** and **Quality Improvement Authority**

Weaver's House
RQIA ID: 11974
Moneymore Road
Cookstown
BT80 8EH

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Unannounced Care Inspection of Weaver's House

29 February 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 29 February 2016 from 10:35 to 15:20 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.

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

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 18 May 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 Mrs Brenda Rushe, registered manager and the deputy manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Runwood Homes Ltd Mr Nadarajah (Logan) Logeswaran – Responsible Person	Registered Manager: Mrs Brenda Rushe
Person in Charge of the Home at the Time of Inspection: Mrs Brenda Rush – Registered Manager	**Date Manager Registered:** 16 January 2015
Categories of Care: NH – DE to a maximum of 30 patients RC – DE to a maximum of 24 residents RC – I, PH and PH(E) to a maximum of 11 residents	**Number of Registered Places:** 65
Number of Patients Accommodated on Day of Inspection: Nursing: 30 Residential: 32	**Weekly Tariff at Time of Inspection:** Nursing £593 Residential £470

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 and deputy manager
- discussion with staff on duty
- discussion with patients
- review of a selection of records
- observation during a tour of the premises
- evaluation and feedback.

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 and medicines management inspections
- the previous care inspection report
- the inspector's pre-inspection assessment audit

During the inspection, the inspector met with 20 patients individually and with others in smaller groups, 13 nursing and care staff and two housekeeping staff.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes
- training records
- compliment records
- supervision and appraisal planner
- three patient and five resident care records and six patient care charts
- palliative care/end of life/grievance and bereavement resource files

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 dated 23 June 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Last Care (Same specialism) Inspection

Last Care Inspection Statutory Requirements		**Validation of Compliance**
There were no requirements made		
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time	The registered person should ensure that charts relating to the management of bowels are recorded accurately ad consistently throughout the home and that senior staff evidence any action taken to address concerns regarding the bowel pattern and particularly for those patients requiring laxative therapy.	**Met**
	Action taken as confirmed during the inspection: Review of records and discussion with staff and the registered manager evidenced that this recommendation had been met.	

Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered person should ensure that staff date and sign any record they create in accordance with best practice and professional guidance. **Action taken as confirmed during the inspection**: Review of records evidenced that this recommendation had been met.	**Met**
Recommendation 3 **Ref**: Standard 4.5 **Stated:** First time	The registered person should ensure that where patients, or their families, have a personal preference for the gender of the staff providing intimate care their wishes would be recorded in the patient's care plan **Action taken as confirmed during the inspection**: Review of records and discussion with staff evidenced that this recommendation had been met.	**Met**

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A procedure on general communication was available along with additional information. The policy was reflected of DHSSPS care standards for nursing homes (Standard 19) and regional guidance on 'Breaking Bad News'.

Discussion with staff demonstrated that staff were knowledgeable regarding this guidance and of how to communicate effectively with colleagues, patients, relatives and other healthcare professionals.

Review of induction record templates for registered nurses (RNs) and care staff confirmed that staff had to complete training in relation to communicating effectively with patients and with families/representatives.

Staff spoken with and the registered manager confirmed that staff had attended training in relation to communicating effectively in December 2015.

Is Care Effective? (Quality of Management)

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

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

Is Care Compassionate? (Quality of Care)

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

The inspection process allowed for consultation with patients individually and with others in small groups. Those who could verbalise their feelings on life in Weaver's House commented positively in relation to the care they were receiving and in relation the attitude of 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.

Staff were commended by the inspectors for their knowledge and attitude toward their patients and colleagues.

Areas for Improvement

There were no requirements or recommendations made in relation to communicating effectively.

Number of Requirements:	0	Number of Recommendations:	0

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 were available to staff within a comprehensive resource file on end of life care/palliative care. The folder included a copy of the regional guidance document, Palliative and End of Life Care Guidelines for Nursing and Residential Homes produced (GAIN, November 2013). The registered manager had also included information for relatives and a tool to enable patients, relatives and staff to 'Think Ahead'.

Staff confirmed they were aware of these documents and the availability of resource file.

Review of induction records evidenced that staff were trained/inducted in the management of serious illness/deteriorating patient/resident and what to do when death occurred.

The registered manager and staff confirmed that they had attended regional training provided on palliative and end of life care in December 2015. This was also confirmed following review of training records.

The home was also participating in the ECHO project a quality improvement project which has been established by the Public Health Agency (PHA) to facilitate quality improvement in relation to palliative and end of life care within nursing homes. Participants 'logged' into an online forum via a web cam. The topics for discussion were known in advance and discussion

was facilitated. The registered manager confirmed that she and staff found this forum very effective and the knowledge gained helped improve standards of care within the home.

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

Discussion with nursing and care staff and a review of care records evidenced that staff were proactive in identifying when a patient condition was deteriorating or nearing end of life and that appropriate actions, including referrals to other healthcare professionals, had been taken.

A protocol for timely access to any specialist equipment or drugs was in place and discussion with registered nurses (RN) confirmed their knowledge of the protocol.

Is Care Effective? (Quality of Management)

A review of care records and discussion with staff evidenced that, where required, patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain, bowel and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered.

Care records evidenced discussion between the patient/resident, their representatives and staff in respect of death and dying arrangements. Within one resident's care records it was observed that the specific contact details for the resident's clergy was not included in the care plan. However, following discussion with the registered manager it was confirmed that contact details for local clergy were available in the office within the unit and that staff knew how to contact clergy.

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

Discussion with RN and care staff confirmed that reasonable arrangements for relatives/representatives had been made to ensure patients who were ill or dying could have their relatives stay with them. Staff confirmed that relatives were supported with tea, coffee, meals and advice as required.

A review of notifications of death to RQIA during the previous inspection year confirmed that any death occurring in the home was notified appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences generally and, as appropriate, in relation to end of life care.

Staff consulted demonstrated a detailed knowledge/ awareness of patients' expressed wishes and needs as identified within their care plan. Staff spoken with demonstrated clearly their compassion for the patients, their relatives and friends.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. This was commended.

Staff confirmed that as far as possible, in accordance with the person's wishes; family/friends were enabled to spend as much time as they wished with the person who was seriously ill or dying. Staff informed the inspectors of how they would provide support to families whose loved ones were dying.

From discussion with the registered manager, staff and a review of the compliments record, there was evidence that appropriate arrangements were in place within the home to support relatives during this time. Compliment records recorded that relatives had commended the management and staff for their efforts towards the family and patient. Some examples of comments made by relatives included:

'The family had no hesitation in recommending that …become a resident of Weaver's House'.

'Thank you so very much for taking such wonderful care of our … We are indebted to you for being so compassionate and tender toward …'.

'Like to thank you for the hospitality, sensitivity and respect shown to us the family as we sought to share our love and make … passing comfortable'.

There were also comments recorded by relatives in respect of individual staff praising their love, care and professionalism in caring for their loved ones.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death by attending the patient's funeral, if this was appropriate. The registered manager informed the inspectors that as a mark of respect staff and patients, as appropriate, provided a 'guard of honour' for any deceased person leaving the home.

Areas for Improvement

There were no requirements or recommendations made in relation to palliative and end of life care.

Number of Requirements:	0	Number of Recommendations:	0

5.5 Additional Areas Examined

5.5.1 Consultation with Patients, Staff and Patient Representative/Relatives

Patients

Twently patients were spoken with individually and others in small groups. Patients were complimentary regarding the standard of care they received, the attitude of staff and the food provided. Patients unable to express verbally their views indicated by their demeanour that they were content and relaxed in the home and with staff. There were no concerns raised with the inspectors.

Ten questionnaires for patients were left with the registered manager for distribution. One was returned. The patient indicated that they felt safe and that the care they received was effective and staff were compassionate. The patient did indicate that they were less satisfied with how their privacy and independence was maintained by recording the following statement, *'other*

residents enter my room, not possible to leave when I want'. The patient also recorded *'I think the staff are super they always take time to listen to one, whatever they may be doing."*

Staff

In addition to speaking with 13 staff on duty, 10 questionnaires were provided for staff not on duty. The registered manager agreed to forward these to the staff selected. At the time of writing this report seven had been returned. Staff indicated that they received training in safeguarding, whistleblowing, palliative and end of life care and that they were satisfied or very satisfied that care was safe, effective and compassionate.

Additional comments recorded included:

'I am very happy in my workplace and feel that each resident needs are all met effectively'.

'With new management the residents are the most important. The care is outstanding, dignify, choice and time to listen'.

'Residents are well cared for and everyone works together. Very happy in my post'.

'It is rewarding to work in an environment which is well equipped'.

There were no concerns raised with the inspectors or within the returned questionnaires.

Representatives/relatives

Ten questionnaires were provided for patient representatives/relatives for distribution by the registered manager. At the time of writing this report two had been returned. Relatives had indicated that they were 'most satisfied' that care was safe, effective and compassionate.

Additional comments recorded included:

'Tender, loving care are the most important things required. They are provided in Weaver's in abundance…'.

'As a family we are deeply indebted to all the staff who care for and help my … on an ongoing and daily basis'.

5.5.2 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms, bathrooms, lounge and dining rooms and storage rooms on each floor.

The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients were observed relaxing in their bedrooms or in one of the lounge areas available. Patients spoken with were complimentary in respect of the home's environment.

The house keeping staff were commended for their efforts.

5.5.3 Record keeping

Generally care records for patients and residents were found to be maintained in accordance with professional standards and the DHSSPS care standards for nursing homes.

However, it was evidenced that in one care record a care plan dated October 2015 regarding a pressure ulcer had not been updated/discontinued to reflect that the wound had healed and in another record the most recent care management review was not readily available in the care record. A recommendation had been made.

In addition discussion took place during feedback in regards to the establishment of a management overview to record a list of the Trust's care management reviews planned and undertaken for each patient/resident.

Areas for Improvement

It was recommended that care records are reviewed to ensure they accurately reflect the needs of the patient and that any records regarding reviews or discussion with other healthcare professionals are retained within the patient own care record.

Number of Requirements:	0	Number of Recommendations:	1

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Brenda Rushe, Registered Manager, and the deputy 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 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	
Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be Completed by:** 1 April 2016	Care records should be reviewed to ensure they accurately reflect the needs of the patient and when a care plan is no longer required it should be discontinued; and any records regarding care review or discussion with other healthcare professionals should be retained within the patient's own care record. Ref: Section 5.5.3
	Response by Registered Person(s) Detailing the Actions Taken: The care plan that was discontinued has now been removed from the file and all staff informed to continue this practice in the future. A copy of the residents care review is now in the file.

Registered Manager Completing QIP	Brenda Rushe	**Date Completed**	11/03/16
Registered Person Approving QIP	Logan. N. Logeswaran	**Date Approved**	14.3.16.
RQIA Inspector Assessing Response		**Date Approved**	

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

RQIA Inspector Assessing Response	Lyn Buckley	Date Approved	16/03/2016