Hillview Lodge
RQIA ID: 1201
23 Old Mountfield Road
Omagh
BT79 7EL

Inspector: Bridget Dougan
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Unannounced Care Inspection
of
Hillview Lodge

06 January 2016

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

1. Summary of Inspection

An unannounced care inspection took place on 06 January 2016 from 10.00 to 15.00 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern and no areas for improvement were identified.

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 15 April 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	0

The details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Julie Taylor, 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: Mrs Bernadette Kiernan O'Donnell	**Registered Manager:**
Person in Charge of the Home at the Time of Inspection: Mrs Julie Taylor	**Date Manager Registered:** Mrs Julie Taylor Acting Manager
Categories of Care: NH-I, NH-DE	**Number of Registered Places:** 20
Number of Patients Accommodated on Day of Inspection: 19	**Weekly Tariff at Time of Inspection:** £593 - £605

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

Prior to inspection the following records were examined:

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

During the inspection, the inspector met with 19 patients, one registered nurse, four care staff, two ancillary staff and four patients' representatives.

The following records were examined during the inspection:

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

5 The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced medicines management inspection dated 28 September 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the last care inspection on 15 April 2015

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 19.1 **Stated:** Second time	The responsible person should ensure that care plans for the management of continence should be audited regularly.	**Met**
	Action taken as confirmed during the inspection: A sample of three patients care records was reviewed. There was evidence of monthly audits of care plans including the management of continence. There was also evidence that audit findings had been acted upon to enhance continence care for patients.	
Recommendation 2 **Ref**: Standard 19.2 **Stated:** Second time	The responsible person should ensure that the incontinence management and catheter care policies are reviewed and updated to reflect best practice guidance. The manager should also ensure that a policy and procedure has been developed to cover the management of stoma care.	**Met**
	Action taken as confirmed during the inspection: Incontinence management and catheter care policies had been reviewed and updated to reflect best practice guidance. A policy and procedure on the management of stoma care was in place.	

Recommendation 3 **Ref**: Standard 13.1 **Stated:** Second time	The responsible person should ensure that activities are planned and provided with regard to the needs of the patients. Activities records should evidence a structured approach to the assessment, planning and evaluation of activities.	**Met**
	Action taken as confirmed during the inspection: Discussion with the activities therapist and review of records evidenced a structured approach to the assessment, planning and evaluation of activities. Activities were planned to meet the assessed needs of patients.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on breaking bad news. Discussion with one registered nurse and four care staff confirmed that they were knowledgeable regarding this policy and procedure.

A sample of training records reviewed evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives. Training in relation to palliative and end of life care included guidance for breaking bad news as relevant to staff roles and responsibilities. This training was completed in May 2015 with further training arranged for January 2016. Nursing staff consulted were able to demonstrate their skills and knowledge regarding this aspect of care.

Is Care Effective? (Quality of Management)

Three care records examined reflected patients' individual needs and wishes regarding end of life care. Recording within records included reference to the patient's specific communication needs, including sensory and cognitive impairments.

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

One registered nurse consulted, demonstrated her ability to communicate sensitively with patients and /or their representatives when breaking bad news. All staff demonstrated a good awareness, relevant to their role, of the need for sensitivity when communicating with patients and or their representatives.

Is Care Compassionate? (Quality of Care)

Observations of delivery of care and staff interactions with patients confirmed that communication was well maintained and patients were observed to be treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time.

Discussion with 19 patients individually evidenced that they were happy living in the home. Patients confirmed staff were polite and courteous and that they felt safe in the home.

Areas for Improvement

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 and included guidance on the management of the deceased person's belongings and personal effects. These policies and procedures referenced current best practice guidance.

Training, induction and competency and capability records evidenced that staff had received training in palliative care and the management of death, dying and bereavement. Further training was scheduled for staff in this regard. Staff spoken with clearly demonstrated their knowledge of delivering palliative and end of life care and how to support the patients and relatives at this time.

Discussion with registered 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 and other specialist practitioners.

Discussion with the manager, registered 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 palliative care link nurse had been identified for the home. The link nurse was available at time of the inspection and discussed how their role has had added value to this area of practice within the home.

A written protocol was in place for access to any specialist equipment or drugs out of hours, through the local Trust. Discussion with registered nursing staff confirmed their knowledge of the protocol.

Is Care Effective? (Quality of Management)

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

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

Discussion with the manager, one registered nurse and a review of three care records evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/ representatives to be with patients who had been ill or dying. Facilities have been made available for family members to spend extended periods with their loved ones during the final days of life. Meals, snacks and emotional support had been provided by the staff team.

A review of notifications of deaths to RQIA evidenced these were notified in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005.

Is Care Compassionate? (Quality of Care)

Discussion with one registered nurse and a review of three care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences.

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

From discussion with the manager, registered nurses and care staff and a review of the compliments records there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments records that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the 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.

Seven 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 support from management, peer support and also reflections at staff meetings.

Information regarding support services was available and accessible for staff, patients and their relatives.

Areas for Improvement

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

5.5 Additional Areas Examined

5.5.1 Consultation with patients, patient representatives and staff

Discussion took place with 19 patients individually. Comments from patients regarding the quality of care, food and in general the life in the home were very positive.

A number of patients were unable to express their views due to the frailty of their condition. All patients appeared well t presented and comfortable in their surroundings. Ten patients completed questionnaires. No concerns were raised. A few comments are detailed below:

- "Very happy and content to be in Hillview. I am well cared for and attended very well."
- "Everything is good. No problems."
- "I am very content. I have good visitors coming in and out of the home."
- "All my family are made welcome at all times. They get tea and cake when they come in to visit. I am happy in Hillview, the staff are very good."
- "Very pleased with staff. When I am down, they would comfort me and stay with me until I feel a bit better."
- "I am happy in Hillivew. All my needs are met."

Four patients' representatives met with the inspector and one patient's representative completed a questionnaire during the inspection. Overall the comments indicated that the quality of care was good, that staff were attentive and caring and that they were kept informed of changes to their loved one's care. No concerns were raised. Some comments received included:

- "Staff are lovely and caring in every aspect and we would have no hesitation in recommending this care facility."
- "Everything is very good. There are activities provided and my mother enjoys these."

Seven staff took the time to speak with the inspector and six staff completed questionnaires. The general view from staff cited in completed questionnaires and during discussions was that they took pride in delivering safe, effective and compassionate care to patients. Staff members were looking forward to receiving further training in palliative/end of life care and felt that this will enhance their knowledge in this area of practice.

Discussion with the activities therapist evidenced that she would appreciate further training in the provision of activities for patients with dementia and felt this would enhance the overall provision of activities within the home. This was discussed with the manager who agreed to address this issue.

A few staff comments are detailed below:

- “I am here 11 years and I have always got good training and always got a lot of support from management, nurses and carers.”
- “I am very pleased with the training sessions for 2015.”
- “Residents are treated with dignity and respect at all times.”

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.

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Julie Taylor	**Date Completed**	26.01.16
Registered Person	T McGarvey	**Date Approved**	29.01.16
RQIA Inspector Assessing Response	B. Dougan	**Date Approved**	01.02.16

Please provide any additional comments or observations you may wish to make below:

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