Dunmurry Manor
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# Unannounced Care Inspection
# of
# Dunmurry Manor

# 11 November 2015

The Regulation and Quality Improvement Authority
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## 1. Summary of Inspection

An unannounced care inspection took place on 11 November 2015 from 10.00 to 17:15.

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.

For the purposes of this report, the term 'patients' will be used to described those living in Dunmurry Manor 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 9 July 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** | 3 | 8 |

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

## 2. Service Details

| | |
|---|---|
| **Registered Organisation/Registered Person:**<br>Runwood Homes Ltd<br>Logan Logeswaran | **Registered Manager:**<br>Joy McKay |
| **Person in Charge of the Home at the Time of Inspection:**<br>Shelia King | **Date Manager Registered:**<br>Joy McKay– application not yet submitted |
| **Categories of Care:**<br>RC-DE, NH-DE | **Number of Registered Places:**<br>76 |
| **Number of Patients Accommodated on Day of Inspection:**<br>43 | **Weekly Tariff at Time of Inspection:**<br>Nursing - £593 - £717 per week<br>Residential - £470 - £593 per week |

## 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 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 in the previous inspection year
- the previous care inspection report

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with 10 patients, five care staff, three registered nurses staff, ancillary staff and five patient's representatives. There were no visiting professionals available during the inspection.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- the staff duty rota
- six patients' care records
- staff training records
- staff induction records
- competency and capability assessments of the registered nurse in charge of the home in the absence of the manager
- policies for communication, death and dying 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 finance inspection dated 30 July 2015. The completed QIP was returned and approved by the specialist inspector.

### 5.2 Review of Requirements and Recommendations from the Last Care Inspection dated 9 July 2015

| **Last Care Inspection Statutory Requirements** | | **Validation of Compliance** |
|---|---|---|
| **Requirement 1**<br><br>**Ref:** Regulation 13 (1) (b)<br><br>**Stated:** Third time | Care records should be maintained in an accurate and factual manner. Evidence should be present of:<br>• The accurate and complete assessment and care planning of continence needs, including a bowel assessment<br>• The daily progress record should be specific and include information referencing the Bristol Stool Chart when recording bowel patterns | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Six care records were reviewed, three from the nursing unit and three from the residential unit. There was evidence of improvement in nursing care records and a consistent approach to the assessment and care planning regarding the elimination needs of patients was present. However, the care records in the residential unit did not evidence the same level of improvement regarding consistency of approach and completion of records. | |

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| **Requirement 2**<br><br>**Ref:** Regulation 29 (5)<br><br>**Stated:** First time | Copies of the Regulation 29 reports must be available in the home. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>With the exception of October 2015 the regulation 29 reports were available for inspection. The manager stated monitoring visits had been undertaken in October however the regional manager for Runwood Homes in Northern Ireland had not forwarded the report by the time of the inspection. Please refer to section 5.5.2 for further information. | |
| **Requirement 3**<br><br>**Ref:** Regulation 17 (1)<br><br>**Stated:** First time | The auditing of care records should ensure that all sections of patients' assessment of need are completed, for example, restrictive practice and continence needs. | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br>The audits of care records which were reviewed did not evidence the date when the audit was completed, the audits were not signed/validated by the manager and the remedial action taken where a shortfall was identified was not in evidence. | |
| **Requirement 4**<br><br>**Ref:** Regulation 7, 9 and 21 Schedule 2<br><br>**Stated:** First time | Recruitment and selection procedures should be reviewed and revised, where applicable, to ensure the process is in accordance with legislation and best practice. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Three staff personnel records were selected for review. The review evidenced recruitment and selection procedures were in accordance with legislation and best practice. | |

| Last Care Inspection Recommendations | | Validation of Compliance |
|---|---|---|
| **Recommendation 1**<br><br>**Ref:** Standard 46.1 and 46.2<br><br>**Stated:** First time | Staff are to be informed that their responsibilities regarding infection prevention and control measures are to be adhered to daily and will be monitored by management. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>The review of staff training records which were submitted to RQIA evidenced that the last recorded training in respect of infection prevention and control procedures was in July 2014.<br><br>The manager was unable to provide any information in respect of how management audit the standard of infection prevention and control in the home. | |
| **Recommendation 2**<br><br>**Ref:** Standard 4<br><br>**Stated:** First time | Staff should receive training and support in respect of care planning so as their understanding of providing individualised care and support is enhanced and staff understand their responsibility and accountability regarding this area of care. Evidence is to be available in the home that the training and support, in whatever form, has taken place. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>The manager was unable to provide information to evidence and support that staff had completed training in respect of care planning. | |

## 5.3 Standard 19 - Communicating Effectively

**Is Care Safe? (Quality of Life)**

A policy and procedure was not available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. Reference was made to communicating effectively with the palliative/end of life care policy however this did not reflect the regional guidelines. Discussion with staff did not confirm that they were knowledgeable regarding this policy and procedure.

A sampling of training records did not evidence that staff had completed training in relation to communicating effectively with patients and their families/representatives. This training should include the procedure for breaking bad news as relevant to staff roles and responsibilities.

**Is Care Effective? (Quality of Management)**

Care records reflected patient individual needs and wishes regarding the end of life care. Recording within records included reference to the patient's specific communication needs

A review of care records evidenced that the breaking of bad news was discussed with patients, care and treatment plans were also discussed, where appropriate.

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

Staff were consulted and discussed their ability to communicate sensitively with patients and/or representatives. When the need for breaking of bad news was raised, care staff felt this was generally undertaken by nursing staff. However, staff were aware of communication aids/cues, for example, non-verbal cues and gestures. They also 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 was undertaken with staff regarding how they communicate with patients and their representatives.

All staff presented as knowledgeable and had a strong awareness of the need for sensitivity when communicating with patients and their representatives.

A number of communication events were observed throughout the inspection visit which validated that staff embedded this knowledge into daily practice. These observations included staff assisting patients with meals, and speaking to patients with a cognitive or sensory impairment. There was a calm, peaceful atmosphere in the home throughout the inspection visit.

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

**Areas for Improvement**

A policy on communicating effectively which reflects the regional guidance, breaking bad news should be written and made available to staff.

Training in respect of communicating effectively should be undertaken by staff.

Management should implement a system to evidence staff have read the policy on communicating effectively.

| **Number of Requirements:** | **0** | **Number of Recommendations**: | **3** |
|---|---|---|---|

## 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 documents did not reflect best practice guidance such as the Gain Palliative Care Guidelines, November 2013. The guideline referenced within the policy was the NICE 2004 guidelines.

Training records did not evidence that staff were trained in the management of death, dying and bereavement. However, registered nursing staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

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.

There was no specialist equipment, for example, syringe drivers, in use at the time of the inspection.

### 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 evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A key worker/named nurse were identified for each patient approaching end of life care.

Discussion with the manager and staff 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.

A review of notifications of death to RQIA during the previous inspection year, evidenced they were appropriately submitted.

### Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of six care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding their 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. Arrangements also included the provision of catering/snacks.

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 would be given an opportunity to pay their respects after a patient's death.

**Areas for Improvement**

The policy on palliative and end of life care should be reviewed and amended to reflect the Gain Palliative Care Guidelines, November 2013

Staff should undertake training in respect of palliative and end of life care.

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

## 5.5 Additional Areas Examined

### 5.5.1. Questionnaires

As part of the inspection process, we issued questionnaires to staff and patients. We observed care practice and spoke to patients on an individual and/or small group basis.

**Staff Views**

Six staff completed questionnaires. All staff agreed that patients were treated with dignity and respect. Five of the returned questionnaires confirmed staffs' satisfaction with all aspects of patient care in respect of palliative and end of life care.

One respondent expressed dissatisfaction with:
- the arrangements in place to manage patient's pain
- supportive systems were not in place to inform patients and staff of a death
- supportive systems were not in place to enable staff to pay their respects following the death of a patient

**Patient's Representative Views**

Five patient's representatives completed and returned a questionnaire. We spoke to six patient's representatives at the time of the inspection.

Comments included:
"Nursing care has really improved; they are very fast at getting GP advice, if necessary."
"Dunmurry Manor has the potential to be a very good care home, things have greatly improved since Shelia, Alison and Carol stepped in and started turning things around."
"I think the company still need to work on staff morale."
"Issues remain regarding laundry services the amount of sugary food available and portion sizes."
"The home addresses any issues I have over care and medication promptly."
"The staff have made every effort to form a relationship with me and keep me informed. I find their support for myself a great help at a very stressful time."

"I have nothing but positive comments about the staff and facilities at Dunmurry Manor."
"I find everything very satisfactory, my thanks go to staff at all levels."
"Dunmurry Manor is a very good care home, on a score of 1-10 I would give it 9."
"The home has improved considerably since August."
"Staff are fantastic and the manager is approachable."
"Good and bad staff, routines not always kept."

### 5.5.2. Governance and Management Arrangements

The governance and management arrangements in Dunmurry Manor have been disrupted during the year due to a number of management changes. However, Shelia King assumed general management responsibilities for the home in August 2015 and Alison Wylie was appointed as the deputy manager and clinical lead in October 2015. A new manager has been appointed Joy McKay and Ms McKay will commence in the home in December 2015.

Ms King stated her focus from commencing in the home has been to improve care standards, enhance communication and relationships with relatives and stabilise the staff team. Relatives who met with inspectors and/or completed questionnaires confirmed that there has been improvement in these areas from August 2015. This is commendable.

However, the need for robust governance and management arrangements must now be given a priority as compliance with regulatory requirements must be in evidence.

The review of the quality of services provided by the home through the completion of quality audits was not available. We were unable to review quality audits for, for example; infection control and cleanliness and hygiene. Audits of care records were made available but these audits did not evidence a systematic approach to the auditing of care records. Evidence was not present of the date when the audit was completed or where a shortfall had been identified that remedial action had been taken. This requirement has been stated for a second time.

Regulation 29 monthly monitoring reports were available, with the exception of the report for October 2015. The reports were completed by Northern Ireland Operational Director for Runwood Homes, John Rafferty. Mr. Rafferty visits the home a number of times per month. The dates of the visits were listed on the monthly report. However, the report read as a summary of the collective visits as opposed to an in-depth assessment of a specific visit, which is specified in The Nursing Homes Regulations (Northern Ireland) 2005. A recommendation has been made.

Staff training records were not available at the time of the inspection and were submitted to RQIA at a later date. The review of the submitted information did not evidence training requirements of staff were completed in accordance with regulatory requirements. The information submitted did not evidence any training had taken place from July 2014. This was very concerning as there was no evidence that staff had completed training or updated training on an annual basis in, for example; fire safety procedures or the protection of vulnerable adults. A requirement has been made.

The complaints record must be maintained in accordance with Regulation 24, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The complaints record maintained by the home must evidence all communication with complainants; the result of any investigation; the action taken, whether or not the complainant was satisfied with the outcome, and how the level of satisfaction was determined. A recommendation has been made.

A more systematic and robust programme of quality auditing must be implemented. The issues identified during the inspection should have been identified by the home and regional management and remedial action taken, for example auditing the quality of services provided by the home and staff training requirements.

## 6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Shelia King, general 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.

## Quality Improvement Plan

| Statutory Requirements | |
|---|---|
| **Requirement 1**<br><br>**Ref:** Regulation 17 (1)<br><br>**Stated:** Second time<br><br>**To be Completed by:**<br>11 January 2016 | The auditing of care records should ensure that all sections of patients' assessment of need are completed, for example, restrictive practice and continence needs.<br><br>**Ref: Section 5.5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Care record audits have a new revised format and this will cover all of the residents' needs. This new process will be implemented from January 2016. |
| **Requirement 2**<br><br>**Ref:** Regulation 20 (1) (c) (i)<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>8 February 2016 | The registered person must ensure staff undertake mandatory training in accordance with the required timescales. A record of any training undertake by staff must be retained in the home and be available for inspection.<br><br>**Ref: Section 5.5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>All staff have received their mandatory training within the required time scales. Staff that are reaching their training deadlines are notified. A record will be maintained in the home for inspection. |
| **Requirement 3**<br><br>**Ref:** Regulation 19 (2) Schedule 4<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>11 January 2016 | The registered person must ensure all records. As specified in Schedule 4, are retained in the home and are available for inspection.<br><br>**Ref: Section 5.5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>All records detailed in schedule 4 are available for inspection. |

| Recommendations | |
|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 46.1 and 46.2<br><br>**Stated:** Second time<br><br>**To be Completed by:**<br>11 January 2016 | Staff are to be informed that their responsibilities regarding infection prevention and control measures are to be adhered to daily and will be monitored by management. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>A Clinical lead has been appointed who has infection control responsibilities and will over see this area. This person will report to the manager and complete infection control audits and these records will be maintained for inspection. |
| **Recommendation 2**<br><br>**Ref**: Standard 4<br><br>**Stated:** Second time<br><br>**To be Completed by:**<br>11 January 2016 | Staff should receive training and support in respect of care planning so as their understanding of providing individualised care and support is enhanced and staff understand their responsibility and accountability regarding this area of care. Evidence is to be available in the home that the training and support, in whatever form, has taken place. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Care planning training is incorporated into the preceptorship training. Further care planning training is planned for early 2016 and a record will be maintained for inspection |
| **Recommendation 3**<br><br>**Ref**: Standard 19.1<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>11 January 2016 | A policy on Communicating Effectively should be written. The policy should reflect regional guidance document, Breaking Bad News<br><br>**Ref: Section 5.3** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>A new policy on communication is being developed. There is already available a number of policies which deal with communication. These include a new policy on breaking bad news and communicating difficult information. |
| **Recommendation 4**<br><br>**Ref**: Standard 19 and 32<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>8 February 2016 | Training on communicating effectively and palliative and end of life care should be undertaken by staff.<br><br>**Ref: Sections 5.3 and 5.4** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Training has already been provided to staff on communicating effectively and this was included in the palliative and end of life care training already undertaken by staff.There is new guidance published for all staff members called Caring at end of life / a summary of best practice, support and guidance for care staff. |

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| **Recommendation 5**<br><br>**Ref**: Standard 19 and 32<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>11 January 2016 | Management should implement a system to evidence staff have read the policy on communicating effectively and palliative and end of life care.<br><br>**Ref: Sections 5.3 and 5.4** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>A record will be maintained to illustrate that staff have read the indicated policies. |
| **Recommendation 6**<br><br>**Ref**: Standard 32<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>11 January 2016 | The home's policy on palliative and end of life care should reflect current best practice/regional guidelines, Gain Palliative Care Guidelines, November 2013.<br><br>**Ref: Section 5.4** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The current policy on palliative care does reflect current best practice / regional guidelines and includes the Gain guidelines. |
| **Recommendation 7**<br><br>**Ref**: Standard 35.7<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>11 January 2016 | The Regulation 29 monthly monitoring report should reflect on one visit to the home to monitor the quality of services. In keeping with Regulation 29, The Nursing Homes Regulations (Northern Ireland) 2005, this visit should be unannounced.<br><br>**Ref: Section 5.5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>A new regulation 29 monthly monitoring report wil be formulated to reflect one visit to the home. There will be a section to include other visits as well. |
| **Recommendation 8**<br><br>**Ref**: Standard 16.11<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>11 January 2016 | The complaints record maintained by the home must evidence all communication with complainants; the result of any investigation; the action taken, whether or not the complainant was satisfied with the outcome, and how the level of satisfaction was determined.<br><br>**Ref: Section 5.5.2** |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>The complaints records are being reviewed in line with the inspector's recommendations. |

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| **Registered Manager Completing QIP** | Joy McKay | **Date Completed** | 18/12/15 |
| **Registered Person Approving QIP** | Logan. N Logeswaran | **Date Approved** | 22.12.15 |
| **RQIA Inspector Assessing Response** | | **Date Approved** | |

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| **RQIA Inspector Assessing Response** | Heather Sleator | **Date Approved** | 04/02/16 |