Parkside
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4 North Circular Road
Lisburn
BT28 3AH

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Unannounced Care Inspection
of
Parkside

20 July 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 20 July 2015 from 10.00 to 15.30.

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

Overall 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. A Quality Improvement Plan (QIP) is not included in 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.

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 16 December 2014.

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Arthur Dodds	**Registered Manager:** Paulene Rogers
Person in Charge of the Home at the Time of Inspection: Gloria Polancos	**Date Manager Registered:** 1 April 2005
Categories of Care: NH – I, NH – PH, NH – PH(E), NH - TI	**Number of Registered Places:** 29
Number of Patients Accommodated on Day of Inspection: 26	**Weekly Tariff at Time of Inspection:** £593 - £637 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
- pre inspection assessment audit

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with 12 patients, three care staff, two nursing staff, one ancillary staff member and one visiting relative. 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
- three patient care records
- accident/notifiable events records
- staff training records
- staff induction records
- records of competency and capability of the registered nurse in charge of the home in the absence of the registered manager
- policies for communication, death and dying and palliative and end of life care were unavailable at the time of inspection however, they were forwarded to RQIA at a later date

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced pharmacy inspection dated 18 May 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 19.1 **Stated:** First time	It is recommended the continence assessment is revised to provide comprehensive and detailed assessment information.	**Met**
	Action taken as confirmed during the inspection: The review of four patients' care records evidenced the continence assessment had been revised and more detail was provided.	
Recommendation 2 **Ref**: Standard 19.1 **Stated:** First time	It is recommended continence care plans detail the type of continence product to be used and the details of the patient's toileting programme. **Ref: Criterion 19.1**	**Met**
	Action taken as confirmed during the inspection: The review of four patients' care records evidenced the type of continence product required and the frequency of assistance required was stated.	

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 staff confirmed that they were knowledgeable regarding this policy and procedure.

A sampling of staff training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives. This training included the procedure for breaking bad news as relevant to staff roles and responsibilities.

Is Care Effective? (Quality of Management)

Four care records reflected patients' individual needs and wishes regarding the end of life care. Recording within records included reference to the patient's specific communication needs (inspectors to include examples where appropriate of any barriers such as, language, cognitive ability, or sensory impairment).

A review of four 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 the records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Three care staff and two registered nurses 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 a registered nurse or the registered manager

Is Care Compassionate? (Quality of Care)

Discussion was undertaken with staff regarding how staff communicates 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, speaking to frail, ill patients. 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 day one in 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.

The inspection consulted with 12 patients individually. All patients confirmed that staff treated them with respect and dignity at all times. No patient representatives were available during the inspection visit.

Areas for Improvement

There were no areas for improvement identified.

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 documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects.

Training records evidenced that staff were trained in the management of death, dying and bereavement. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

A review of training records evidenced that the following training had been completed by staff:

Supporting Patients and Carers at End of Life – 15 staff, February 2015
Palliative Pain and Symptom Management – 5 registered nurses, April 2015
Palliative Care for Nursing Home Staff – 8 staff, February 2014
End of Life Care – 8 staff, November 2013
Assessment of the Deteriorating Patient – 6 registered nurses, February 2014

The registered manager had completed training In February 2015 which included the following aspects; grief, a normal response to loss, providing effective support in grief situations and creating a supportive work environment.

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 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 protocol for timely access to any specialist equipment or drugs was in place and discussion with staff confirmed their knowledge of the protocol.

There was no specialist equipment in use in the home at the time of the inspection.

A palliative care link nurse had been identified within the staff team.

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 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 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 staff and a review of 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.

Reviews of notifications of death to RQIA during previous inspection year were appropriately submitted.

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 spiritual preferences regarding end of life care. Staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

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.

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

Recent comments included:
"Thank you for your unfailing care."
"Can't thank you enough for the way you have cared for my …."
"No words can express what it meant to us knowing that our … was so well cared for."
"Thank you for all the professional care, dignity, love and support you gave my …"

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 confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements include bereavement support; staff meeting and 1:1 counselling. Staff informed that the registered manager accompanied a staff member on a course as she knew the staff member becomes very emotional regarding end of life care.

Information regarding support services was available and accessible for staff, patients and their relatives on a notice board in the home.

Areas for Improvement

There were no areas for improvement identified.

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

5.5 Additional Areas Examined

Questionnaires

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

Questionnaire's issued to	Number issued	Number returned
Staff	10	10
Patients	0	0
Patients representatives	5	4

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

Staff

"I have experience of care homes previously and can honestly say the team and care provided at Parkside is the best I have ever seen."
"Each patient is respected and treated as an individual and we aim to provide a place where the patient can feel at home."
"We are always getting great feedback from relatives and friends of patients."
"A relative from abroad praised us for the care we give; said Parkside was more a home than a nursing home."
"Parkside is a well-run home."
"I feel Parkside is one of the nicest homes in the area."
"I feel management work hard to achieve such high standards."
"I am proud to be a part of Parkside."

Relatives

"I feel that my ... is well looked after in the home and staff are very good."
"I am very satisfied that Parkside is the right place for my …"
"We are very satisfied with the care and attention given by staff."
"Staff give every consideration with great patience."
"The home cooking compliments the home."
"Staff are very helpful and polite."

Patients

"This is a very good home."
"I am happy here."
"If anything was wrong I could speak to the staff."
"I have no complaints."

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Paulene Rogers	**Date Completed**	14.8.2015
Registered Person	Arthur Dodds	**Date Approved**	14.8.2015
RQIA Inspector Assessing Response	Heather Sleator	**Date Approved**	14/08/2015

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

***Please complete in full and returned to RQIA nursing.team@rqia.org.uk ***