



The Regulation and
Quality Improvement
Authority

Inspector: Linda Thompson
Inspection ID: IN021783

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**Unannounced Care Inspection
of
Hawthorn House**

2 June 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 02 June 2015 from 08.45 to 15.00.

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 found no significant areas of concern.

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 30 October 2014.

1.2 Actions/Enforcement Resulting from this Inspection

Urgent actions or 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

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care/Dr Maureen Claire Royston	Registered Manager: Kerrie Wallace
Person in Charge of the Home at the Time of Inspection: Sonia Barbosa registered nurse followed by the registered manager from 10am onwards.	Date Manager Registered: 1 June 2010
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	Number of Registered Places: 32
Number of Patients Accommodated on Day of Inspection: 29	Weekly Tariff at Time of Inspection: £648 - £668

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 standard has been met:

Standard 19: Communicating Effectively

Standard 20: Death and Dying

Standard 32: Palliative and End of Life Care

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 in the previous inspection year
- the previous care inspection report

During the inspection the delivery of care and care practices were observed. An inspection of the general environment of the home was also undertaken. The inspection process allowed for discussion with 29 patients either individually or in small groups. Discussion was also undertaken with six care staff, three nursing staff and three patient's representatives.

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP
- the staff duty rota
- three patient care records
- records of accident/notifiable events
- 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.

5.0 The Inspection

5.1 Review of Requirements and Recommendations from the last care inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
<p>Requirement 1</p> <p>Ref: Regulation 19</p> <p>Stated: First time</p>	<p>The registered person must ensure that accurate records in keeping with schedule 3 are maintained.</p> <p>Records such as;</p> <ul style="list-style-type: none"> • Bowel function should be recorded in the individual patient's progress notes • Fluid intake and output records must be accurately totalled and the information transferred into daily progress records. <p>Action taken as confirmed during the inspection: Inspector confirmed that patient care records are maintained as required in respect of bowel function and fluid intake and output records.</p>	Met
<p>Requirement 2</p> <p>Ref: Regulation 14(1)(b)</p> <p>Stated: First time</p>	<p>The registered manager must ensure that the identified patient is referred to the GP or the continence nurse specialist in the referring HSC Trust for guidance on the management of the patient's urinary catheterisation.</p> <p>Action taken as confirmed during the inspection: Inspector confirmed that the identified patient had been referred to the appropriate member of the multi professional team as required.</p>	

5.1 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Policy guidance for staff was available on communicating effectively and referred to regional guidelines on 'breaking bad news'.

A sampling of communication training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives.

Is Care Effective? (Quality of Management)

Three care records evidenced that patients individual needs and wishes in regards to daily living were appropriately recorded.

Recording within care records did include reference to the patient's specific communication needs.

The registered manager did however agree that the barrier to communication in this area rests with staff and their concerns regarding the sensitivity of the issue. It was further agreed that training on breaking bad news and communication around end of life care would be very beneficial for all grades of staff. This training is already ongoing in the home.

A review of three care records evidenced that the breaking of bad news was not discussed with patients and/or their representatives other than in respect of a DNAR directive.

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

Two registered nursing staff consulted, demonstrated their ability to communicate sensitively with patients when breaking bad news. They advised they sat down with the patient in a private area, held the patients hand and using a calm voice, spoke with the patient in an empathetic manner using clear speech offering reassurance and an opportunity for the patient to ask any questions or voice any concerns. Care staff considered the breaking of bad news to be the responsibility of the registered nursing staff and failed initially to recognise that they would do this on a regular basis and that it does not necessarily mean informing a patient that a loved one has died.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and many staff interactions with patients, the inspector can confirm that communication is well maintained and patients are observed to be treated with dignity and respect. There were a number of occasions when patients had been assisted to redirect their anxieties by care staff in a very professional way.

The inspection process allowed for consultation with 20 patients. In general the patients all stated that they were very happy with the quality of care delivered and with life in Hawthorn House. They confirmed that staff were polite and courteous and that they felt safe in the home.

One patient's representatives discussed care delivery with the inspector and also confirmed that they were very happy with standards maintained in the home.

A number of compliment cards were displayed from past family members.

Areas for Improvement

There were no specific areas of improvement identified for the home in respect of communication.

Number of Requirements:	0	Number of Recommendations:	0
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5.2 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and 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 recently updated and available for inspection. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013. The registered manager and two registered nursing staff were aware of the Gain Palliative Care Guidelines November 2013 a copy of which was available in the home.

Training records evidenced that registered nursing staff were trained in the management of death, dying and bereavement. This training was available within the homes e learning system and whilst it was not considered mandatory by Four Seasons Healthcare the registered manager actively encourages all grades of staff to complete these modules.

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

The home maintains one registered nurse as a palliative care link nurse. The link nurse attends the regular palliative group meetings and minutes were available for reference in the home.

Discussion with the registered manager, seven staff and a review of three 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 two registered nursing staff confirmed their knowledge of the protocol.

The registered nursing staff confirmed that they are able to source a syringe driver via the community nursing team if required. It was also confirmed that staff are trained in the use of this specialised equipment.

Is Care Effective? (Quality of Management)

A review of the care records for one patient who was considered as receiving end of life care were examined. In addition, two care records for patients who were receiving palliative care were also examined. All three care records evidenced that patients' needs for palliative or end of life care were assessed and reviewed on an ongoing basis and documented in patient care plans. This included the management of hydration and nutrition, pain management and symptom management. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. This mostly referred to the establishment of a DNAR directive and did not wholly consider other end of life situations.

Discussion with the registered manager, two registered nurses, four care staff and a review of three care records evidenced that environmental factors had been considered when a patient was end of life. Staff consulted confirmed that 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 has been provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that all had been reported 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. Nursing staff were able to demonstrate an awareness of patient's expressed wishes and needs in respect of DNAR directives as identified in their care plan.

Arrangements were in place in the home to facilitate, as far as possible the patient's wishes, for family/friends to spend as much time as they wish with the person. Staff discussed openly a number of recent deaths in the home and how the home had been able to fully support the family members in staying overnight with their loved ones.

From discussion with the registered manager and 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.

One such comment from the family of a recently deceased patient is detailed below;

'We have always found Hawthorn House very homely and each member of staff shows genuine love, care and concern not only to my mum but also to us. You were always able to listen and showed real love and thoughtfulness.'

No concerns were raised by relatives in relation to the arrangements regarding the end of life care of patients in the home.

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

From discussion with the registered manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included 1:1 support from the registered manager and support through staff meetings. Information regarding bereavement support services was available and accessible for staff, patients and their relatives.

Areas for Improvement

No areas for improvements are identified at this time.

Number of Requirements:	0	Number of Recommendations:	0
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5.3 Additional Areas Examined

Consultation with patients, their representatives, staff and professional visitors

As part of the inspection process 10 patients were spoken with individually or in small groups. Comments from patients regarding the quality of care, food and in general the life in the home were very positive. A few comments received are detailed below;

'I am very happy here there is usually something to do each day.'

'I have a lovely room and have made the right decision to live here.'

'I would rather be at home but I realise that I need more help and need to be in the home.'

Questionnaires were issued to a number of nursing, care and ancillary staff and these were returned during the inspection visit. The general findings from all questionnaires confirmed that staff felt that care delivered in Hawthorn was safe, effective and compassionate. No additional comments were recorded on any of the questionnaires returned.

One patient representative discussed the quality of care delivery with the inspector and agreed that they have no concerns in recommending the home and they were very happy with the standards of service provided.

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.

6.0 Quality Improvement Plan

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Kerrie Wallace	Date Completed	12.6.15
Registered Person	Dr Claire Royston	Date Approved	15.06.15
RQIA Inspector Assessing Response	<i>Kerrie Thompson</i>	Date Approved	19/6/15

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

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