Lansdowne
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Unannounced Care Inspection
of
Lansdowne

30 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 30 July 2015 from 09.10 to 17.50.

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 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.

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 20 October 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	4

The details of the Quality Improvement Plan (QIP) within this report were discussed with the manager Karen Agnew and the deputy manager She Pastrana as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care Dr Maureen Claire Royston	**Registered Manager:** Karen Agnew (Acting)
Person in Charge of the Home at the Time of Inspection: Karen Agnew	**Date Manager Registered:** Karen Agnew – application not yet submitted
Categories of Care: NH – DE; NH – I; NH – PH; NH – PH(E); NH – TI	**Number of Registered Places:** 86
Number of Patients Accommodated on Day of Inspection: 52	**Weekly Tariff at Time of Inspection:** £593 - £637

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 analysed:

- 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, the inspector met with 10 patients, five care staff, four registered nurses and four patient's visitors/representative.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- the staff duty rota
- six patient care records
- accident/notifiable events records
- staff training records
- staff induction records
- policy documentation in respect of communicating effectively, palliative and end of life care
- complaints
- compliments
- best practice guidelines for palliative care and communication

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced Estates inspection dated 24 November 2014. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection on 10 October 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 14 (5) **Stated:** First time	The Registered Person must ensure that patients are not restrained unless as a last resort and agreed by a multi-disciplinary team and recorded in accordance with best practice guidance on restraint. **Ref: Section 12**	**Met**
	Action taken as confirmed during the inspection: A sample review of the patient's care records evidenced that the use of a restrictive practice had been discussed with the multi-disciplinary team and recorded in accordance with best practice guidance on restrictive practice.	
Requirement 2 **Ref**: Regulation 15 (2) (a) (b) **Stated:** First time	The Registered Person must ensure that patients' needs are reviewed and care plans updated following a change in circumstances, for example, on return to the home following a hospital admission. **Ref: Section 10**	**Met**
	Action taken as confirmed during the inspection: A sample review of patients' care records evidenced that care plans had been updated following a hospital admission.	

Requirement 3 **Ref**: Regulation 14 (2) (a) (b) (c) **Stated:** First time	The Registered Person must ensure as far as reasonably practicable that all parts of the home to which patients have access are free from avoidable risks • the electric room must remain locked when not in use • the storage of equipment in the electric room must cease • sluice rooms must remain locked when not in use • bed mattresses must not be used as crash mats or "fall out mats" **Ref: Section 11**	**Met**
	Action taken as confirmed during the inspection: On inspection, the electric room was locked and was not being used for storage. The sluice room in the dementia unit was open when it should have been locked. This was discussed with the manager who gave assurances that she would follow up with staff and the door would remain locked. No mattresses were seen to be used as crash mats.	
Requirement 4 **Ref**: Regulation 20 (1) (c) **Stated:** First time	The Registered Person must ensure that staff receive training in relation to the use of restraint. **Ref: Section 12**	**Met**
	Action taken as confirmed during the inspection: Training statistics on restrictive practice were forwarded to the inspector and the manager confirmed that 40 staff members out of 63 have completed the training in the use of restraint. Further training dates have been requested.	
Requirement 5 **Ref**: Regulation 13 (7) **Stated:** First time	The Registered Person must make suitable arrangements to minimise the risk of infection • patients clothing and belongings must not be stored in the bathroom **Ref : Section 12**	**Met**
	Action taken as confirmed during the inspection: Patients clothing and belongings were not stored in the bathroom.	

Requirement 6 **Ref**: Regulation 13 (1) (a) **Stated:** First time	The Registered Person must ensure that recommendations made by the Tissue Viability Nurse are undertaken and recorded in the patients' care records in relation to pressure area care. **Ref: Section 10 and Section 11**	**Met**
	Action taken as confirmed during the inspection: A sample review of patients' care records evidenced the recommendations made by the tissue viability specialist nurse had been implemented and care plans had been updated.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 13.2 **Stated:** First time	The registered person should review the provision of activities to ensure the needs of patients who have dementia are met. **Ref: Section 11**	**Met**
	Action taken as confirmed during the inspection: An activities person for the dementia unit has been interviewed and is currently awaiting an Access NI clearance. Seven Care assistants in the dementia unit have received training in the provision of activities.	
Recommendation 2 **Ref**: Standard 32.3 **Stated:** First time	The registered person should develop the environment in the dementia unit in accordance with best practice guidance to meet the needs of patients who have dementia. **Ref: Section 11**	**Met**
	Action taken as confirmed during the inspection: The theming of corridors in the dementia unit has been well developed. The manager confirmed that other plans are in place for the future theming of a corridor currently not themed.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was not available on communication. This was discussed with the manager and a recommendation has been made that a policy on communication should be developed. Regional guidance on Breaking Bad News was available in the home. Discussion with eight staff confirmed that they were knowledgeable regarding breaking bad news.

A sampling of training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives. This training, which involved 12 staff, included residents' experience training where staff are put in the place of the patients and offered similar experiences as patients would face on a regular day. Sensory impairment training was completed by 16 staff. Lansdowne Nursing home is also involved with Queens University Belfast in promoting informed decision making and effective communication through advance care planning for people living with dementia and their family / carers. This was noted as a commendable exercise enhancing the end of life care for the patients.

Is Care Effective? (Quality of Management)

Four nursing care records evidenced that patients' individual needs and wishes in regards to daily living and end of life decisions were appropriately recorded.

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

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

Four registered nurses consulted demonstrated their ability to communicate sensitively with patients and/or their representatives when breaking bad news. They discussed the importance of an environmentally quiet private area to talk to the recipient and the importance of using a soft calm tone of voice using language appropriate to the listener. Staff also described the importance of reassurance and allowing time for questions or concerns to be voiced**.** Care staff were also knowledgeable on breaking bad news and offered similar examples when they have supported patients when delivering bad news. A best practice guideline on Breaking Bad News was available in the Home.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and staff interactions with patients, it was evident that effective communication was well maintained and patients were observed to be treated with dignity and respect.

The inspection process allowed for consultation with nine patients individually and others in small groups. All patients stated they were very happy with the care they were receiving in Lansdowne. They confirmed that staff were polite and courteous and they felt safe in the home.

One patient representative discussed care delivery and confirmed that the care their relative was receiving matched their care needs. They felt any issue was dealt with immediately and the "nurses were second to none." Some other patient representative comments are recorded in section 5.5.1 below.

Areas for Improvement

The registered person should develop a policy and procedure on communication in line with best practice guidelines and make reference to regional guidance on breaking bad news.

Number of Requirements:	**0**	**Number of Recommendations**:	**1**

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; Living Matters Dying Matters; European Association for Palliative Care; Palliative Care a Human Right and the End of Life Care for People With Dementia. Information leaflets on Caring at the End of Life and Grief and Bereavement were available at the entrance to the home.

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. Three staff had completed the European Certificate in Palliative Care and four other staff had completed Palliative Care Awareness training in June/July 2015. Further palliative awareness training is scheduled for October 2015. Six staff had completed recent training on the use of syringe drivers.

A review of the staff training records evidenced that six staff had completed supervision in respect of palliative/end of life care carried out by the deputy manager and covered areas such as contacting the palliative care team, palliative care support, out of hour's access to syringe drivers and out of hours nursing team.

Discussion with four registered nurses 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, six 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 four staff confirmed their knowledge of the protocol.

The manager is the identified palliative care link nurse for the home.

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 individual wishes were also considered.

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 acting 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. Through discussion, there was evidence that staff had managed shared rooms.

A review of notifications of death to RQIA during the previous inspection year, were deemed to be appropriate.

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 regarding end of life 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. Staff were able to discuss previous examples of where they provided light refreshments and offered comfort measures, such as comfortable chairs for family/friends to spend time with their loved ones. 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 two concerns were raised in relation to communication following the death of a patient and both were very quickly resolved following management intervention.

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

Areas for Improvement

There were no areas for improvement in relation to palliative care / death and dying.

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

5.5 Additional Areas Examined

5.5.1. Consultation with patients, their relatives/representatives and staff

During the inspection process, nine patients, 10 staff and four patient representatives were consulted to ascertain their personal view of life in Lansdowne. Six staff and six patient questionnaires given out were returned and one patient representative questionnaire was returned. Overall, the feedback from the patients, representatives and staff indicated that safe, effective and compassionate care was being delivered in Lansdowne.

A few patient comments are detailed below:
'It's very comfortable. The girls are very good.'
'I love it here.'
'It's like a holiday camp.'
'The nurses are very good. It's fine here.'

One relative stated she was very happy with the care her mother was receiving. However, she was not happy with the shared room environment. This matter was passed to the manager to address. Another relative expressed that her mother has received first class treatment and that the staff were always responsive to her needs.

In general, the staff were satisfied and enjoyed working in Lansdowne.

A few staff comments are as follows:
'This is a wonderful place to work. I'm not leaving.'
'I really enjoy it here working with the elderly.'
'The staff are very friendly and I like working here.'
'I love it working here.'

Some staff commented on the pressure of working short staffed. Following a discussion with the staff members, it was noted that the staff shortage is occasional/short notice sick leave. This was brought to the manager's attention who gave assurance that when someone rings in sick, the home tries to obtain sickness cover through contacting staff not on duty and/or bank and agency staff to cover the shift. The manager also gave assurance that she follows the organisation's attendance management policy in relation to managing staff sick leave.

5.5.2. Quality Assurance

The manager carries out monthly audits in respect of the quality of nursing and other services provided by the home. However, it was also noted that the deficit findings in the audits did not include an action plan to address the shortfalls nor did they include any documented record of outcomes. This was discussed with the manager who had in the past re-audited the field to address any deficit. A recommendation has been made for action plans and documented outcomes to be added to the auditing process.

5.5.3. Infection Prevention and Control and the Environment

A tour of the home confirmed that rooms and communal areas were clean and spacious.

However, a range of matters were identified that were not managed in accordance with infection prevention and control guidelines:

- not all signage and noticeboards within the home were laminated/treated to ensure the surface may be cleaned
- the top of a patients chair in the dining room was ripped and the stuffing protruding through
- the type of shelving used in the home in the identified storage area did not have a cleanable surface
- there was inappropriate storage and clutter in identified rooms in the home.

All of the above was discussed with the manager on the day of inspection. The manager agreed that signage and noticeboards would be laminated/treated. The chair was confirmed as a specially fitted chair for the patient and that remedial action would be taken until a new chair is delivered. Shelving would be changed/resurfaced. Items would be stored correctly and clutter prevented. An assurance was given by the manager that these areas would be addressed with staff to prevent recurrence. A recommendation is made for management systems to be in place to ensure the home's compliance with best practice in infection prevention and control.

5.5.4. Activities

The home does not have an activities coordinator in the dementia unit. Discussion with the manager confirmed that an interview was conducted for the post at the beginning of June and they are awaiting final documentation before the person commenced in the home. Currently seven staff in the dementia unit undertakes activities with the patients and have completed the organisations 'Meaningful Activity' training.

5.5.5. Staff training and Development

Whilst there was evidence of staff training and development, there was a deficit noted in the recording of training attended by staff. A training matrix needs to be developed and maintained to reflect all current staff training attended and to ensure lapsed training or training to be scheduled is identified. A recommendation has been made.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the manager, Karen Agnew and the deputy manager, She Pastrana 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 Manager/Registered Person

The QIP must be completed by the registered person/ 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 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.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 36 Criteria (1) (2) **Stated:** First time **To be Completed by:** 30 August 2015	A policy on communication should be developed which includes reference to current best practice guidelines. A system to implement the policy should confirm that all relevant staff have read the document with evidence of staff signature and date. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: FSHC currently working on this policy
Recommendation 2 **Ref**: Standard 35 Criteria (16) **Stated:** First time **To be Completed by:** 30 August 2015	Quality monitoring and audit systems in the home should evidence the action taken to address any identified shortfall and improvement with validation of outcomes by the manager. **Ref: Section 5.5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Defecits identified during audit will be added to the home remedial action plan with clearly defined actions,timescales for completion and followup.
Recommendation 3 **Ref**: Standard 46 Criteria (1) (2) **Stated:** First time **To be Completed by:** 15 September 2015	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection. **Ref: Section 5.5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Cork notice boards being replaced on rolling basis - these have already been sealed wth clear varnish. Monitoring of identified rooms is included in the managers daily audit of the facility.Signage has been reviewed and where necessary laminated.Maintencemen are in the process of sealing the open plan shelving with wipeable varnish/paint. The specialist chair has been repaired by BHSCT.

Recommendation 4 **Ref**: Standard 39 Criteria (9) **Stated:** First time	The registered person should ensure a more robust system of recording staff training is developed to ensure that staff attend training and achieve and maintain competency as well as meeting requirements for ongoing professional development. **Ref: Section 5.5.6**
To be Completed by: 30 August 2015	**Response by Registered Person(s) Detailing the Actions Taken:** FSHC have implemented a new online training system. Initial difficulties accessing a training matrix have been addressed. However it should be noted that a training matrix from prior system was available within the home completed 20/04/15

Registered Manager Completing QIP	Karen Agnew	**Date Completed**	22/9/15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	25.09.15
RQIA Inspector Assessing Response	Dermot Walsh	**Date Approved**	29/9/15

Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address