Mullaghboy
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Unannounced Care Inspection
of
Mullaghboy

21 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 21 July 2015 from 09.30 to 13.30.

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 significant areas of concern; however, two areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within 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 16 February 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	2

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

2. Service Details

Registered Organisation/Registered Person: Mullaghboy Nursing Home/Robert Maxwell Duncan, Heather Duncan & Anne Duncan	**Registered Manager:** Anne Dugan
Person in Charge of the Home at the Time of Inspection: Ryan Ingram, registered nurse initially followed shortly afterwards by Anne Dugan	**Date Manager Registered:** Prior to 1 April 2005
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: 28 (three of whom were in hospital)	**Weekly Tariff at Time of Inspection:** £593 - £643

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 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 10 patients either individually or in small groups. Discussion was also undertaken with four care staff, two nursing staff, one ancillary staff and two patient's representatives.

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP
- the staff duty rota
- two patient care 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.

5. The Inspection

5.1 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	The registered person should ensure that continence assessments are completed for patients who require continence management.	**Met**
	Action taken as confirmed during the inspection: Having examined a number of patient nursing care records it was confirmed that continence assessments are completed for those patients who require continence management.	
Recommendation 2 **Ref**: Standard 19.1 **Stated:** First time	The registered person should ensure that care plans for continence management are developed in consultation with the patient and/or their representative.	**Met**
	Action taken as confirmed during the inspection: There was evidence available to confirm that patients and or their representatives are involved in the care planning process.	
Recommendation 3 **Ref**: Standard 30.1 **Stated:** First time	The registered person should review care assistant hours allocated to activities to ensure that the needs of the patients are met.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that time is allocated to the provision of activities in the home each afternoon. The activity board in the foyer of the home identified the activity programme for the week. The inspector was advised that the patients' opinion of the availability and quality of activity provision is sought by the home on a regular basis and feedback is used to improve service delivery.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 4 **Ref**: Standard 26.5 **Stated:** First time	The registered person should ensure that policies and procedures are dated when issued, reviewed or revised.	**Met**
	Action taken as confirmed during the inspection: The policy folder was examined and there was evidence that policies are dated when issued or reviewed.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Policy guidance for staff on communicating effectively was available 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)

The staff induction template and the competency and capability record for the registered nurse in charge of the home in the absence of the registered manager, both referred to end of life care.

One nursing care record from a recently deceased patient and two other nursing care records were examined. There was evidence that each patient's individual needs and wishes in regards to daily living were appropriately recorded.

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.

However, there was no evidence in the nursing care records of the recently deceased patient to confirm that end of life care needs had been discussed with either the patient or their representative other than the Do Not Resuscitate directive. The assessments of patient need and care plans failed to evidence recent updating as the patient's needs had changed from palliative to end of life care. This issue is discussed further in section 5.4 below.

Two registered nursing staff consulted, demonstrated their ability to communicate sensitively with patients when breaking bad news. They advised that in the past they sat down with the patient or representative in a private area used a calm voice, spoke with the patient / representative in an empathetic manner using clear speech, offering reassurance and an opportunity for the patient / representative to ask any questions or voice any concerns. Care staff were knowledgeable on how to break bad news and offered similar examples when they have supported patients when delivering bad news.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and many staff interactions with patients, it was confirmed that communication was well maintained and patients were 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 10 patients individually and with many others in small groups. In general the patients all stated that they were very happy with the quality of care delivered and with life in Mullaghboy. They confirmed that staff were polite and courteous and that they felt safe in the home.

Two patient's representatives discussed care delivery and confirmed that they were very happy with standards maintained in the home. Some patient representative comments are recorded in section 5.5.1 below.

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

Areas for Improvement

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

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

5.3 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 not available during the inspection. Best practice guidelines such as the Gain Palliative Care Guidelines, November 2013 were available in the home. It is recommended that a policy on palliative / end of life care be developed. This policy should be drafted in keeping with the Gain Palliative Care Guidelines 2013.

Both registered nursing staff on duty during the inspection were aware of the Gain Palliative Care Guidelines November 2013.

The registered manager advised the inspector that training in palliative care / end of life care had not yet been delivered in Mullaghboy. The training was scheduled to be delivered by a representative of the palliative care team of the South Eastern Health and Social Care Trust (SEHSCT) on 23rd and 30th July 2015. The inspector suggested that this training also be offered to ancillary and catering staff. Training on bereavement support is also scheduled with the support of a local undertaker.

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 two registered nurses as a palliative care link nurse. The link nurses attend the regular palliative care group meetings and minutes were available for reference in the home.

Discussion with the registered manager, six staff and a review of nursing care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life. Nursing care records demonstrated that the multiprofessional team would be involved as required however there was a lack of evidence to demonstrate that the patient's representatives were informed of the approaching end of life situation and therefore opportunities to ensure that the patient's wishes for end of life care may be missed.

It is anticipated by the inspector that the training planned in palliative and end of life care for July 2015 will provide the registered manager and the registered nursing team the knowledge of how to approach this challenging subject and how to maintain the evidence required.

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 all registered nursing staff are trained in the use of this specialised equipment and would also receive update training prior to using one in the home. .

Is Care Effective? (Quality of Management)

A review of the care records for one patient who had recently died 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 care were assessed and reviewed on an ongoing basis and documented in patient care plans.

The distinction between palliative care and end of life care however was not clearly defined in the nursing records of the recently deceased patient. There was no evidence that the patient's assessment of need or care plans had been reviewed and updated to reflect this change. Despite the absence of updated assessments of need and care plans the daily progress records did confirm that the patient had been well cared for in the final days of life. The daily progress records evidenced that the management of hydration, nutrition, pain management and symptom control were all considered.

A recommendation is made to ensure that when it is identified that the patient requires end of life care that an update of the assessment of need is completed, care plans are drafted to direct care and the patient's representatives are kept fully informed of the changing circumstances.

It was confirmed that environmental factors had been considered when a patient was considered 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 have 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 for long periods or overnight with their loved ones.

From discussion with 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.

Some comments from recent compliment cards are detailed below;

'Just a few lines to express our appreciation and thanks to you all for the attention and care given to our dad. Dad had settled in the home very well and was very content, he often told us that you were all like his family to him and it gave us great piece of mind to know he was so happy there.'

'Just to say thank you so much for everything you did for Dad. We hope you know that you realise how much we appreciated the care you gave to him.'

'With many thanks and deep appreciation of the wonderful loving care you gave to …. The understanding and support given to us will never be forgotten.'

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.

Areas for Improvement

Two recommendations are made as detailed above. When these are appropriately actioned the home will be in a better position to evidence that palliative and end of life care is well delivered.

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

5.4 Additional Areas Examined

5.4.1 Consultation with patients, their representatives, staff and professional visitors

Part of the methodology in collecting data for the inspection process included speaking with staff, patients and patient's relatives asking them to give their own personal views on their impression of Stewart Suite. Questionnaires were also given out for completion to aid data collection.

Overall feedback from the staff, patients and the relative involved confirmed that safe, effective and compassionate care was being delivered in the home.

A few patient comments are detailed below:-

'It's just like being at home'
'I like the company and the place is really nice'
'I like being in my own room'
'The nurses are lovely and very kind'
'My daughter can come when she wants'.
'I would really rather be at home but appreciate that I need the care here'

One relative stated he was very happy with the care his loved one was receiving and thought that staff were always very welcoming'

Another relative stated that they were always kept informed of any changes in their loved ones health and felt that their loved one was safe in the home.

One professional visitor met with the inspector and also confirmed that they were very happy with the quality of care delivered in Mullaghboy.

The general feeling from the staff questionnaires and conversations indicated that they took pride in delivering safe, effective and compassionate care.

A few staff comments are detailed below:-

'The quality of care is of a high standard. Residents are treated with dignity and respect at all times. It is a very good home and it is a pleasure to work in.'

'I have been here for a few years now and I know that the quality of care here is very high. Patients are treated by all staff with respect and dignity'

'Care is of a high standard. All residents are cared for with dignity and encouraged to be as independent as possible. End of life care is delivered sensitively.'

'Activities are good and specialised. The person centred end of life care is brilliant by all staff.'

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Anne Dugan registered 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.

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

Statutory Requirements: No requirements resulted from this inspection.

Recommendations

Recommendation 1 **Ref**: Standard 36 **Stated:** First time **To be Completed by:** 31 August 2015	It is recommended that a policy on palliative / end of life care is developed. The policy should be developed with reference to the Care Standards for Nursing Homes April 2015 and GAIN Palliative Care Guidelines November 2013. **Ref section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Further development of policy to refer to Care Standards and GAIN guidelines.
Recommendation 2 **Ref**: Standard 32 **Stated:** First time **To be Completed by:** From date of inspection and ongoing	It is recommended that the registered manager ensures assessment of need and care plans are updated when a patient is identified as requiring end of life care. The records should also reflect evidence of communication with the patient's representative to ensure that the patient's wishes for end of life care are fully considered. **Ref section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Nursing Care Plans elaborated to include specific assessment of end of life care taking into consideration the wishes of the patient and their next of kin.

Registered Manager Completing QIP	Anne Dugan	**Date Completed**	03/08/15
Registered Person Approving QIP	Robert Duncan	**Date Approved**	09/08/15
RQIA Inspector Assessing Response	Karen Scarlett	**Date Approved**	17/8/15

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