Nicholson House
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8 Antrim Road
Lisburn
BT28 3DH

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Unannounced Care Inspection
of
Nicholson House

16 December 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 16 December 2015 from 11 30 to 15 30 hours.

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 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. 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 23 June 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	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: Andrew Johnston Ruth Johnston	**Registered Manager:** Ruth Johnston
Person in Charge of the Home at the Time of Inspection: Registered nurse Gail McConnell	**Date Manager Registered:** 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: 31	**Weekly Tariff at Time of Inspection:** £621.00 - £652.50

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:

- discussion with the registered manager
- discussion with staff
- discussion with patients
- discussion with a relative
- review of records
- observation during a tour of the premises
- evaluation and feedback

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- recently submitted application for variation to registration
- written and verbal communication received since the previous care inspection
- the previous care inspection report and QIP

During the inspection, we met with six patients individually and with others in small groups, one registered nurse, three care staff and one patient's relative.

The following records were examined during the inspection:

- three care records
- policies and procedures regarding communication, death and dying, palliative and end of life care
- staff training records
- record of complaints and compliments.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the Nicholson House was an unannounced care inspection dated 23 June 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 1.1 **Stated:** Second time	In keeping with patient dignity, each patient should have continence supplied solely for their personal use.	Met
	Action taken as confirmed during the inspection: Staff spoken with explained that continence aids were now allocated on an individual basis and named for individual patients as required; for example continence pants.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. A copy of the DHSSPS regional guidance on breaking bad news was available in the home.

A review of training records evidenced that the registered manager had attended training in relation to communicating and palliative care on 2 December 2015. Whilst formal training had not been provided on communication and the breaking of bad news staff spoken with were knowledgeable and experienced in communicating with patients and their representatives. Discussion with staff confirmed that they were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication.

Is Care Effective? (Quality of Management)

A review of three care records evidenced that patients' specific communication needs including sensory and cognitive impairment had been identified. There was evidence within the care records that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Staff spoken with demonstrated their ability to communicate sensitively with patients and relatives when breaking bad news and provided examples of how they had done this in the past. Care staff considered the breaking of bad news to be the responsibility of the registered nursing staff but felt confident that, should a patient or relative choose to talk to them about a diagnosis or prognosis of illness, they would have the necessary skills and confidence to do so.

Is Care Compassionate? (Quality of Care)

Patients were observed to be treated with dignity and respect by all grades of staff. There were a number of occasions when patients were assisted by nursing and care staff in a compassionate manner which ensured the patients' dignity was maintained. There was evidence of good relationships between patients and staff.

Patients spoken with all stated that they were happy with the quality of care delivered and with life in the home. There were no issues or concerns raised.

We spoke with one relative; they were complimentary of staff and the care provided. Good relationships were evident between staff and the patients and visitors. Consultation with patients and their representatives is further discussed in section 5.5 of this report.

Compliment cards and letters were retained. Review of these indicated that relatives were appreciative of the care provided.

Areas for Improvement

There were no areas for improvement identified with this standard**.**

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 end of life care and death and dying were available and referenced GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013. A copy of this best practice guidance was also available in the home.

Records evidenced that eight registered nurses had attended training entitled "Palliative care medications and end of life" delivered by the local health and social care trust in June 2015. Training in the management of syringe drivers was attended by four registered nurses in April 2015; the registered manager confirmed that ongoing support was available from the local health and social care trust for the management of syringe drivers. Following the inspection the registered manager confirmed by email that further training sessions to update staff in palliative care would be arranged for January 2016.

Discussion with the registered nurses and care staff evidenced that staff were knowledgeable in identifying when a patient's condition was deteriorating or nearing end of life and the appropriate actions to take.

The registered manager confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services through the local health and social care trust. Procedures for timely access to any specialist equipment or drugs were in place.

Is Care Effective? (Quality of Management)

A sampling of care records and discussion with the registered manager and a registered nurse evidenced that death and dying arrangements were part of the activities of daily living assessment completed for each patient. This physical and psychological assessment contained a section entitled "Dying." A review of three care records evidenced that discussion had taken place regarding end of life care with individual wishes identified. An advanced care plan pro forma was available in two of the care records reviewed. Questions included in the pro forma were "What element of care is important to you and what would you like to happen?" and "Do you have any special requests or preferences or comments?" Examples of wishes identified related to pain management and preferred place of care. Completed advanced care plans also included who the patient would want involved in decision making if it became too difficult for them to make decisions and any special requests or preferences; this included spiritual support and involvement. The registered nurse explained that the completion of advanced care plans to identify end of life wishes was a practice which had been completed in the home for a number of years. One care record reviewed contained an advanced care plan which was originally completed in 2011. This care plan had been subject to regular review with the patient, family and GP.

The registered manager explained that work in this area of care planning was ongoing with patients and relatives and would generally take place when a relationship had been formed with the patient and their family/representative. The third care record reviewed did not contain a completed advanced care plan as this patient had recently been admitted to the home. In the assessment, under the section entitled "dying", it was recorded that these needs would be assessed after admission.

Discussion with staff evidenced that environmental factors, which had the potential to impact on patient privacy, for example shared bedrooms, had been considered. Staff confirmed that facilities were made available for family members to spend extended periods with their loved ones during the final days of life. Meals, snacks and emotional support were provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that these had been reported appropriately.

Is Care Compassionate? (Quality of Care)

The religious, spiritual or cultural need of the patients had been identified in care records and there was evidence of consideration of these areas in respect of end of life care. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs on a regular basis.

Arrangements were in place in the home to facilitate family and friends to spend as much time as they wished with the patient.

Staff discussed their experiences of caring for patients who were dying in the home and how the home had been able to support the family members in providing refreshments and facilitating staying overnight with their loved ones. Staff confirmed that they were given an opportunity to pay their respects after a patient's death and to support each other following a death in the home.

From discussion with the registered manager, four staff and a review of the compliments record, there was evidence of sound arrangements in the home to support relatives.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"Thank you for all the care and attention to our mum …while she was with you. Also for the consideration you showed to our family in the last few weeks."

"Unfortunately I cannot thank you enough for all the kindness and care you gave to dad over the years and particularly towards the end. Thank you for all the concern and consideration you showed to mum and me which certainly made our lives easier."

"Just wanted to say a big thank you to all the staff at Nicholson House for looking after my mum and making her final days so comfortable."

Areas for Improvement

There were no areas for improvement identified with this theme**.**

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

5.5 Additional Areas Examined

5.5.1 Activities

When we arrived in the home the patients and staff were getting ready to go out for their Christmas dinner in a local hotel; an annual event organised by the home. There was a lively atmosphere and both patients and staff were looking forward to the lunch and afternoon entertainment. The registered manager explained that some patients' relatives and friends would join them at the hotel. It was evident from the patients' appearance that a lot of time and effort had been spent that morning making sure that everyone looked their best. Out of 31 patients there were 10 who were not going out; this was due to either personal choice or health issues.

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

Discussion took place with six patients individually and with the majority of others in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were positive. Patients did not raise any issues or concerns about care delivery in the home. As patients were going out for lunch there was limited time available to speak with them; therefore ten patient questionnaires were issued. None were returned prior to the issue of this report.

One patient's relative confirmed that they were happy with the standard of care and communication with staff in the home. The registered manager explained that the relatives who would usually visit during the day were joining them for lunch. Therefore additional patient relative/representative questionnaires were issued; a total of ten. Three were returned.

All of the respondents were very satisfied that care was safe, effective and compassionate. Some of the comments received are detailed below:

"My … has been in the home for …years and I have always felt she has been greatly cared for and looked after by staff. The staff go above and beyond to attend to her needs and desires."

"…Both nursing and care staff are excellent, know you by name and always have time to talk. My … needs are met 100%."

"Quality of care is excellent, food very good and surroundings very comfortable. We are very happy as a family to have our mum so well looked after."

"Mum was made to feel welcome from day one, and allowed to integrate in her own way and at her own pace."

Staff commented positively with regard to staffing and the delivery of care. Staff were knowledgeable regarding their patient's needs, wishes and preferences.

Again due to the limited time to speak with staff on duty the number of questionnaires issued to nursing, care and ancillary staff was increased to ten. One was returned following the inspection visit. The staff indicated that they were very satisfied that care was safe, effective and compassionate.

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Ruth Johnston	**Date Completed**	25.01.2016
Registered Person	Andrew Johnston	**Date Approved**	25.01.2016
RQIA Inspector Assessing Response	Sharon McKnight	**Date Approved**	26-01-16

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

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