Oakridge Clinic – EMI Unit
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Inspector: Aveen Donnelly
Inspection ID: IN21836

Unannounced Care Inspection
of
Oakridge Clinic – EMI Unit

15 June 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 15 June 2015 from 10.00 to 18.30 hours.

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

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 23 May 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	2

The total number of requirements and recommendations above includes both new and those that have been ‘restated’.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the 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: Four Seasons Health Care Maureen Claire Royston	**Registered Manager:** Rachel McCaffrey
Person in Charge of the Home at the Time of Inspection:	**Date Manager Registered:** 15/08/2013
Categories of Care: NH-DE	**Number of Registered Places:** 40
Number of Patients Accommodated on Day of Inspection: 32	**Weekly Tariff at Time of Inspection:** £470 - £604

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 (QIPs) 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 three care staff and two nursing staff.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care.

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 04 February 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the last care inspection on 23 May 2014.

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: 19(1)(a), schedule 3, 2(k) **Stated:** Second time	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence the care delivered.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed the repositioning charts of four patients were accurately maintained.	
Requirement 2 **Ref**: 15(2)(a)(b) **Stated:** First time	The registered person must ensure the patient's Do Not Resuscitate plan is kept under review and revised at any time and in any case not less than annually.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that Do Not Resuscitate plans were reviewed by the registered nurses on a monthly basis, in conjunction with patient family/representatives. The Do Not Resuscitate plans were reviewed annually by the general practitioners.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 16.2 **Stated:** Second time	It is recommended that all induction programmes are reviewed, and where required developed, to include awareness and reporting responsibilities for all grades of staff. Induction records should be further developed to include a general awareness of the correct use of restraint.	**Met**
	Action taken as confirmed during the	

	inspection: Inspector confirmed that the induction programme for two staff members included reporting responsibilities for all grades of staff and a general awareness of restraint.	
Recommendation 2 **Ref**: Standard 6.2 **Stated:** First time	It is recommended that all entries in care records be dated and signed with the signature accompanied by the designation of the signatory.	**Not Met**
	Action taken as confirmed during the inspection: A review of progress notes, relating to four patients care records identified that the designation of the signatory was not consistently entered. 22 out of 35 entries were not accompanied by the signatory's designation. This recommendation is made for the second time.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure on communicating effectively was currently under review, by the organisation, at the time of the inspection. However, this was available in draft format and available in a reference manual. A review of the draft policy confirmed that it reflected current best practice, including regional guidelines on Breaking Bad News. Discussion with four staff confirmed that they were knowledgeable regarding this policy and procedure.

A sampling of training records evidenced that all staff had completed training in relation to communicating effectively with patients and their families/representatives. Training as relevant to staff roles and responsibilities, on the procedure for breaking bad news was included in palliative care training, provided by the Trust.

Is Care Effective? (Quality of Management)

Discussion was undertaken with five staff, including two registered nurses who had the responsibility of being in charge of the home, regarding how staff communicates with patients and their representatives. All staff demonstrated a good awareness, relevant to their role, of the need for sensitivity when communicating with patients and/or their representatives. We observed a number of communication interactions throughout the inspection that confirmed that this knowledge was embedded into practice. These observations included staff assisting patients with personal care, assisting patients with meals and speaking with frail patients.

Staff spoken with emphasised the importance of developing good relationships with patients and/or their representatives. Nursing staff consulted were able to demonstrate how they delivered bad news sensitively.

A review of the compliments records evidenced that patient representatives' were appreciative of the care and support provided to them when their relative was receiving end of life care.

Is Care Compassionate? (Quality of Care)

Discussion was undertaken with staff regarding how they communicate with patients and or their representatives. Staff were knowledgeable and had a strong awareness of the need for sensitivity when communicating with patients and or their representatives.

Staff were observed to be responding to patients in a dignified manner. These observations included staff assisting patients with meals and assisting patients with personal care. There was a calm, peaceful atmosphere in the home throughout the inspection.

Nursing staff consulted, provided examples of how they would break bad news if required.

A review of compliments records evidenced that families appreciated the care, compassion and respect shown to the person receiving care and also to themselves.

Areas for Improvement

A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively.

Number of Requirements:	**0**	**Number of Recommendations**: *1 recommendation made is stated under Standard 32 below	***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 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 are currently under review by the organisation. However, the policy was available in draft format were available in a reference manual. A review of the draft policy confirmed that it 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 staff training records evidenced that all registered nurses and all senior care assistants had completed training in respect of palliative/end of life care. All care staff had completed a workbook for death, dying, bereavement and loss. This included the psychological effects of dying; pain management; respiratory issues; oral hygiene; symptom management; repositioning; psychological support and communication skills.

Discussion with nursing staff confirmed that arrangements would be made if required to specialist palliative care services.

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

There was no specialist equipment, in use in the home on the day of inspection. A review of training records confirmed that registered nurses were trained in the use of the McKinley syringe driver. Considering that the home is registered to provide care for patients who are terminally ill, the need for update training was discussed with the registered manager, who provided assurances that update training would be accessed through the local healthcare trust nurse, if necessary.

There was no specialist equipment, in use in the home on the day of inspection. Considering that the home is registered to provide care for patients who are terminally ill, the training needs of staff were discussed with the registered manager who provided assurances that training in the use of syringe drivers would be accessed through the local healthcare trust nurse.

There were two palliative care link nurses in the home, who attended quarterly oncology and palliative care link nurse meetings with the local healthcare palliative care link nurse. One link nurse gave an example of how this supported their practice, regarding pain relief for an identified patient.

Is Care Effective? (Quality of Management)

There were no patients requiring end of life care at the time of the inspection. However, a review of five care records evidenced that patients' needs were assessed and reviewed on an ongoing basis. 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 Do Not Resuscitate decisions, however there were no care plans in place for death and dying arrangements. Discussion with the registered manager confirmed that there were no patients identified as requiring end of life care. The registered manager confirmed that the nursing home was involved in a pilot project in conjunction with Queen's University. The aim of the research was to develop ways of promoting informed decision making and effective communication through advance care planning for people living with dementia and their family carers. The home intends to review the end of life care plans, as appropriate for patients receiving palliative care and end of life care, following the completion of this study.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals would be made to the specialist palliative care team and any deterioration in patients' condition was referred to the patient's GP.

Discussion with the manager, five staff and a review of five 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. Through discussion, there was evidence that staff had managed shared rooms appropriately.

A review of notifications of death to RQIA during the previous inspection year confirmed that they were submitted appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of five 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.

Staff described experiences from their past, of how they supported the spiritual wishes of patients. The registered manager also described a patient's funeral, where two staff members had been pall bearers, at the deceased person's request. Staff described how they would ensure that patients who had no living relatives would be supported, by citing examples of when they sat with the patient.

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. Overnight stays were facilitated where possible and catering/snacks were provided to family members during this time.

From discussion with the manager, staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives. There was evidence in the compliments records that relatives had commended the management and staff for their efforts towards the patient and family, when the patient was receiving end of life care.

The registered manager discussed one complaint, in relation to a patient's funeral that was not attended by any staff members. However, staff consulted confirmed that they were generally given an opportunity to pay their respects after a patient's death.

From discussion with the manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included for example, bereavement support; staff meeting and I:I counselling if deemed appropriate.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included leaflets from the Health and Social Care Bereavement Network including, *Caring at End of Life* and *Information and Guidance after the Death of a Relative or Friend in a Nursing Home.* Information on bereavement counselling was present on the relatives' notice board.

Areas for Improvement

A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of palliative and end of life care.

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

5.4 Additional Areas Examined

Complaints
A review of the complaints in the previous inspection year confirmed that records were appropriately maintained.

Questionnaires

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

Questionnaire's issued to	Number issued	Number returned
Staff	6	5
Patients	0	0
Patients representatives	5	0

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

Staff

'Our team always do their best to make the resident comfortable during his/her end stage of life, along with their families'
'I believe Oakridge delivers a high standard of care at all times and have residents' best interest as their focus at all times'
'Residents have the freedom to make their own choices, eg. Menu, clothes, bath times'
'It is very good here'.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the 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	
Recommendations	
Recommendation 1 **Ref: Standard 6.2** **Stated: Second time** **To be Completed by: 13 August 2015**	It is recommended that all entries in care records be dated and signed with the signature accompanied by the designation of the signatory.
	Response by Registered Person(s) Detailing the Actions Taken: All staff have been advised that they are required to document their designation beside their signature on all records. this will be monitored by the Registered Manager and senior staff during auditing.
Recommendation 2 **Ref: Standard 32.1** **Stated: First time** **To be Completed by: 13 August 2015**	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; and palliative and end of life care.
	Response by Registered Person(s) Detailing the Actions Taken: All staff will be asked to read new policies and procedures and confirm that they have an understanding of these. This will be monitored during observation of care delivery and reviewed during supervision.

Registered Manager Completing QIP	Rachel McCaffrey	**Date Completed**	18/08/2015
Registered Person Approving QIP	Dr M Claire Royston	**Date Approved**	19/08/2015
RQIA Inspector Assessing Response	**Aveen Donnelly**	**Date Approved**	**27/08/2015**

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

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 ***