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Unannounced Care Inspection
of
Richmond Nursing Home

5 May 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 5 May 2015 from 11:30 to 16:30 hours.

This inspection was underpinned by:

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)

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 24 July 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 registered manager, Sharon Radcliffe-Bryans and the assistant manager, Ruth Wilson, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Mr Robin Francis Bryans	**Registered Manager:** Mrs Sharon Ruth Radcliffe-Bryans
Person in Charge of the Home at the Time of Inspection: Ruth Wilson - Assistant Manager	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-I, NH-PH, NH-PH(E) and NH-TI	**Number of Registered Places:** 35
Number of Patients Accommodated on Day of Inspection: 28	**Weekly Tariff at Time of Inspection:** £593-£810

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 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)

The inspection also sought to assess progress with the issues raised during and since the previous inspection.

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
- any communication/information received by RQIA regarding the home since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection, the inspector met with five patients individually and with others in small groups, five nursing and care staff and three patients' visitors/representatives. Six questionnaires for staff not on duty during the inspection were provided along with six relative/representatives questionnaires for distribution by the assistant manager.

The following records were examined during the inspection:

- evidence linked to the previous QIP which included
  - infection control audits
  - staff meeting notes December 2014
  - food, fluid and repositioning charts
- two patient care records
- staff training records and management overview and planner for 2015
- staff induction records
- policies and procedures regarding communication, death and dying, 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 unannounced care inspection on 24 July 2014. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last Inspection.

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 13 (7) **Stated:** First time	It is required that the registered persons shall make suitable arrangements to minimise the risk of infection and toxic conditions and spread of infection between patients and staff.	**Met**
	Action taken as confirmed during the inspection: Infection control audits reviewed evidenced that audits had been conducted on a regular basis and included the actions taken to address identified deficits. Review of notes from a staff meeting conducted in December 2014 evidenced that the wearing of jewellery had been addressed by management. Staff were observed to be appropriately attired and adhering to regional guidance.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 7 **Stated:** First time	It is recommended that the registered person ensures that all staff are aware of the importance of seeking permission/consent before undertaking tasks for or to patients. This is also in the interests of dignity and respect.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and review of notes from a staff meeting conducted in December 2014 evidenced that the management had addressed this recommendation with staff.	
Recommendation 2 **Ref**: Standard 5.6 **Stated:** First time	It is recommended that care records and charts are clear and accurate in relation to the information recorded. Registered nurses should make use of specific and measurable data when describing care delivery evaluations/outcomes and avoid duplicating information which can cause confusion.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff, review of notes from a staff meeting conducted in December 2014 and review of patient records evidenced that the management had addressed this recommendation with staff.	
Recommendation 3 **Ref**: Standard 27.4 **Stated:** First time	It is recommended that charts clearly specify/define what has to be recorded. For example, food charts record food intake.	**Met**
	Action taken as confirmed during the inspection: Review of notes from a staff meeting conducted in December 2014 and review of patient records evidenced that this recommendation had been met.	

Recommendation 4 **Ref**: Standard 6.3 **Stated:** First time	It is recommended that any alterations to records are dated timed and signed and made in such a way that the original entry can still be read.	**Met**
	Action taken as confirmed during the inspection: Review of patient care records evidenced that this recommendation had been met.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The assistant manager confirmed that work had recently commenced on the development of a communication policy and procedure which would incorporate the breaking of bad news.

Discussion with management, nursing and care staff confirmed that staff were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication. However, there was no awareness of the regional guidance on breaking bad news or of the regional guideline for end of life palliative care and end of life care in nursing and residential homes GAIN (Nov 2013). A copy of the new DHSSPS nursing homes minimum standards April 2015 was available in the main office but nursing and care staff were unaware of it. A recommendation is made.

Advice was provided in respect of accessing the GAIN guidance for palliative and end of life care in nursing and residential homes and the availability of links to other relevant guidelines and documents, within the nursing homes minimum standards.

Review of training records and discussion with staff evidenced that while staff were knowledgeable regarding effective and sensitive communication, these skills and knowledge were 'passed on' through observation/role modelling and informal discussion with more experienced nursing staff and the hospice nurse aligned to the home. A recommendation is made that formal training is provided and that all learning is recorded.

Is Care Effective? (Quality of Management)

Review of patient care records and a selection of additional care charts reflected patients' individual needs and wishes regarding the end of life care. Recording within records included references to the patient's specific communication needs. For example, the inclusion of family members in the care planning and/or decision making process, as appropriate.

A review of care records and discussion with patients and relatives evidenced that the breaking of bad news was discussed with sensitivity, and in private. Options and treatment plans were also discussed, where appropriate.

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 observed when patients were assisted by nursing and care staff in a professional and 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 very happy with the quality of care delivered and with life in Richmond nursing home. They confirmed that staff were polite, caring and courteous and that they felt safe in the home.

Relatives spoken with were satisfied with communication between them and the staff; one relative had some concern regarding the care needs of their loved one but felt that staff would assist when they had spoken with them about their concern.

A stated previously nursing and care staff were knowledgeable regarding the importance of effective and sensitive communication. A recommendation has been made regarding formal training.

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

Areas for Improvement

Two areas for improvement were identified.

A recommendation is made in relation to the availability and implementation of current and relevant minimum standards, guidelines and guidance within the home. This will assist staff in the delivery of care, development of policies and procedure and in the monitoring of the effectiveness of care and service delivery.

A recommendation is also made that training for staff in relation to communicating effectively and breaking bad news is provided. Records of all learning in the home should be maintained in accordance with minimum standards.

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

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 were available in the home. However, these were dated 2010 and were not reflective of current best practice guidance such as the Gain Palliative Care Guidelines, November 2013. A recommendation is made.

Review of records and discussion with management, staff, relatives and patients evidenced that palliative and end of life care was delivered in a caring, sensitive and effective manner.

As stated previously, these skills and knowledge were 'passed on' by observation/role modelling and informal discussion with more experienced nursing staff and the hospice nurse aligned to the home. A recommendation has been made in relation to the provision of formal training as stated in section 5.2.

Staff were not aware of the regional guidance for palliative and end of life care or the new DHSSPS minimum standards for nursing homes issued in April 2015. A recommendation has been made previously in relation to this concern as stated in section 5.2.

Discussion with nursing staff 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 management, nursing and care 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.

Review records of patient records and discussion with nursing staff evidenced that close working arrangements were in place with GPs, and specialist healthcare workers to ensure the needs of patients were met in a timely manner including weekends and out of hours.

The assistant manager is the identified palliative care link nurse in the home. The home also has access to a specialist palliative care nurse aligned to the home.

Is Care Effective? (Quality of Management)

A review of 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 wishes and their social, cultural and religious preferences were also considered. There was also evidence of discussion between the patient, their representatives and staff in respect of death and dying arrangements.

Care records evidenced that the assessed needs of patients were reviewed on at least a monthly basis. There was clear evidence of the involvement of the wider healthcare team in the provision of palliative care. For example, care records included recommendations from the patient GP, optician, occupational therapist (OT), palliative nurse specialist, tissue viability specials, dietician, and speech and language therapist (SALT). However, care plans did not always reflect the most recent specialist recommendations. A recommendation is made.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals had been made to the specialist palliative care team and were instructions had been provided, these were evidently adhered to.

A review of notifications to RQIA evidenced that the home notified RQIA of any death which occurred in the home in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005.

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. Staff consulted demonstrated an awareness of patients' expressed wishes and needs.

Management and staff confirmed that arrangements for relatives/representatives to be with patients who had been ill or dying were in place and viewed as being as important as caring for the dying patient. Staff described arrangements with ease and with confidence in their ability to provide this support.

There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient. Some statements relating to communicating included:
'*loving care and understanding shown'*
'…appreciated your support'
'thank you for the past years'
'your staff were so good to … and made … final days a comfort'

Discussion with the manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

Staff confirmed that they were given an opportunity to pay their respects after a patient's death. This included staff contributing to a sympathy card which was sent to the next of kin.

Areas for Improvement

Two areas for improvement were identified:

A recommendation is made that the registered manager review and develops policies and procedures in relation to palliative and end of life care that are reflective of current and relevant regional guidance and best practice guidelines.

A recommendation is made that when specialist healthcare professionals issue recommendations, following a visit to a patient, that the patient's care plans are reviewed to ensure they reflective the 'current' recommendations made and that the 'out of date' recommendations are archived.

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

5.4 Additional Areas Examined

Comments from patients, relatives and staff

During the inspection, the inspector met with five patients individually and with others in small groups, five nursing and care staff and three patients' visitors/representatives. Six questionnaires for staff not on duty during the inspection were provided along with six relative/representatives questionnaires for distribution by the assistant manager.

It was evident that there were good relationships between patients and staff. Patients spoken with all stated that they were very happy with the quality of care delivered and with life in Richmond nursing home. They confirmed that staff were polite, caring and courteous and that they felt safe in the home. Comments made included;
'Care is good'
'staff are lovely'
'I am well looked after'
'I have no worries'.

As stated previously relative spoken with during the inspection were complimentary in their comments and felt that staff would address their concerns.

One relative returned their questionnaire which indicated that they were satisfied that the care provided was safe, effective and compassionate. Comments recorded included; *'staff are very approachable and supportive with us as a family for our requests with my … needs'.*

There were no staff questionnaires returned. Staff spoken with were knowledgeable regarding their patient's needs, wishes and preferences and believed they delivered safe, effective and compassionate care.

Environment

The home was found to be warm, comfortable, spotlessly clean and maintained to a good standard of décor throughout.

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, Sharon Radcliffe-Bryans and the assistant manager, Ruth Wilson 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 35 (3) **Stated:** First time **To be Completed by:** 30 June 2015	The registered person must ensure the availability and staff awareness of current and relevant minimum standards and practice guidance in relation to communicating effectively, breaking bad news and palliative/end of life care. **Response by Registered Person(s) Detailing the Actions Taken:** **April 2015 Care Standards for Nursing Homes are now available in Nurses' Office. Updated policies for Effective Communication, Breaking Bad News and Palliative/End of Life Care are now available in Nurses' Office. Staff made aware of the availability of same.**
Recommendation 2 **Ref**: Standard 39 (4) **Stated:** First time **To be Completed by:** 30 June 2015	The registered person must ensure that training for staff in relation to communicating effectively, breaking bad news, palliative and end of life care is provided. Records of all learning in the home should be maintained in accordance with minimum standards. **Response by Registered Person(s) Detailing the Actions Taken:** **Dates have been organised with Hospice Education facilitator for training in relation to Effective Communication, Breaking Bad News and Palliative/End of Life care for RN staff on 17 September 2015 and 1 October 2015 for Care staff.**
Recommendation 3 **Ref**: Standard 36 **Stated:** First time **To be Completed by:** 30 June 2015	The registered person must ensure that policies and procedure relating to communicating effectively, breaking bad news, palliative and end of life care are reviewed to reflect current minimum standards and regional guidance. **Response by Registered Person(s) Detailing the Actions Taken:** **Policies and procedures for Effective Communication, Breaking Bad News and Palliative/End of Life Care have now been reviewed and updated and reflect current Care Standards and regional guidance.**
Recommendation 4 **Ref**: Standard 4 (4) **Stated:** First time **To be Completed by:**	The registered person must ensure that when specialist healthcare professionals issue recommendations, following a visit to a patient, that the patient's care plans are reviewed to reflective the 'current' recommendations made and that the 'out of date' recommendations are archived.

30 June 2015	**Response by Registered Person(s) Detailing the Actions Taken: RNs have ensured "out of date" recommendations have been archived. Action underpinned by minutes of staff meeting on 24 June 2015.**

Registered Manager Completing QIP	**Sharon Bryans**	**Date Completed**	**25/6/15**
Registered Person Approving QIP	**Robin Bryans**	**Date Approved**	**25/6/15**
RQIA Inspector Assessing Response	**Lyn Buckley**	**Date Approved**	**30/06/15**

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