Seaview House
RQIA ID: 1293
276 Seacliff Road
Bangor
BT20 5HS

Inspector: Sharon McKnight
Inspection ID: IN021925

Tel: 02891460833
Email: seaviewhouse@hotmail.co.uk

Unannounced Care Inspection
of
Seaview House

3 June 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 3 June 2015 from 10.15 to 14 00 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 5.1 and 6.3 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Seaview House which provides both nursing and residential care.

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 7 January 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	1	3

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

2. Service Details

Registered Organisation/Registered Person: Fiona Gilmore	**Registered Manager:** Clair O'Connor
Person in Charge of the Home at the Time of Inspection: Clair O'Connor	**Date Manager Registered:** 21 April 2015
Categories of Care: RC-I, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 22 – 20 nursing and 2 residential
Number of Patients Accommodated on Day of Inspection: Total of 19 patients – 17 nursing and 2 residential	**Weekly Tariff at Time of Inspection:** Residential £470 Nursing £620 - £632

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 registered manager
- discussion with staff
- discussion with patients
- 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
- submitted reports on the conduct of the home as required under regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report and QIP.

During the inspection, the inspector met with five patients individually and with the majority generally and with three care staff.

The following records were examined during the inspection:

- care records of three patients
- policies and procedures linked to the focus of the inspection
- regulation 29 reports
- record of complaints and compliments.

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 dated 7 January 2015. The completed QIP was returned and approved by the care inspector.

Review of Requirements and Recommendations from the last care inspection

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 29 (5) **Stated:** Third time	The registered person must ensure that a copy of the regulation 29 report is forwarded to the inspector by the end of the first week of each subsequent month.	**Met**
	Action taken as confirmed during the inspection: The inspector confirmed that a copy of the regulation 29 report was being sent to RQIA monthly.	
Requirement 2 **Ref**: Regulation 17 (1) **Stated:** Second time	The registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and other service provision in or for the purposes of the nursing home and that any such review is undertaken not less than annually.	**Met**
	Action taken as confirmed during the inspection: The inspector confirmed that an annual report for Seaview House had been received by RQIA.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 20.3 **Stated:** First time	It is recommended in keeping with best practice that DNAR directives are subject to review.	**Met**
	Action taken as confirmed during the inspection: Review of the recording of DNAR directives evidenced that this recommendation has been met.	
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time	It is recommended that the management of odours in the identified areas are reviewed and eliminated.	**Met**
	Action taken as confirmed during the inspection: There were no issues identified with the management of odours during this inspection.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

There was no policy or procedure available on communicating effectively. A copy of the DHSSPS regional guidance on breaking bad news was available in the home.

Training had not been provided on breaking bad news. However, discussion with the registered manager and care staff confirmed that staff were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication. Staff spoken with were knowledgeable, experienced and confident in communicating with patients and their representatives.

Is Care Effective? (Quality of Management)

The registered manager and care staff 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 records made reference to the patients' specific communication needs including sensory and cognitive impairment.

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/or representatives when breaking bad news. They emphasised the importance of building caring relationships with patients and their representatives and the importance of regular, ongoing communication regarding the patient's condition.

Is Care Compassionate? (Quality of Care)

Observations of the delivery of care and staff interactions with patients confirmed that communication was well maintained and patients were observed to be treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time.

Discussion with five patients individually and with the majority of patients generally evidenced that patients were content living in the home.

One patient's representative also confirmed that they were kept informed of any changes to their relative's condition and of the outcome of visits and reviews by healthcare professionals.

Areas for Improvement

It is recommended that a policy to guide and direct staff on communicating effectively is put in place.

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

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 end of life care and death and dying were available in the home. The policy entitled "Terminal Care", issued May 2011, stated that the policy would be reviewed when new directives were issued. Guidelines and Audit Implementation Network (GAIN) issued Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes in December 2013. The policy had not been reviewed and updated to reflect this best practice guidance.

The policy entitled "Death and bereavement support of a resident" stated that patients wishes regarding specific care and arrangements at the time of their death would be included in their care plan. As discussed in the next section of this theme care records did not contain information on patients' individual needs and wishes regarding end of life care.

The GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013 were available in the home.

The registered manager confirmed that training in palliative care and the management of syringe drivers was being organised by the local healthcare trust. Dates had not been confirmed at the time of inspection.

Formal training in the management of death, dying and bereavement had not been provided. However care staff demonstrated experience and knowledge of the action to take in the event of a patient's death.

There was one registered nurse identified as a link worker in palliative care. The registered manager confirmed that the identified nurse attended regular palliative care link nurse meetings arranged by the local health care trust.

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. The provision of syringe drivers for symptom management was provided by the local health and social care trust. Procedures for timely access to any specialist equipment or drugs were in place and the registered manager confirmed their knowledge of the procedure.

Is Care Effective? (Quality of Management)

A sampling of care records and discussion with the registered manager evidenced that death and dying arrangements were part of the needs assessment completed for each patient.

Of the three care records reviewed two evidenced discussion between the patient, their representatives and staff, however there was limited information recorded in respect of end of life care. The registered manager acknowledged that, whilst some discussion had taken place regarding the wishes of patients and relatives for end of life care, there was a need to create further opportunities to discuss this area in greater detail, in particular in the event of patients becoming suddenly unwell.

Discussion with staff evidenced that environmental factors, which had the potential to impact on patient privacy, 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 been 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 needs of two of the patients reviewed had been recorded but there was no 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 within the home.

Arrangements were in place in the home to facilitate family and friends to spend as much time as they wish with the patient. Staff discussed openly a number of recent deaths 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.

From discussion with the registered manager, three care staff and a review of the compliments record, there was evidence that there were sound arrangements in the home to support relatives during this time. 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:

"It was always a comfort to know that … was so well looked after."
"Thank you for making the last few days so peaceful."
"The last few hours spent in her room with her were special and the staff were amazing."
"It helped so much to have their gentle support combined with privacy in those very precious hours."

Discussion with the registered 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.

All of the 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.

Areas for Improvement

The policies regarding palliative and end of life care should be reviewed and updated to ensure that are reflective of best practice guidance.

To ensure that staff knowledge and care delivery is reflective of best practice in palliative and end of life care it is recommended that when the policy is updated staff should receive an induction/training on the content.

Working practices within the home should be reviewed to ensure that they are compliant with internal policies reviewed.

It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Discussion should include patients' wishes in relation to their religious, spiritual and cultural needs.

Number of Requirements:	**0**	**Number of Recommendations:** ***1 recommendation made is stated under Standard 19 above**	**2***

5.4 Additional Areas Examined

5.4.1. Care records

In addition to the care records held in the nursing office there were care charts available in a number of patient's bedrooms. These charts included repositioning charts, fluid intake charts and a chart entitled "progress notes" where care staff recorded changes they had observed to the patient's condition. There was no evidence in the care records held in the nursing office or those held in patients' bedrooms of any action taken to address the minor changes recorded. Discussion with the registered manager evidenced that these progress notes were used at the mid-morning report during which care staff updated the registered nurse of issues identified throughout that morning. It is required that registered nurses must take the appropriate action to ensure that any changes to patients' condition are reviewed and records maintained of any action taken. It was agreed that the registered manager would review the care charts to ensure that information is recorded in the most appropriate place and to minimise duplication.

5.4.2. Consultation with patients, their representatives, staff and professional visitors

Discussion took place with five 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 very positive. Patients did not raise any issues or concerns about care delivery in the home.

There were no relatives or patients' representatives available during the inspection.

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

Six questionnaires were issued to nursing, care and ancillary staff. Four were returned following the inspection visit. Two staff indicated that they were satisfied or very satisfied that care was safe, effective and compassionate. One respondent indicated that they were unsatisfied that patients were encouraged to maintain their independence and unsatisfied with the arrangements in place to meet patients' spiritual, psychological and cultural needs. No additional comments were provided to quantify this opinion.

No professional visitors were available in the home at the time of the inspection.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Clair O'Connor, 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	
Requirement 1 **Ref**: Regulation 13(1) **Stated:** First time **To be Completed by:** 3 July 2015	The registered person must ensure that proper provision is made for the health and welfare of patients. Registered nurses must ensure that any changes to patients' condition are reviewed and records maintained of the action taken. **Response by Registered Person(s) Detailing the Actions Taken:** To ensure above Requirement is met a daily handover from care team takes place informing nurse of changes to patients condition. Nurses have been made aware of need to accurately record changes and action required
Recommendations	
Recommendation 1 **Ref:** Standard 36.2 **Stated:** First time **To be Completed by:** 3 July 2015	It is recommended that: • a policy to guide and direct staff on communicating effectively is put in place • the policies regarding palliative and end of life care should be reviewed and updated to ensure that are reflective of best practice guidance. . The registered person should review the working practices within the home to ensure that they are compliant with these internal policies. **Response by Registered Person(s) Detailing the Actions Taken:** A new policy is now in place to meet this requirement and staff will meet following a death to discuss care provided and express feelings if wish to do so.
Recommendation 2 **Ref:** Standard 39 **Stated:** First time **To be Completed by:** 3 July 2015	It is recommended that when the policies regarding palliative and end of life care are updated staff should receive an induction/training on the content to ensure that staff knowledge and care delivery is reflective of best practice and in keeping with the home's policy. **Response by Registered Person(s) Detailing the Actions Taken:** New policy has been made available to all staff who must read and sign same and inform manager with any questions regarding same
Recommendation 3 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 3 July 2015	It is recommended that further opportunities, to discuss end of life care, are created and documented as appropriate by the registered nurses. Discussion should include patients' wishes in relation to their religious, spiritual and cultural needs **Response by Registered Person(s) Detailing the Actions Taken:** Registered nurses have been made aware of need to discuss and include more detailed accounts of patients wishes at end of life in their care plans.

Registered Manager Completing QIP	CConnor	**Date Completed**	7.8.15.
Registered Person Approving QIP	F Gilmore	**Date Approved**	8.8.15.
RQIA Inspector Assessing Response	E. Buckley	**Date Approved**	18/8/15.

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 ***