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Inspector: Sharon McKnight
Inspection ID: IN022027

Unannounced Care Inspection
of
Clonlee

29 September 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 29 September 2015 from 09.50 to 16.00 hours.

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

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

There were no further actions required to be taken following the last care inspection on 11 December 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	3*

*Please note: One of the three recommendations included in this total was made as a result of the inspection undertaken on 9 September 2013. It had not been met and has been stated for a second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Perpetua Latta, 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: Hutchinson Homes Ltd	**Registered Manager:** Mrs Perpetua Latta
Person in Charge of the Home at the Time of Inspection: Mrs Perpetua Latta	**Date Manager Registered:** 01 April 2005
Categories of Care: NH-I, NH-PH	**Number of Registered Places:** 53
Number of Patients Accommodated on Day of Inspection: 48	**Weekly Tariff at Time of Inspection:** £623.00 - £633.00

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)

On 20 August 2015 an anonymous phone call was received via the RQIA duty inspector. The caller raised concerns regarding staffing on night duty. The register manager provided RQIA with assurances that staffing was appropriate to the meet the needs of the patients. Staffing was reviewed during this inspection.

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 relatives
- 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
- written and verbal communication received since the previous care inspection
- the previous care inspection report.

During the inspection, the inspector met with 10 patients individually and with the majority of others in smaller groups, four care staff, three registered nurses, and seven patient's visitors/representative.

The following records were examined during the inspection:

- five patient care records
- policies and procedures regarding the inspection focus and theme staff induction records
- patient register
- complaints and compliments
- reports of the visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- staff training.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced pharmacy inspection dated 25 June 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Care Inspection completed in 17 June 2014.

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 15 (1) (a) **Stated:** First time	The registered person shall not provide accommodation to a patient at the nursing home unless: The needs of the patient have been assessed by a suitably qualified or suitably trained person.	**Met**
	Action taken as confirmed during the inspection: Review of care records evidenced that the needs of the patients' had been assessed. This requirement has been met.	
Requirement 2 **Ref**: Regulation 16(2)(b) **Stated:** First time	The registered person shall ensure that the patients care plan is kept under review.	**Met**
	Action taken as confirmed during the inspection: Care plans examined had been reviewed regularly with a meaningful statement of the patient's condition. This requirement has been met.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 28.1 **Stated:** First time	The registered manager must ensure that induction records for all staff are available in the home for inspection at all times. It is recommended that the following information is also included in the induction records: • Date of completion of each section of the induction programme • Final statement of competency signed by the registered manager.	**Met**
	Action taken as confirmed during the inspection: Induction programmes were available in the home and two records reviewed contained the date of completion of each section of the induction programme and a final statement of competency signed by the registered manager. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 17.1 **Stated:** First time	It is recommended that the registered manager records the satisfaction of the complainant with the outcome of the complaint.	**Met**
	Action taken as confirmed during the inspection: The satisfaction of the complainant with the outcome of the complaint was included in the record of complaint. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 25.12 **Stated:** First time	It is recommended that the Regulation 29 report addresses the progress made in meeting the requirements and recommendations of RQIA inspections.	**Not Met**
	Action taken as confirmed during the inspection: The template of the Regulation 29 report included a section “visits by regulators.” The reports for the period September 2014 to August 2015 did not include any comment on the progress made in meeting the requirements and recommendations of RQIA inspections.	

	This recommendation has not been met and was stated for a second time. This recommendation was made on 9 September 2013. Therefore the registered manager agreed to discuss the issue with the registered persons. It was agreed that written confirmation of the action taken to address this recommendation would be provided to RQIA by 9 October 2015.	
Recommendation 4 **Ref**: Standard 19.2 **Stated:** First time	The registered manager should ensure the following guidelines are readily available to staff and used on a daily basis: • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that the guidelines were available in the home.	
Recommendation 5 **Ref**: Standard 19.4 **Stated:** First time	The registered manager should ensure that training in male catheterisation has been provided for all registered nurses.	**Met**
	Action taken as confirmed during the inspection: Training records evidenced that two registered nurses had attended training in male catheterisation on 26 January 2015. The registered manager confirmed that staff would be identified to attend future sessions when they were confirmed by the local and health and social care trust. RQIA were satisfied that there were systems in place to ensure that this training would be provided for all registered nurses. This recommendation has been met.	

Recommendation 6 **Ref**: Standard 19.4 **Stated:** First time	A recommendation is made that regular audits of the management of incontinence are undertaken and the findings acted upon to enhance already good standards of care.	**Met**
	Action taken as confirmed during the inspection: Review of the records evidenced that there was a system of audit in place which included continence management. The last audit was completed on 16 June 2015. There were no areas for improvement identified. This recommendation has been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating entitled “Breaking Bad News.” There was no reference to the regional guidelines on Breaking Bad News. A copy of the DHSSPS regional guidance on breaking bad news was available in the home. A recommendation has been made.

Training had not been provided on breaking bad news. However, discussion with the registered manager, registered nurses 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)

Review of five care records evidenced that patients’ individual needs and wishes in respect of aspects of daily living were appropriately recorded. However, there was limited evidence that end of life issues were discussed with the exception of Do Not Attempt Resuscitation (DNAR) directives. This is discussed further in section 5.4.

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.

The registered manager and registered nurses 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 choose to talk to them about a diagnosis or prognosis of illness, they would have the necessary skills to do so.

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

Patients' relatives 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 the policy entitled "Breaking Bad News" is reviewed and updated to ensure that it is reflective of best practice guidance such as DHSSPS Breaking Bad News, Regional guidelines, February 2003.

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

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 palliative and end of life care and death and dying were available in the home. The policies were dated March 2014. 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 relevant policies should be reviewed and, where necessary updated, to ensure they reflect this best practice guidance. The recommendation made in section 5.3 was extended to include all relevant policies.

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

Records evidenced that seven registered nurses had attended training in the management of syringe drivers delivered by the local health and social care trust in February 2013. Support to manage syringe drivers was available from the district nursing services. Registered nurses had also attended palliative and end of life training provided by Macmillan Cancer Support in 2013.

At the time of this inspection two staff where attending a four week programme entitled "Foundations in Palliative Care".

Two staff were booked to attend the Royal College of Nursing (RCN) Palliative and End of life Care on 12 November 2015. The registered manager confirmed that further dates for training would be available with staff identified to attend.

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)

As previously discussed care records evidenced that death and dying arrangements were part of the activities of daily living assessment completed for each patient. This assessment contained a section entitled "Spirituality and Dying". None of assessments evidenced that discussion had taken place regarding end of life care. Examples of comments recorded in the five care records were:

"None expressed"
"unable to express"
"unable to assess understanding."

The registered manager explained that annually a form entitled "Projection for end of life care" was given to patients, were appropriate, and relatives. This form provided an opportunity for end of life care needs to be identified. However, there was no reference of this form, or any evidence of information gained from this form, in the care records reviewed.

The registered manager and registered nurses recognised that, whilst some discussion had taken place regarding the wishes of patients and relatives for end of life care with regard to DNAR directives, 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.

RQIA acknowledges there will be occasions when patients and/or their relatives do not wish to discuss end of life care, opportunities, to discuss end of life care, should be created by the registered nurses and any expressed wishes of patients and/or their representatives formulated into a care plan for end of life care. A recommendation has been made.

Discussion with staff evidenced that environmental factors, which had the potential to impact on patient privacy, for example shared rooms, 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 patient care records 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 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 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.

Staff spoken with confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with the registered manager, seven 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:

"We would like to say a huge thank you for the love and excellent care you showed mum…..It was comforting for us to know that her final years were happy ones."

"We would like thank … and the care assistants who looked after him in his short time at Clonlee. Special thanks to …who in his final hours gave us so much comfort and consideration."

"For all the love, care and attention you gave to mum in her 3 1/2 years with you."

Areas for Improvement

It is recommended that policies on palliative and end of life care and death and dying policies should be reviewed and, where necessary updated, to ensure they reflect best practice guidance. When the relevant policies are updated staff should receive an induction/training on the content.

It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.

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

5.5 Additional Areas Examined

5.5.1. Staffing

The registered manager confirmed that there was one registered nurse and three care assistants on duty between 23 00 and 08 00 hours for 48 patients. And that this staffing met the needs of the patients.

The registered manager confirmed that two registered nurses and three care staff had been successfully recruited. Following successful induction staffing on night duty for the identified hours would be increased from three to four care staff from week commencing 9 October 2015.

There were no issues of concerns identified with staffing during this inspection.

5.5.2. Consultation with patients, their representatives and staff.

Discussion took place with 10 patients individually and with the majority of patients in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were positive. One patient spoken with expressed dissatisfaction with the morning routine and preferred rising times. The patient was very satisfied with all other aspects of their care. This concern was discussed with the registered manager and registered nurses and advice given in regards to determining patient preferences. The registered manager also confirmed that she would speak further with the patient to provide assurances.

Seven patients' representatives confirmed that they were happy with the standard of care and communication with staff in the home. There were no issues or concerns raised about standards of care within the home.

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

Ten questionnaires were issued to nursing, care and ancillary staff. Two were returned. Staff indicated that they were satisfied or very satisfied that care was safe, effective and compassionate. The following comment was included:
"I feel care delivered is to a high standard. I feel we have good relationships with staff/relatives/multi-disciplinary team etc."

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Perpetua Latta, 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 any 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 25.12 **Stated:** Second time **To be Completed by:** 9 October 2015	It is recommended that the Regulation 29 report addresses the progress made in meeting the requirements and recommendations of RQIA inspections.
	Response by Registered Person(s) Detailing the Actions Taken: Following the inspection, the Regulation 29 Inspector was contacted and this recommendation along with the feedback from the day was discussed. A meeting has been arranged with the Director and herself regarding her role/input, also discussed was the possibility of being involved with the RQIA workshops so that she could be aware of the yearly focus and assist in the working towards the meeting of the standards.
Recommendation 2 **Ref**: Standard 36.2 **Stated:** First time **To be Completed by:** 10 November 2015	It is recommended that the policies on breaking bad news, palliative and end of life care and death and dying are reviewed and updated to ensure that they are reflective of regional best practice guidance. When the relevant policies are updated staff should receive an induction/training on the content to ensure their knowledge and care delivery is reflective of best practice in palliative and end of life care.
	Response by Registered Person(s) Detailing the Actions Taken: .The policies have been updated and reflective of best practice. Staff discussion on the updated policies on the 2/11/15 and 4/11/15
Recommendation 3 **Ref**: Standard 20.2 **Stated:** First time **To be Completed by:** 10 November 2015	It is recommended that further opportunities, to discuss end of life care, are considered and created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.
	Response by Registered Person(s) Detailing the Actions Taken: The monthly audits on the careplan will monitor the end of life care, those families that have responded to the questionaire on the "projection for end of life care" will be carried forward to the careplans.

Registered Manager Completing QIP	Perpetua Latta	**Date Completed**	11/11/15
Registered Person Approving QIP	Janet Montgomery	**Date Approved**	16/11/15

RQIA Inspector Assessing Response	Sharon Mcknight	**Date Approved**	25-11-15

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address