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Templepatrick
BT39 0AT

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Inspection ID: IN022026

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Unannounced Care Inspection
of
Kingscourt

11 June 2015

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 11 June 2015 from 11.30 to 15.30 hours.

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

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 areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within 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 03 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**	**2**

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Mr Liam Dowd, nurse in charge as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Manor Healthcare Ltd Mr Eoghain King	**Registered Manager:** Mr Brian Campbell
Person in Charge of the Home at the Time of Inspection: Mr Liam Dowd, Nurse in Charge	**Date Manager Registered:** 01 April 2005
Categories of Care: NH - LD, LD(E)	**Number of Registered Places:** 19
Number of Patients Accommodated on Day of Inspection: 19	**Weekly Tariff at Time of Inspection:** £600.00 - £675.00

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)

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to inspection the following records were examined:

- 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 (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report.

During the inspection, the inspector met with 12 patients, one nursing, four care staff, one ancillary staff and one visiting professional.

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP
- three patient care records
- records of accident/notifiable events

- staff training records
- staff induction records
- policies for communication, death and dying, and palliative and end of life care
- complaints and compliments records.

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 17 February 2015. The completed QIP was returned and approved by the specialist inspector.

Review of Requirements and Recommendations from the last care Inspection

<table>
<tr><th colspan="2">Last Care Inspection Statutory Requirements</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Requirement 1

Ref: Regulation 20 (1) (a)

Stated: First time</td><td>The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of patients:

Ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients.

The registered person must review the domestic staffing arrangements to ensure that cleaning standards are maintained.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Discussion with the nurse in charge and review of staffing rotas evidenced that the level of domestic staffing had been increased to ensure adequate cleaning standards are maintained.</td></tr>
<tr><td rowspan="2"></td><td></td><td rowspan="2"></td></tr>
<tr><td></td></tr>
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Requirement 2 **Ref**: Regulation 27 (2) (d) **Stated:** First time	The registered person shall, having regard to the number and needs of patients, ensure that the following issues are addressed: • patients bedrooms need repainted • treatment room needs repainted • two vanity units in patients bedrooms need replaced • valance sheets were not in place on a number of patients beds • one patients bed had no head board • bathroom on first floor had loose tiles around the bath.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of the internal environment confirmed that this requirement had been met.	
Requirement 3 **Ref**: Regulation 15 (2) (a) **Stated:** First time	The registered person shall ensure that the assessment of the patients' needs is kept under review. Risk assessments should be reviewed monthly or more frequently having regard to any changes in the patient's condition.	**Met**
	Review of three patients care records evidenced that this requirement had been met.	
Requirement 4 **Ref**: Regulation 16 (2) (b) **Stated:** First time	The registered person shall ensure that the patients care plan is kept under review. Care plans should be reviewed monthly or more frequently having regard to any changes in the patient's condition.	**Met**
	Review of three patients care records confirmed that care plans were kept under review.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 5.6 **Stated:** First time	The registered manager must ensure that contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.	**Met**
	Action taken as confirmed during the inspection: Review of three patients care records evidenced that this recommendation had been met.	
Recommendation 2 **Ref**: Standard 5.2 **Stated:** First time	It is recommended that for consistency only one validated risk assessment tool such as the Braden risk assessment is used in assessing the patients' risk of developing pressure ulcers. A recommendation is also made that the Malnutrition Universal Screening Tool (MUST) is used as the tool of choice to identify patients who are at risk of malnourishment.	**Met**
	Review of three patients care records evidenced that this requirement had been met.	
Recommendation 3 **Ref**: Standard 12.1 **Stated:** First time	The registered manager must ensure that fluid intake charts reflect individualised patient need and ensure the following: • the total fluid intake for the patient over 24 hours • an effective reconciliation of the total fluid intake against the fluid target established • action to be taken if targets are not achieved • a record of reconciliation of fluid intake in the daily progress notes.	**Met**
	A sample of fluid intake charts and patients care plans were reviewed and evidenced that this recommendation had been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News. Discussion with six staff confirmed that they were knowledgeable regarding this policy and procedure.

A sampling of six training records evidenced that two nurses had completed training in relation to communicating effectively with patients and their families/representatives regarding the procedure for breaking bad news. The nurse in charge agreed that training on breaking bad news and communication around end of life care would be very beneficial for all grades of staff.

Is Care Effective? (Quality of Management)

Three care records evidenced that patient individual needs and wishes in respect of aspects of daily living were appropriately recorded. The nurse in charge confirmed that breaking of bad news was discussed with patients and/or their representatives, options and treatment plans were also discussed, where appropriate. While spiritual needs care plans were in place for all patients, there was no evidence of end of life care plans. Recording within records did include reference to the patient's specific communication needs.

There was evidence within the care records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

The nurse in charge demonstrated his ability to communicate sensitively with patients and relatives when breaking bad news and provided examples of how he had done this in the past.

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 12 patients individually evidenced that patients were happy living in the home. Comments received included:

- "I like it here."
- "Everybody is very good to me."

One professional visitor also confirmed that they were happy with standards maintained in the home.

Areas for Improvement

Training in communication skills including breaking bad news for all staff will further enhance the quality of life in the home. It is recommended that end of life care plans are developed for patients as appropriate

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

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. These documents 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 two nursing staff had received palliative care training. It is recommended that all staff receive an update in palliative care/end of life training appropriate to their roles and responsibilities. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

Discussion with nursing staff and a review of three care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the nurse in charge and a review of three 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 two nursing staff confirmed their knowledge of the protocol.

Is Care Effective? (Quality of Management)

A review of three 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 and cultural preferences were also considered. As previously stated, a recommendation has been made for end of life care plans to be developed. Care records should evidence discussion between the patient, their representatives and staff in respect of death and dying arrangements.

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 where instructions had been provided, these were evidently adhered to.

Discussion with the nurse in charge and a review of three 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. Facilities have been made available for family members to spend extended periods with their loved ones during the final days of life. Meals, snacks and emotional support has been provided by the staff team.

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

Is Care Compassionate? (Quality of Care)

Discussion with nursing staff and a review of three care records evidenced that patients and/or their representatives had been generally consulted in respect of their cultural and spiritual preferences.

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 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 nurse in charge, six staff and a review of the compliments records there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the nurse in charge 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.

Six staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with the staff it was evident that arrangements were in place to support staff following the death of a patient.

Areas for Improvement

It is recommended that update training for registered nurses in relation to end of life/palliative care needs is provided.

As previously identified under standard 19 a recommendation is made that care plans document end of life needs and preferences.

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

5.5 Additional Areas Examined

5.5.1 Consultation with patients, their representatives and staff

Discussion took place with 12 patients individually. Comments from patients regarding the quality of care, food and in general the life in the home were very positive. A few comments received are detailed below:

- "I am well looked after, well fed. You can go to bed when you want to there is no set time. I have good friends."
- "I'm happy here."
- "I love living in Kingscourt."

One visiting professional confirmed that they were happy with standards maintained in the home.

Staff commented positively with regard to staffing and the delivery of care. No issues were raised by staff.

Nine questionnaires were issued to nursing, care and ancillary staff and nine were returned following the inspection. Staff indicated that they were satisfied or very satisfied that care was safe, effective and compassionate.

Some comments received from staff are detailed below:

- "Excellent work setting. All staff well trained, friendly and work well together."
- "I love working here because this house is very happy. Staff are friendly."
- "All the staff at Kingscourt are friendly and always give the residents the best of care. It's a really nice environment for residents to be living in with all their individual needs met."

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr Liam Dowd, Nurse in Charge 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 39 **Stated:** First time **To be Completed by:** 30 September 2015	It is recommended that the registered person ensures that all grades of staff receive training on the following; 1. Palliative /End of life care 2. Breaking bad news communication skills. **Response by Registered Person(s) Detailing the Actions Taken:** The aforementioned training will be provided for all care and nursing staff as a matter of priority.
Recommendation 2 **Ref**: Standard 19 **Stated:** First time **To be Completed by:** 31 July 2015	The registered manager should ensure that end of life care plans are developed. **Response by Registered Person(s) Detailing the Actions Taken:** End of life care plans for residents which this applies to are currently being developed or enhanced in conjunction with the residents named nurses.

Registered Manager Completing QIP	Brian Campbell	**Date Completed**	29.07.2015
Registered Person Approving QIP	Eoghain King	**Date Approved**	29.07.2015
RQIA Inspector Assessing Response	Bridget Dougan	**Date Approved**	17.08.2015

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