Jordanstown
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Jordanstown

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Unannounced Care Inspection
of
Jordanstown

12 November 2015

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1. Summary of Inspection

An unannounced care inspection took place on 12 November 2015 from 10.00 to 17.00 hours. RQIA were assisted by a lay assessor who met with residents to obtain their views on the quality of care provided within the home.

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 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 24 February 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	0	6

The details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Jean Elizabeth Steel, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care Dr Maureen Claire Royston	**Registered Manager:** Mrs Jean Elizabeth Steel
Person in Charge of the Home at the Time of Inspection: Mrs Jean Elizabeth Steel	**Date Manager Registered:** 01 April 2005
Categories of Care: NH-I	**Number of Registered Places:** 53
Number of Patients Accommodated on Day of Inspection: 48	**Weekly Tariff at Time of Inspection:** £593 - £643

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

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
- previous care inspection report.

During the inspection, the inspector met with 20 patients, two registered nurses, six care and two ancillary staff.

The following records were examined during the inspection:

- validation of evidence linked to the previous QIP
- four 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 Jordanstown Care Home was an announced estates inspection dated 02 June 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 24 February 2015

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 30.1 **Stated:** First time	The registered manager should review the staffing levels to ensure that patients care needs are being met in a timely manner.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that staffing levels had been reviewed in line with patient dependency and there was sufficient staff on duty at all times to meet the assessed needs of patients. No concerns regarding staffing levels were raised at inspection.	

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 two registered nurses and six care staff confirmed that they were knowledgeable regarding this policy and procedure.

A sampling of training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives. Nursing staff consulted were able to demonstrate their skills and knowledge regarding this aspect of care.

Is Care Effective? (Quality of Management)

Four care records reflected patients' individual needs and wishes regarding the end of life care. Reference had been made to patients' specific communication needs. Discussion with the registered manager and nursing staff evidenced that they were aware of patients' religious preferences/ spiritual needs, however these had not been documented in the patients' end of life care plans. A recommendation has been made.

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

Two registered nurses consulted, demonstrated their ability to communicate sensitively with patients and /or their representatives when breaking bad news. All staff demonstrated a good awareness, relevant to their role, of the need for sensitivity when communicating with patients and or their representatives.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and staff interactions with patients, it was evident 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 taking the time to offer reassurance to patients as required.

Discussion with twenty patients individually evidenced that patients were happy living in the home. Some patients were unable to verbally express their views due to the frailty of their condition. These patients appeared comfortable and relaxed in their surroundings. No concerns were expressed by any of the patients.

Areas for Improvement

Patients religious preferences/spiritual needs should be documented in end of life care plans.

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. These documents included guidance on the management of the deceased person's belongings and personal effects.

Training records evidenced that staff were trained in the management of death, dying and bereavement. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

A review of staff training records evidenced that all registered nurses and care staff had completed online training in 2015 in respect of palliative/end of life care. All registered nurses and the majority of care assistants had completed face to face training and workbooks on death, dying and bereavement. Further face to face training in palliative and end of life care had been arranged.

Discussion with two nursing staff and a review of four care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services. Staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

While a written protocol was not in place, nursing staff confirmed that the home had access to syringe drivers and other specialist equipment through the local Trust. They also confirmed that they were given the support of the community nursing team as required.

The registered manager was the palliative care link nurse for the home.

Is Care Effective? (Quality of Management)

A review of four care records evidenced that while the needs of patients for palliative and end of life care were assessed, they were not reviewed on a regular basis. This included the management of hydration and nutrition, pain management and symptom management. A number of risk assessments and care plans for two patients had not been reviewed since August 2015. A recommendation has been made in this regard.

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 patients religious preferences/spiritual needs to be included in end of life care plans.

A 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 two registered nurses and four care staff 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 had 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 had been provided by the staff team.

A review of notifications evidenced that the home had 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 two registered nurses and a review of four care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences. However patients' spiritual/ religious preferences had not been documented in respect of end of life care.

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 registered manager, registered nursing and care 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 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.

Nursing and care staff 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. The arrangements included support from management, peer support and also reflections at staff meetings.

Information regarding support services was available and accessible for staff, patients and their relatives.

Areas for Improvement

The assessment of the patient's needs should be kept under review, and revised at any time when it is necessary to do so, having regard to any change of circumstances. The patient's care plan should also be kept under review and reflect the current assessment of needs and care delivery.

Patients religious preferences/spiritual needs should be included in end of life care plans.

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. Care Practices and Care Records

Patients were observed to be well groomed and appropriately dressed. However, two patients who were observed in bed rest did not appear to have care delivered for oral hygiene according to the condition of their mouths. Care plans for the management of personal care did not include oral hygiene and daily care records had not been recorded since 02/11/15.

These matters were discussed at feedback to include the training staff had received in relation to oral hygiene care delivery. It was agreed by management that this area of practice and record keeping would be monitored and that training would be provided to further enhance the standard of care being delivered in this regard. A recommendation has been made.

A number of Do Not Attempt Resuscitation Orders were in place and this information was clearly visible on the outside covers of care records. To ensure confidentiality is maintained, an alternative method of communicating this information is recommended.

5.5.2. Environment

An inspection of the premises was undertaken and the majority of the patients' bedrooms, sitting areas, dining rooms, and bath/shower and toilet facilities were viewed. The home was found to be generally clean, warm and comfortable. However a small amount of debris was observed on carpets in the hallways throughout the home. This was discussed with the registered manager who confirmed that one member of cleaning staff had to go off duty unexpectedly on the day of the inspection, leaving one member of cleaning staff on duty. The registered manager agreed to monitor staffing levels to ensure cleaning standards are maintained throughout the home.

5.5.3. Accidents/Incidents

A review of the accident and incident notifications since the previous inspection established that these had been reported and managed appropriately.

5.5.4 Consultation with Patients and Staff

A lay assessor met with six patients individually in order to obtain patients' views on the quality of care provided within the home. All patients indicated that they were generally happy with their life in the home, their relationship with staff and the provision of care. Two patients raised issues with regard to the provision of activities and personal care/privacy in the home. These issues were discussed with the registered manager and two recommendations have been made.

Some comments included:

"I have no complaints, the staff are very good"
"I go to bed early because I'm bored, there's nothing to do"
"I'm fairly satisfied. Staff are very nice. Carers are very good"
"I'm not keen on men working with me"
"I can't complain about anything at all, I'm quite happy"
"considering they are short staffed, it is ok"
"generally speaking it's better here than hospital"
"if there is any better place than this, I have yet to see it"
"I don't think any member of staff would have a bad word for anybody"

The inspector met with a further twelve patients individually. Comments from patients were very positive. No concerns were brought to the attention of the inspector by any of the patients consulted.

Staff

The general view from staff during discussions was that they took pride in delivering safe, effective and compassionate care to patients. No concerns were raised by staff.

A few staff comments are detailed below:

- "the standard of care is excellent"
- "I enjoy working in this home"
- "there is plenty of training"

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Jean Elizabeth Steel, 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 20.2 **Stated:** First time **To be Completed by:** 12 December 2015	The registered person should ensure that patients religious preferences/spiritual needs are documented in end of life care plans. **Ref: Section 5.1**
	Response by Registered Person(s) Detailing the Actions Taken: End of Life care plans will contain details of the patients religious preferences /spiritual needs
Recommendation 2 **Ref**: Standard 4.7 **Stated:** First time **To be Completed by:** 12 December 2015	The registered person should ensure that, with regard to care records – • the assessment of the patient's needs is kept under review, and • revised at any time when it is necessary to do so having regard to any change of circumstances • the patient's care plan is kept under review and reflects the current assessment of needs and care delivery. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Care records and care plans are being kept under review to ensure they reflect the current assessment of needs and care
Recommendation 3 **Ref**: Standard 6.14 **Stated:** First time **To be Completed by:** 30 November 2015	It is recommended that patients personal care needs are regularly assessed and met to include (but is not limited to) oral health care. Records should be completed to evidence care delivered or not delivered. Training should be provided for all care staff to further enhance the delivery of care in this regard. **Ref Section: 5.3.1**
	Response by Registered Person(s) Detailing the Actions Taken: training has been given to staff with regard to patients personal needs records are being completed for each resident on a daily basis to evidence care has been given
Recommendation 4 **Ref**: Standard 37.5 **Stated:** First time **To be Completed by:** 30 November 2015	The registered person should review the system of placing Do Not Attempt Resuscitation notices on the covers of care records. An alternative method of communicating this information is recommended to ensure confidentiality is maintained. **Ref Section: 5.3.1**
	Response by Registered Person(s) Detailing the Actions Taken: Do Not Attempt Resusitation Notices have been placed inside the cover of the Care Records

Recommendation 5 **Ref**: Standard 6.3 **Stated:** First time **To be Completed by:** 13 November 2015	The registered person should ensure that patients are enabled to exercise choices and give their consent regarding the provision of intimate care, including, but not limited to the gender of the staff providing the care where possible and practical. **Ref Section: 5.3.4**
	Response by Registered Person(s) Detailing the Actions Taken: Residents are encouraged to execise their preference and give their consent with regard to all aspects of their care.This is then incorporated into the patients care plan
Recommendation 6 **Ref**: Standard 11.1 **Stated:** First time **To be Completed by:** 30 November 2015	The registered person should review the provision of activities to ensure the programme of events and activities provide positive and meaningful outcomes for patients and are based on their identified needs, life experiences and interests. **Ref Section: 5.3.4**
	Response by Registered Person(s) Detailing the Actions Taken: The PAL is reviewing the provision of activities to ensure the programme of events is based on the identified needs of each patient

Registered Manager Completing QIP	jean steele	**Date Completed**	21 st December 2015
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	30.12.15
RQIA Inspector Assessing Response	Bridget Dougan	**Date Approved**	04/01/16

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