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Unannounced Care Inspection
of
Leabank
Private Nursing Home

25 January 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 25 January 2016 from 10:10 to 16:20 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.

For the purposes of this report, the term 'patients' will be used to described those living in Leabank Private Nursing Home 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 27 April 2015.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent action record regarding the storage of chemicals within unlocked sluice rooms was issued to the manager at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home. Refer to section 5.2 (requirement 2) for details.

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	1

*Indicates that this requirement was stated for a second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Herlinda Roble, and the regional manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Persons: Mr Brian Macklin and Mrs Mary Macklin	**Registered Manager:** Herlindina Roble
Person in Charge of the Home at the Time of Inspection: Herlinda Roble – registered manager	**Date Manager Registered:** 26 January 2016
Categories of Care: NH-DE, I and PH RC-DE, I and PH, Maximum of 10 residents within RC I and PH Maximum of two residents within RC DE Maximum of two patients within NH DE	**Number of Registered Places:** 52
Number of Patients Accommodated on Day of Inspection: 48	**Weekly Tariff at Time of Inspection:** £470 - £637

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 the registered manager;
- discussion with the regional manager;
- discussion with a selection of staff on duty;
- consultation with patients;
- observation of care delivery;
- observation of patient and staff interactions;
- tour of the home and review of a random selection of patient bedrooms, bathrooms and communal areas; and
- evaluation and feedback.

Prior to inspection the following records were analysed:

- notifiable events submitted since 1 January 2015;
- the registration status of the home;
- written and verbal communication received by RQIA since the previous care inspection;
- the returned quality improvement plans (QIP) from the last care inspection; and
- the previous care inspection report.

During the inspection, the inspector spoke with the seven patients individually and met others in smaller groups. The inspector also spoke with two housekeeping staff, five care staff and two registered nurses.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes;
- training records;
- compliment records;
- complaint records; and
- four patient care records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was announced estates follow up inspection dated 27 May 2015. All areas identified for improvement within the QIP issued by the estates inspector on 9 December 2014 had been met.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 13 (1) **Stated:** Second time	It is required that the registered persons ensure that record keeping is accurate and reflective of patients/residents assessed needs and any guidance.	**Met**
	Action taken as confirmed during the inspection: Review of care records evidenced that this requirement had been met.	

Requirement 2 **Ref**: Regulation 14 (4) **Stated:** First time	The registered person must ensure that chemicals for use in the home are stored in accordance with COSHH guidance.	**Not Met**
	Action taken as confirmed during the inspection: Observations during a tour of the home, accompanied by the registered manager, confirmed that management had put a lockable cupboard within each sluice for chemical storage as the sluice door was not locked. However, in three of the four sluices staff had not locked the cupboard and in one sluice on the ground floor, staff had left a bottle of 'actichlor' beside the sluice sink. An urgent action record regarding the storage of chemicals within unlocked sluice rooms was issued to the registered manager at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home. This requirement is not met and is stated for a second time.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 4 **Stated:** First time	Each care plan should contain relevant and current information. Care plans should not be 'added' to when a patients care needs change but reviewed and rewritten as needs change. This should ensure that care plans reflect the patient's assessed needs and clearly directs care.	**Met**
	Action taken as confirmed during the inspection: Review of care records evidenced that this recommendation had been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure on communicating effectively was available dated April 2015.

Regional guidelines on Breaking Bad News were available and staff spoken with were aware of the policies, procedures, guidelines and the Minimum Care Standards for Nursing Homes (April 2015); in relation to communicating effectively.

Review of training records confirmed that training in 'core values and culture' had taken place January 2016 and this included communicating effectively.

Discussion with staff confirmed that they were knowledgeable of how to communicate effectively with patients, relatives, other healthcare professionals and each other. Staff were also aware of the importance of effective communication in ensuring continuity and quality of care.

Is Care Effective? (Quality of Management)

Care records reviewed, included reference to the patient's specific communication needs and actions required to manage barriers such as, language, cognitive ability, or sensory impairment.

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

Staff consulted clearly demonstrated their ability to communicate sensitively with patients and their families. It was evident that staff were aware of the individual needs and wishes of their patients. This was commended by the inspector.

Is Care Compassionate? (Quality of Care)

Observation of the delivery of care and interactions between patients and staff clearly evidenced that communication was compassionate and considerate of the patient's needs. Patients were treated with dignity and respect.

Patients who could verbalise their feelings on life in Leabank commented positively in relation to the care they were receiving from staff and the attitude of staff. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

Positive comments were also recorded by relatives in letters and cards received by the home.

Areas for Improvement

There were no areas for improvement identified in relation to communicating effectively.

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

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 dated April 2015. Polices reflected best practice regional guidance in relation to palliative and end of life care.

Records reviewed and discussion with the registered manager and staff evidenced that training in palliative care and end of life had been delivered during 2015. Staff also confirmed their participation in the ECHO project.

The ECHO project is a quality improvement project established by the Public Health Agency (PHA) to facilitate quality improvement in relation to palliative care within nursing homes. Participants 'log' into an online forum via a web cam. The topics for discussion were known in advance and discussion was facilitated. The registered manager and staff spoken with confirmed that they found this forum very effective and the knowledge gained helped improve standards of care within the home.

GAIN Palliative Care Guidelines, November 2013, were available in the home. Staff spoken with were aware of the guidance and the minimum care standards for nursing homes; standards 20 and 32.

Discussion with 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 the registered manager, nursing 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.

Is Care Effective? (Quality of Management)

A review of care records and discussion with staff 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.

Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

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.

Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Staff were able to describe clearly how the families would be supported during this time and enabled to stay overnight in the home when their loved ones were dying.

A review of notifications of death to RQIA since the 1 January 2015 confirmed that any death occurring in the home was notified appropriately.

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 demonstrated an awareness of patients' expressed wishes and needs as identified in their care plan.

Staff consulted demonstrated clearly their compassion for the patients, their relatives and friends. The inspector commended how staff interacted with patients and the detailed knowledge demonstrated to ensure patients were afforded privacy, dignity and respect.

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

Arrangements were in place to facilitate, as far as possible, in accordance with the person's wishes; family/friends to spend as much time as they wish with the person. All staff spoken with informed the inspector of how they could provide support to families who were 'sitting with loved ones' who were dying.

Discussion with the registered manager, staff and a review of the compliments record, evidenced that arrangements in the home supported relatives when their loved one was dying. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Some examples of comments made by relatives included:

'A little note of thanks for the way in which you all looked after my…'

'My family and I would like to express our gratitude to everyone involved. [name] received care of the highest quality which resulted in … being content and at ease'

'Thanks to all who provided such superb attention for my …'

'To thank you all most sincerely for the excellent care you all provided'

'You all have to accept great credit for the job you do on a daily basis. You do it cheerfully and unobtrusively and the family will always remember that.'

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.

Areas for Improvement

There were no areas for improvement identified in relation to palliative and end of life care

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

5.5 Additional Areas Examined

5.5.1 Consultation with Patients, Staff and Patient Representative/Relatives

Patients

Seven patients were spoken with individually and others in smaller groups. Patients were complimentary regarding the standard of care they received, the attitude of staff and the food provided. One patient express their dislike of being in the home but agreed this was because they preferred to be at home rather than the fault of 'the girls'.

Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff. There were no concerns raised with the inspector.

Twelve questionnaires for patients were provided and four were completed and returned during the inspection. The remaining eight were forwarded to RQIA. Patients indicated that they were either satisfied or most satisfied with the care and support they received from staff and that the home delivered safe, effective and compassionate care. Comments recorded included:

'Staff very nice and helpful'.

'I like the help offered'.

'Staff are very helpful and friendly-I'm happy and content'.

'Get treated like a mother – have fun with the girls [staff] – very happy and content'.

Staff

In addition to speaking with nine staff on duty, eight questionnaires were provided for staff not on duty. The registered manager agreed to forward these to the staff selected. At the time of writing this report two had been returned.

Comments from the staff ion duty are reflected in sections 5.3 and 5.4.

Staff indicated, from the returned questionnaires that they had received training in relation to safeguarding, reporting poor practice/whistleblowing and patient consent. In addition the staff indicated that they were satisfied or most satisfied that patients were treated with dignity and respect and that the patients' needs and wishes were respected and met. Staff confirmed that the care was safe, effective and compassionate.

There were no additional comments recorded.

Representatives/Relatives

There were no relatives spoken with during the inspection. Comments recorded by relatives in thank you cards and letters to the home can be viewed in section 5.4.

Eight questionnaires were provided for patient representatives/relatives. The registered manager agreed to forward these and five were returned. Comments recorded evidenced that relatives/representatives were either satisfied or most satisfied with the care provided for their loved ones.

Additional comments recorded included:

'Very satisfied and …has settled well'.

'I find that each and every staff member is polite, caring and have the patients' needs and comfort as their priority. My … is happy and pleased with the care and has only praise for the staff'.

'My … is very happy and feels very much at home. Staff are kind and attentive to … and …is content'.

5.5.2 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms, bathrooms lounge and dining rooms and sluices on each floor.

A requirement is stated for a second time in relation to the storage of chemicals in sluice rooms. Refer to section 5.2 (requirement 2) for details.

The home was found to be warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended by the inspector for their efforts.

Patients were observed relaxing in their bedroom or in one of the lounge areas available. Patients were complimentary in respect of the home's environment.

During the tour of the home, accompanied by the registered manager, it was observed that patient care charts were stored on the handrails outside patient bedrooms. Following discussion with the registered manager, it was agreed that this information formed part of the patient's record and should therefore be held confidentially. A recommendation was made.

5.5.3 Staffing

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met.

Discussion with patients and staff and a review of the returned questionnaires evidenced, there were no concerns regarding staffing levels.

5.5.5 Management Arrangements

Since the previous care inspection Mr H Roble had been appointed as the home manager on 1 July 2015. Discussion with staff and patients confirmed that they felt the 'new manager' to be a positive influence on the day to day operation of the home.

Areas for Improvement

Number of Requirements:	0	Number of Recommendations:	1

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with registered manager, Herlinda Roble, and the regional 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.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation 14(4) **Stated:** Second time **To be Completed by:** Immediate action required	The registered person must ensure that chemicals for use in the home are stored in accordance with COSHH guidance. Ref: Section 5.2(requirement 2)
	Response by Registered Person(s) Detailing the Actions Taken: On the day of the inspection, staff given memo on making sure the cupboards in the store are all locked and key put away to make sure residents are not at risk. All staff responsible in taking chemicals should lock the cupboards after use. Manager does daily rounds of same.
Recommendations	
Recommendation 1 **Ref**: Standard 5.8 **Stated:** First time **To be Completed by:** 24 February 2016	All patient information should be held in a confidential manner to safeguard the privacy and dignity of patients. Ref: Section 5.5.2
	Response by Registered Person(s) Detailing the Actions Taken: On the day of the inpsection this was amended, all the files were placed inside every patient's room and all staff are aware of same.

Registered Manager Completing QIP	Herlindina Roble	**Date Completed**	07.04.2016
Registered Person Approving QIP	Mary Macklin	**Date Approved**	07.042016
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	13/04/2016

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

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 in this report do not absolve the registered provider/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 provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.