Drummaul House
RQIA ID: 1411
41 New Street
Randalstown
BT41 3AF

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Unannounced Care Inspection
of
Drummaul House

06 October 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 06 October 2015 from 11.00 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 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 06 March 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	1*

*This recommendation was stated for the second time.

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

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 section 5.1 of this report.

The term ‘patients’ will be used to describe those living in Drummaul House which provides both nursing and residential care.

2. Service Details

Registered Organisation/Registered Person: Hutchinson Homes Ltd Ms Naomi Carey & Ms Janet Montgomery	**Registered Manager:** Mrs Maria Bothwell
Person in Charge of the Home at the Time of Inspection: Mrs Maria Bothwell	**Date Manager Registered:** 01 April 2005
Categories of Care: RC-I, RC-MP(E), RC-PH(E), NH-I, NH-PH	**Number of Registered Places:** 43
Number of Patients Accommodated on Day of Inspection: 39 patients	**Weekly Tariff at Time of Inspection:** £520 (Residential) £623 (Nursing)

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 nursing and six care staff. The following records were examined during the inspection:

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

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 5.1 **Stated:** First time	The registered manager must ensure that at the time of each patient/residents admission to the home a nurse carries out an initial risk assessment using validated assessment tools (including a MUST assessment) and draws up a plan of care to meet the patient/residents immediate care needs.	**Partially Met**
	Action taken as confirmed during the inspection: Review of six care records evidenced that risk assessments (including MUST assessments) had been carried out for five patients and care plans were in place to meet the patients' needs. A MUST assessment had not been completed for one patient who had been recently admitted. However a nutrition care plan was in place. This recommendation has been partially met.	
Recommendation 2 **Ref**: Standard 5.3 **Stated:** First time	The registered manager must ensure that the use of bed rails, including the risks have been discussed and agreed with patients/residents and/or their representatives. Written evidence of this consultation should be maintained.	**Met**
	Action taken as confirmed during the inspection: Review of six care records confirmed that this recommendation had been met.	
Recommendation 3 **Ref**: Standard 5.4 **Stated:** First time	It is recommended that risk assessments and care plans are reviewed on at least a monthly basis and more frequently depending on the needs of the patients/residents.	**Met**
	Action taken as confirmed during the inspection: Risk assessments and care plans are reviewed on at least a monthly basis and more frequently depending on the needs of the patients/residents.	

Recommendation 4 **Ref**: Standard 6.2 **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/resident. These records include outcomes for patients/residents.	**Met**
	Action taken as confirmed during the inspection: Review of six care records including a sample of food and fluids and repositioning records evidenced that this recommendation had been met.	

5.1 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 nursing and six care staff confirmed that they were knowledgeable regarding this policy and procedure.

A sample of training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives. Training on palliative and end of life care included guidance for breaking bad news as relevant to staff roles and responsibilities. This training was completed in 2011 with further training arranged for 13 and 20 November 2015. Nursing staff consulted were able to demonstrate their skills and knowledge regarding this aspect of care.

Is Care Effective? (Quality of Management)

Six care records reflected patients' individual needs and wishes regarding the end of life care. Recording within records included reference to the patient's specific communication needs, including sensory and cognitive impairments.

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 and with a number of other patients in small groups 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.

Areas for Improvement

No areas of improvement were identified in regards to this standard.

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

5.2 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 staff were trained in the management of death, dying and bereavement in 2011 and further training had been arranged for 13 and 20 November 2015. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

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

Discussion with the registered manager, registered 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.

A protocol for timely access to any specialist equipment or drugs was available and discussion with registered nursing staff confirmed their knowledge of the protocol.

A palliative care link nurse had been identified for the home.

Is Care Effective? (Quality of Management)

A review of six 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, 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.

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 nursing and six 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 to RQIA 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)

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. From discussion with registered nursing and care staff and a review of compliments records, there was evidence that arrangements were sufficient to support relatives during this time; and 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. There was evidence within compliments records that relatives had commended the management and staff for their efforts towards the family and patient.

All 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. The arrangements included for example bereavement support, staff meetings and 1:1 counselling if deemed appropriate.

Information leaflets on palliative care and grief and bereavement were available at the entrance to the home.

Areas for Improvement

No areas of improvement were identified in regards to this standard.

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

5.3 Additional Areas Examined

Consultation with Patients, Patient Representatives and Staff

In addition to speaking with patients and staff, questionnaires were distributed to staff not on duty during the inspection and for patients and patient representatives to complete**.**

Patients

Twenty patients were spoken with individually. Comments from patients regarding the quality of care, food and life in the home were very positive. There were no concerns raised. Seven patients completed questionnaires. Comments included:

- "I am very content with being here and with my care"
- "I feel this is a good place to be"
- "very happy with all aspects of care"

Staff

Eight staff took the time to speak with the inspector. A further five staff completed questionnaires and returned them following the inspection. The general view from staff cited in completed questionnaires and during discussions was that they took pride in delivering safe, effective and compassionate care to patients. No issues were identified.

A few staff comments are detailed below:

- "it is a very friendly place to work. All the staff get on well together."
- "as a nurse I feel the standard of care delivered is very good"
- "all staff have attended training in end of life care and I feel we provide good emotional support."

Patient Representatives

One patient's representative completed a questionnaire following the inspection. The relative was very complimentary regarding the care and services provided. Comments received are detailed below:

"I am very satisfied with the care my mum receives. All staff work extremely hard and are always available and approachable when they are needed."

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Maria Bothwell, 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 5.1 **Stated:** Second time	The registered manager must ensure that at the time of each patient/residents admission to the home a nurse carries out an initial risk assessment using validated assessment tools (including a MUST assessment) and draws up a plan of care to meet the patient/residents immediate care needs.
To be Completed by: 30 November 2015	**Response by Registered Person(s) Detailing the Actions Taken:** Each time a patient is admitted staff have been reminded of the legislative requirement of completeing a nutritional risk assessment using a validated assessment tool and then drawing up a plan of care to reflect this assessment. This will be closely monitered by management following every admission.

Registered Manager Completing QIP	Maria Bothwell	**Date Completed**	18/11/15
Registered Person Approving QIP	Janet Montgomery	**Date Approved**	18/11/15
RQIA Inspector Assessing Response	Linda Thompson	**Date Approved**	10.12.15

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