Kintullagh Care Home
RQIA ID: 1426
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Carniny Road
Ballymena
BT43 5LW
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Email: manager.kintullagh@runwoodhomes.co.uk

Inspector: Lyn Buckley
Inspection ID: IN021989

Unannounced Care Inspection
of
Kintullagh Care Home

5 November 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 5 November 2015 from 11:10 to 16:15 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 areas of concern. A Quality Improvement Plan (QIP) is not included in 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.

For the purposes of this report, the term 'patients' will be used to described those living in Kintullagh care 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 29 June 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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Runwood Homes Ltd Mr Nadarajah (Logan) Logeswaran – responsible individual.	**Registered Manager:** see box below
Person in Charge of the Home at the Time of Inspection: Ms Jill O'Neill	**Date Manager Registered:** Ms Jill O'Neill – application not yet submitted; refer to section 5.5.4
Categories of Care: NH – I, PH and LD RC – I, PH(E) and MP(E) One named person within NH-LD category. Maximum of three person with RC categories.	**Number of Registered Places:** 62
Number of Patients Accommodated on Day of Inspection: 52	**Weekly Tariff at Time of Inspection:** £470 - £608

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 by RQIA since the previous care inspection
- the returned quality improvement plans (QIP) from the last care inspection;
- the previous care inspection report
- pre-inspection assessment audit.

During the inspection the delivery of care and care practices were observed. A review of the general environment was also undertaken. The inspection process allowed for consultation with nine patients individually and with others in small groups, five care staff, three registered nurses and three ancillary staff.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes
- duty rotas from 25 October to 7 November 2015
- training records
- staff induction templates
- compliment records
- three patient care records
- palliative care/end of life/grievance and bereavement resource files.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 29 June 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 36 **Stated:** First time	The registered persons shall ensure that policies and procedures are kept under review to ensure they reflect legislative requirements; professional evidenced based practice, minimum care standards for nursing homes and regional guidance and protocols.	**Met**
	Action taken as confirmed during the inspection: Review of records, discussion with the manager and confirmation in writing from the Northern Ireland Operational Director provided by email on 20 November 2015 evidenced that, as stated, this recommendation had been met.	
Recommendation 2 **Ref**: Standard 16.11 **Stated:** First time	The registered persons shall ensure that all complaints or expressions of dissatisfaction are recorded in the complaints record.	**Met**
	Action taken as confirmed during the inspection: Review of records and discussion with the manager evidenced that this recommendation had been met.	
Recommendation 3 **Ref**: Standard 35.3 **Stated:** First time	It is recommended that the capacity in which the acting manager is working is clearly recorded. For example, when the acting manager was worked as the lead clinical nurse rather than in the office undertaking management duties.	**Met**

	Action taken as confirmed during the inspection: Discussion with the manager and review of duty rotas from 25 October – 7 November 2015 evidenced that accurate records were maintained of the manager's hours and the capacity in which she worked them.	
Recommendation 4 **Ref**: Standard 35.3 **Stated:** First time	The registered persons shall maintain a record of the checks undertaken by staff to ensure the home is secure, fire doors are not propped open and fire exits are clear.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and review of records evidenced that this recommendation had been met at the time. Refurbishment work had been completed and the checks were no longer required.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on general communication procedure. As stated in section 2, RQIA received written confirmation from the Northern Ireland Operational Director that a review of policies and procedures was being undertaken with completion expected by 31 March 2016.

Recently developed guidance was available to staff on communication and 'Breaking Bad News'. Discussion with staff confirmed that they were knowledgeable regarding this guidance.

A sampling of training and induction records evidenced that staff had or were asked to complete training in relation to communicating effectively with patients and with families/representatives.

The manager confirmed that a training session, for nursing and care staff, on Care, Compassion and Communication was scheduled for 21 January 2015. This was also confirmed from review of the booking email.

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, culture, cognitive ability or sensory impairment. There was also evidence that patients and their representatives were included in discussions regarding communication and for treatments options, where appropriate.

Staff consulted clearly demonstrated their ability to communicate sensitively and effectively with patients and/or representatives.

Is Care Compassionate? (Quality of Care)

Observation of care delivery and interaction between patients and staff clearly demonstrated that communication was compassionate and considerate of the patient's needs. Patients were treated with dignity and respect and responded to in a timely manner.

The inspection process allowed for consultation with nine patients individually and with others in small groups. Patients who could verbalise their feelings on life in Kintullagh Care Home commented positively in relation to the care they were receiving and in relation 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 viewed in letters and cards received by the home from relatives.

Areas for Improvement

There were no requirements or recommendations made.

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. As stated in section 2 and 5.3, RQIA received written confirmation from the Northern Ireland Operational Director that a review of policies and procedures was being undertaken with completion expected by 31 March 2016.

Recently developed guidance relating to palliative/end of life care and bereavement was available to staff. Palliative and End of Life Care Guidelines for Nursing and Residential Homes produced by GAIN, November 2013 were also available. Staff were aware of these documents.

Training and induction records evidenced that staff were trained/inducted in the management of serious illness/deteriorating patient and what to do when death occurred.

The manager confirmed that she had attended regional training provided on palliative and end of life care. Training had been arranged for other staff on 21 January 2015. Staff spoken with confirmed that they would be attending this training.

Discussion with the manager and nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with 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 in place and discussion with registered nurses confirmed their knowledge of the protocol.

Is Care Effective? (Quality of Management)

A review of care records evidenced that, where required, 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. This discussion was documented in the records reviewed as taking place after the patient had settled into the home rather than on the day of admission. The discussion was usually conducted by the manager or a registered nurse.

Following discussion regarding end of life care, a care plan was developed to ensure the patient's wishes and preferences were met.

Discussion with the manager and staff evidenced that management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Staff confirmed that relatives were supported with tea, coffee, meals and advice as required.

A review of notifications of death to RQIA during the previous inspection year 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 consulted demonstrated a detailed knowledge/ awareness of patients' expressed wishes and needs as identified within their care plan. Staff spoken with demonstrated clearly their compassion for the patients, their relatives and friends. This was commended.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

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. All staff spoken with informed the inspector of how they could provide support to families who were 'sitting with loved ones' who were dying.

From discussion with the manager, staff and a review of the compliments record, 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. Some examples of comments made by relatives included:

"On behalf of the entire family I want to thank you so much for the way in which you cared for our beloved… Carers and nurses looked after… as if she was part of their own family and we are so very grateful."

"We knew…was content and knew …was among good, kind caring people. We can't begin to put into words how much we appreciate the support and love we were given during…last days."

"To all the staff for the extreme friendly personal attention you gave …can't thank you enough."

"Really appreciated all you do."

Discussion with the manager confirmed that no concerns had been raised in relation to the arrangements regarding the end of life care of patients in the home.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death which included attending the patient's funeral.

Areas for Improvement

There were no requirements or recommendations made.

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

Nine patients were spoken with individually and others in small groups. Patients were complimentary regarding the standard of care they received, the attitude of staff and the food provided. There were no concerns raised with the inspector.

Eight questionnaires for patients were left with the registered manager for distribution. However, none had been returned at the time of writing this report.

Staff

In addition to speaking with staff on duty, eight questionnaires were provided for staff not on duty. The manager agreed to forward these to the staff selected. At the time of writing this report none had been returned.

Staff spoken with raised no concerns.

Representatives/relatives

Eight questionnaires were provided for patient representatives/relatives for distribution by the manager. At the time of writing this report none were returned.

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 stores on each floor.

The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients were observed relaxing in their bedrooms or in one of the lounge areas available. Patients spoken with were complimentary in respect of the home's environment.

5.5.3 Care Records

Care records examined were found to be maintained in accordance with, regulatory, professional and minimum standards. Additional care charts maintained in patient's bedrooms were found to be recorded contemporaneously and therefore accurate in relation to the delivery of care.

5.5.4 Registration with RQIA

Ms Jill O'Neill was appointed by Runwood Ltd as the permanent manager in June 2015. During the previous inspection discussion took place regarding Ms O'Neill making application to RQIA for registration as manager.

The manager confirmed, during this inspection, that she had recently completed the application for registration. The application was ready for senior management to review and 'sign off'. When this was completed the application would be forwarded to RQIA.

Areas for Improvement

There were no areas for improvement identified in relation to additional areas examined.

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

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.

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Jill O'Neill	**Date Completed**	09.12.15
Registered Person	Logan N Logeswaran	**Date Approved**	11.12.2015
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	18/12/15

Please provide any additional comments or observations you may wish to make below:

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