The Regulation and Quality Improvement Authority

Braefield
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Unannounced Care Inspection of Braefield Nursing Home

1 February 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 01 February 2016 from 09:45 to 16:45 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 Braefield Nursing Home which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

There were no actions required to be taken following the last care inspection on 24 August 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	2

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

2. Service Details

Registered Organisation/Registered Person: Care Circle Ltd Mr Christopher Walsh – Responsible Individual	**Registered Manager:** Mrs Lesley McKillen
Person in Charge of the Home at the Time of Inspection: Lesly McKillen – registered manager	**Date Manager Registered:** 24 July 2014.
Categories of Care: NH- I, PH, PH(E) and DE RC - I A maximum of 13 patients within category NH-DE in the designated dementia unit.	**Number of Registered Places:** 50
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 registered nurses
- discussion with care staff and support staff
- discussion with patients and relatives
- a general tour of the home which comprised of a review of a random selection of patient bedrooms, bathrooms and communal areas
- examination of a selection of care records
- examination of a selection of records pertaining to the inspection focus
- observation of care delivery
- 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 with RQIA since the previous care inspection
- the previous care inspection report
- the inspector's pre inspection assessment audit

During the inspection, the inspector met with 10 patients individually and with others in smaller groups; four care staff, three registered nurses (RNs); three ancillary/support staff; and two patient's visitors/representatives.

The following records were examined during the inspection:

- policies and procedure pertaining to the inspection focus and theme
- staff training records
- complaints records
- compliments records
- three patient care records and care charts

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 24 August 2015. There were no requirements or recommendations made as a result of this inspection.

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A procedure on general communication was available dated June 2012. Guidance on breaking bad news was available to staff. Staff spoken with were aware of the availability of the home's policies, procedures and various guidance documents; for example Breaking Bad News (DHSSPS) and the DHSSPS Care Standards for Nursing Homes (April 2015).

Training and induction records were sampled and evidenced that staff had completed or had been asked to complete training in relation to communicating effectively. The next training date had already been set for 22 March 2016.

Is Care Effective? (Quality of Management)

Care records reviewed, included reference to the patient's specific communication needs and actions required to manager barriers such as language, culture, cognitive ability or sensory impairment. There was also evidence that patients and their representatives were included in discussions where appropriate.

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

Review of care records evidenced that relatives, where appropriate, were kept informed of changes in the patient's condition. This was also confirmed during discussion with one relative.

Is Care Compassionate? (Quality of Care)

Observation of care delivery and interactions between patients and staff clearly demonstrated that communication was compassionate and considerate of the patients' needs.

Patients who could verbalise their feelings commented positively in relation to the care they received and in relation to the attitude of staff.

Patients unable to verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

Areas for Improvement

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

Number of Requirements:	0	Number of Recommendations:	0

5.3 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 August 2015. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013.

Training records evidenced that staff were trained in the management of death, dying and bereavement. An additional training session was planned for 17 February 2016. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

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 and staff 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.

Review of induction templates for RNs and care staff evidenced that the areas of practice relating to the management of death and dying, palliative and end of life care were not included. A recommendation was made.

Review of patient care records evidenced the involvement of the patient's General Practitioner (GP) in decisions regarding 'advanced care planning'.

Is Care Effective? (Quality of Management)

A review of 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 where appropriate.

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 spoken with demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan. Staff demonstrated clearly their compassion for patients, their relatives and friends.

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. Staff informed the inspector of how they would provide support to families whose loved ones were dying.

From discussion with the registered manager 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.

Comments recorded by relatives included:

'apart from caring for all ... physical needs each one of you added your own special touch to the quality of ...life every day'.

'... greatly appreciate the devoted care and attention ...received whilst living in Braefield. The care provided by all staff members and the kindness shown to us all has meant everything to us'.

'Very many thanks to all staff who care and looked after... your attention to ...needs was very much appreciated'.

'...even though ...disease had taken away much of what ...was, the people [staff] of Braefield still saw ... special activities and cared for ... beyond the physical needs'.

'We would like to express our own thanks... to all those that took such great care of ...throughout ...years in Braefield'.

Staff confirmed that they were given an opportunity to pay their respects after a patient's death by attending the funeral, if this was appropriate.

Areas for Improvement

It was recommended that staff inductions included death and dying, palliative care and end of life care.

Number of Requirements:	0	Number of Recommendations:	1

5.4 Additional Areas Examined

5.4.1 Consultation with Patients, Staff and Patient Representatives/Relatives

Patients

Ten 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. At the time of writing this report none had been returned.

Staff

In addition to speaking with 10 staff on duty, eight staff questionnaires were provided for staff not on duty. The registered manager agreed to forward theses to the staff selected. At the time of writing this report one had been returned. The staff member indicated that they received training in safeguarding, whistleblowing, palliative and end of life care and that they were very satisfied that care was safe, effective and compassionate.

Representatives/Relatives

The inspector spoke with two relatives during this inspection. Generally relatives were satisfied with the care their loved one's received. One relative discussed specific concerns but confirmed that theses had been raised and addressed by management. Advice was provided on the role of RQIA in relation to complaints.

Eight questionnaires were provided for representatives/relatives. The registered manager agreed to distribute these.

At the time of writing this report one had been returned. The respondent indicated that they were very satisfied with the care received by their loved one. They recorded that their loved one 'is very pleased with the staff and all are very kind to ...' and that their loved one 'is happy and content in the home'.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 39 **Stated:** First time **To be Completed by:** 7 March 2016	Staff inductions programs should include a section on death and dying, palliative care and end of life care. Ref: Section 5.3
	Response by Registered Person(s) Detailing the Actions Taken: Staff inductions to be reviewed by Senior Management Team
Recommendation 2 **Ref**: Standard 33 **Stated:** First time **To be Completed by:** 7 March 2016	The registered manager should review the recording of do not attempt resuscitation/cardio pulmonary resuscitation orders to ensure records are maintained in accordance with national and regional guidelines. Ref: Section 5.4.4
	Response by Registered Person(s) Detailing the Actions Taken: Policy and documents relating to CPR will be reviewed by Senior Management

Registered Manager Completing QIP		**Date Completed**	26.2.16.
Registered Person Approving QIP	C Jwaksh RNA	**Date Approved**	7.3.16.
RQIA Inspector Assessing Response		**Date Approved**	

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.

RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	08/03/16