Antrim Care Home
RQIA ID: 1434
88 Milltown Road
Antrim
BT41 2JJ

Inspector: Aveen Donnelly
Inspection ID: IN021806

Tel: 02894428717
Email: antrim@fshc.co.uk

Unannounced Care Inspection
of
Antrim Care Home

08 September 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 08 September 2015 from 09.00 to 16.00.

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 significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within 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 Antrim 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 20 November 2014.

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	3	4

The total number of requirements and recommendations above includes both new and those that have been 'restated'.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the deputy 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 Healthcare	**Registered Manager:** Shirley Martin
Person in Charge of the Home at the Time of Inspection: Sharon Smyth	**Date Manager Registered:** 12 February 2015
Categories of Care: RC-I, NH-DE, NH-I, NH-PH, NH-PH (E), NH-TI	**Number of Registered Places:** 53
Number of Patients Accommodated on Day of Inspection: 33	**Weekly Tariff at Time of Inspection:** Trust rates

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 analysed:

- 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 (QIPs) from inspections undertaken in the previous inspection year;
- the previous care inspection report; and
- pre-inspection assessment audit.

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with four patients, three care staff, one registered nurse, two patient's visitors/representatives and two visiting professionals.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP;
- staffing arrangements in the home;
- six patient care records;
- staff training records;
- complaints records;
- regulation 29 monitoring reports;
- policies for communication and end of life care; and
- policies for dying and death and palliative and end of life care.

Specific methods/processes used in this inspection include the following:

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced pharmacy inspection dated 27 April 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the last care inspection on 20 November 2014

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation **16(1)** **Stated:** First time	It is required that a care plan is in place to address all needs identified through the assessment process.	**Not Met**
	Action taken as confirmed during the inspection: A review of four patients' care records identified that care plans regarding the management of continence were in place. However, the care plans reviewed evidenced that the care plans were not person-centred. Discussion with the deputy manager confirmed that the company was in the process of changing the home's supplier of incontinence pads and that the registered nurses were aware that the care plans on continence would need to be updated accordingly. However, there were other matters pertaining to the care plans that were not acceptable. One patient's continence assessment identified their normal bowel habit. This information was not reflected in the patient's care plan. Where the care plan goal was to promote continence, there was no information in the planned actions regarding how this was to be achieved. There was no evidence that the patient's dignity and/or skin integrity had been considered. Another patient's care plan similarly, did not reflect information that was included in the continence assessment. Information such as normal bowel pattern or use of laxatives were not included in the care plan. One patient did not have a bowel assessment or care plan in place. This requirement was stated for the second time.	

Requirement 2 **Ref**: Regulation 13 (1)(a) **Stated:** First time	It is required that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met.	**Not Met**
	Action taken as confirmed during the inspection: Two patient care records were reviewed. Entries in the daily progress notes indicated that patients had taken fluids well. However, a review of the fluid intake monitoring records identified that the patients' fluid intake did not meet their fluid targets on two days in the week preceding the inspection. The care records reviewed did not evidence that care plans had been developed to address poor fluid intake. Discussion with the deputy manager confirmed that the identified patients normally had good fluid intake. However, there was no evidence in the daily progress records reviewed that registered nursing staff had any oversight into the fluid intake of patients over a 24 hour period. This requirement was stated for the second time.	
Requirement 3 **Ref**: Regulation **19 (1)(a)** **Stated:** Second time	It is required that contemporaneous notes of all nursing provided are maintained. Fluid balance charts must be accurately completed.	**Not Met**
	Action taken as confirmed during the inspection: A review of two patient fluid balance charts evidenced that records were not accurately completed. One fluid intake chart included only the Christian name of the patient and did not include the patient's fluid target. There was no evidence that the patients' 24hour fluid intake had been totalled. Refer to inspector comments above. This requirement was stated for the second time.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 19.1 **Stated:** First time	It is recommended that: • bowel assessments should be completed for all patients • separate care plans should be in place for each individual assessed need. • the type of continence pad and size of pants are recorded in the patient's care records • the frequency with which urinary catheters require to be changed should be included in the care plan.	**Not Met**
	Action taken as confirmed during the inspection: A review of two patient's care records did not evidence that bowel assessments had been completed. One identified patient, who had an indwelling catheter did not have the frequency with which it should have been changed, included in their care plan. They also did not have a separate care plan for bowel function. There was no evidence in two care records reviewed that the type of pad had been included. As previously discussed, the deputy manager stated that the company was in the process of changing the home's supplier of incontinence pads and that the registered nurses were aware that the care plans on continence would need to be updated accordingly. This requirement was stated for the second time.	

Recommendation 2 **Ref**: Standard 19.4 **Stated:** First time	It is recommended that consideration is given by the home manager for registered nurses to attended training and gain competency in male catheterisation.	**Met**
	Action taken as confirmed during the inspection: Discussions confirmed that the deputy manager was in the process of completing training in male catheterisation. Plans were in place for the deputy manager to deliver the training to other registered nursing staff within the home and it is intended that the deputy manager will complete staff competencies and capabilities, following this training.	
Recommendation 3 **Ref**: Standard 32.1 **Stated:** First time	It is recommended that the management of odours in the identified area is reviewed and eliminated.	**Not Met**
	Action taken as confirmed during the inspection: Although the specific area referred to in this requirement could not be identified, a general inspection of the home was undertaken and there were no significant malodours identified. Refer to inspector comments in section 5.5. However, discussion with the deputy manager identified that there was, at times, a pervading malodour that was detectable throughout the general nursing unit. The management of malodours was not fully addressed and was stated for the second time.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure on communicating effectively was currently under review, by the organisation, at the time of the inspection. However, this was available in draft format. A review of the draft policy confirmed that it reflected current best practice, including regional guidelines on Breaking Bad News. Discussion with the deputy manager and one registered nurse confirmed that they were knowledgeable regarding this policy and procedure. A policy on the management of an unexpected death was also reviewed.

Discussion with the deputy manager confirmed that plans were in place for all staff to receive training in palliative and end of life care. The planned training material was reviewed and included the procedure for breaking bad news, as relevant to staff roles and responsibilities.

Is Care Effective? (Quality of Management)

A review of three patient care records reflected patient individual needs and wishes regarding end of life care. Recording within records included reference to the patient's specific communication needs.

The care records reviewed evidenced that the breaking of bad news was discussed with patients and/or their representatives and options and treatment plans were also discussed, where appropriate. 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.

Discussion with the deputy manager confirmed that the nursing home was involved in a pilot project in conjunction with Queen's University, Belfast. The aim of the research was to develop ways of promoting informed decision making and effective communication through advance care planning for people living with dementia and their family carers. Three patients' representatives were involved in the pilot project.

Care staff consulted with discussed their ability to communicate sensitively with patients and/or their representatives. When the need for breaking bad news was raised, care staff felt that this was generally undertaken by registered nursing staff. However, staff were aware of communication aids/cues, for example non-verbal cues and gestures. All staff consulted felt they played an important role in supporting patients and their family members following sensitive or distressing news.

Is Care Compassionate? (Quality of Care)

Discussion with four patients individually and with the majority of patients generally evidenced that patients were content living in the home. Observations of the delivery of care and staff interactions with patients confirmed 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 time to reassure patients as was required from time to time.

Staff recognised the need to develop a strong, supportive relationship with patients and relatives. It was appreciated by staff that this relationship would allow the delivery of bad news more sensitively and with greater empathy when required.

Two patient's representative also confirmed that they were kept informed of any changes to their relative's condition and of the outcome of visits and reviews by healthcare professionals.

Areas for Improvement

There were no requirements or recommendations made in relation to Standard 19

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 are currently under review by the organisation. A review of the draft policy confirmed that it 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.

As previously discussed, the deputy manager confirmed that plans were in place for all staff to receive training in palliative and end of life care. There was also an e-learning module on palliative and end of life care and it is anticipated that this will commence in the upcoming months. Registered nursing staff consulted, were aware of and able to demonstrate knowledge of the GAIN Palliative Care Guidelines, November 2013.

Discussion with the deputy manager, one registered nurse and a review of three patient care records confirmed that:

- there were arrangements in place for staff to make referrals to specialist palliative care services; and
- staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

There was no formal protocol for timely access to any specialist equipment or drugs in place. However, discussion with registered nursing staff confirmed that they were knowledge of the procedure to follow, if required.

There was no specialist equipment, in use in the home on the day of inspection. The deputy manager was aware that update training in the use of syringe drivers could be accessed through the local healthcare trust nurse, if required.

There was no palliative care link nurse identified in the home. However, discussion with the registered manager confirmed that plans were in place to nominate a registered nurse, to undertake this role.

Is Care Effective? (Quality of Management)

As previously discussed, the deputy manager confirmed that the nursing home was involved in a pilot project in conjunction with Queen's University, Belfast. The aim of the research was to develop ways of promoting informed decision making and effective communication through advance care planning for people living with dementia and their family carers. Two of the completed end of life care plans were reviewed. The content of the care plans were of a very high standard and were reflective of considerable family involvement. The deputy manager confirmed that each patient's key worker/named nurse will review the end of life care plans, as appropriate for patients receiving palliative care and end of life care, following the completion of this study.

A review of three 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 and symptom management. One staff member commented that pain relief was not managed appropriately. This was discussed with the deputy manager, during feedback. Refer to inspector comments in section 5.5.

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. All staff consulted demonstrated an awareness of patient's expressed wishes and needs, as identified in their care plan.

Discussion with the deputy manager, staff and a review of care records 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.

A review of notifications of death to RQIA during the previous inspection year identified that all deaths were notified appropriately.

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. Staff consulted described how they have provided catering/snack arrangements to family members, when a patient is unwell and receiving end of life care.

Following discussion with the deputy manager and staff and a review of the compliments records, it was evident 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 when their loved one was nearing end of life. One comment referred to the 'excellent care (given by staff) in creating a warm family home from home'.

Discussion with the deputy 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.

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

From discussion with the manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included more experienced staff providing support to those staff, who were new to the caring role and time spent reflecting on the patients time spent living in the home. Information regarding support services was available and accessible for staff, patients and their relatives.

Areas for Improvement

A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; palliative and end of life care and of the management of an unexpected death.

Staff should be provided with the opportunity to discuss symptom management in palliative and end of life care. These discussions should include staff who are not directly involved in direct patient care, if appropriate.

Number of Requirements:	**0**	**Number of Recommendations:**	**2**

5.5 Additional Areas Examined

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	10	10
Patients	7	5
Patients representatives	5	1

All comments on the returned questionnaires were in general positive. Some comments received are detailed below:

Staff

'This home is a good place to work and I enjoy working with the care staff and residents. I love my job'
'I feel very happy with the way our residents are treated. We respect their needs and wishes and try to the best of our ability, to make sure that they are happy and content'
'It is a cosy home with friendly staff and happy residents. It is such a good home'
'I enjoyed the palliative and end of life training'
'I love it here. I have no concerns'
'I think the care provided to patients who are dying is so much better than I have experienced (elsewhere)'

One staff member, who was not involved in the direct delivery of care, commented that it was a disgrace that patients were not always offered syringe drivers for pain relief. This was discussed with the deputy manager, who agreed to clarify this matter with all staff.
As previously discussed in section 5.4, a recommendation is made to address this.

Patients

'The staff are nice. They are all good'
'The food is tolerable'
'I am happy enough here'
'I get want I want and that's all I would ever expect. The girls are grand here'

Patients' representatives

'The staff always speak to (my relative), as they pass their bedroom. My relative really enjoys the banter'
'It is very good here. I could not say enough for the staff'

Environment

A general inspection of the home was undertaken which included inspection of a random sample of bedrooms, bathrooms shower and toilet facilities, sluice rooms, storage rooms and communal areas were examined. In general the areas examined were found to be clean, reasonably tidy and well decorated and warm throughout.

As discussed in section 5.2, there were no significant malodours identified on the day of inspection. However, discussion with the deputy manager identified that there was, at times, a pervading malodour that was detectable throughout the general nursing unit. The recommendation regarding the management of malodours was stated for the second time. Refer to inspector comments in section 5.2.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the deputy 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 and the Residential Care Homes Minimum Standards, August 2011. 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	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 16(1) **Stated:** Second time **To be Completed by:** **06 November 2015**	It is required that a care plan is in place to address all needs identified through the assessment process. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Every resident has a pre admission assessment carried out when we receive an enquiry, this is the followed up by an admission assessment and needs assessment on admission to the home. These form the framework for devising the care plans. The information contained in the care plan from the persons named worker is also taken in to account.
Requirement 2 **Ref:** Regulation 13 (1)(a) **Stated:** Second time **To be Completed by:** **06 November 2015**	It is required that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: When a specific need is identified, a care plan is devised to ensure that this need is fully met. The Deputy Manager has audited 100% of the care plans in the home at todays date 12.10.15 and the findings have been passed on to the Named nurses to act upon to bring all files fully up to date.
Requirement 3 **Ref:** Regulation 19 (1)(a) **Stated:** Second time **To be Completed by:** **06 November 2015**	It is required that contemporaneous notes of all nursing provided are maintained. Fluid balance charts must be accurately completed. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: A series of staff meeting were held in September and October 2015 and all staff were reminded of the importance of completing fluid balance charts accurately.

Recommendations	
Recommendation 1 **Ref**: Standard 19.1 **Stated:** Second time **To be Completed by:** **06 November 2015**	It is recommended that: • bowel assessments should be completed for all patients • separate care plans should be in place for each individual assessed need. • the type of continence pad and size of pants are recorded in the patient's care records • the frequency with which urinary catheters require to be changed should be included in the care plan. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: - A fully completed bowel assessment is in situ in each residents care file - A care plan is also in place for each identified need - All residents within the home have been assessed for the correct type of incontinence aid. This information is retained in their care file and a small discreet card detailing the type of aid required is also in each bedroom - A list of the exact months in which urinary catheters are to be changed will now be specified in the care plan.
Recommendation 2 **Ref**: Standard 32.1 **Stated:** Second time **To be Completed by:** **06 November 2015**	It is recommended that the management of odours in the identified area is reviewed and eliminated. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: The Housekeeper and Domestic staff in the home are fully committed to ensuring that all areas of the home smell clean, fresh and free from odours at all times.
Recommendation 3 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** **06 November 2015**	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; and palliative and end of life care and of the management of an unexpected death. **Ref section: 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Each time a new policy is introduced staff are made aware of this by memo and are informed how to access on the intranet during their induction. A copy of the policy is sent to each unit, if appropriate, with a sheet which all staff are reqired to sign confirming that they have read and understood the contents of the policy and will adhere to the contents therein. All Staff including those not involved in direct patient care will be provided with an opportunity to discuss palliative and end of

	life care during training, formal supervision sessions and at staff meetings.
Recommendation 4 **Ref**: Standard 32.6 **Stated:** First time **To be Completed by:** **06 November 2015**	Staff should be provided with the opportunity to discuss symptom management in palliative and end of life care. These discussion should include staff who are not directly involved in direct patient care, if appropriate. **Ref: Section 5.4 and 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: As above

Registered Manager Completing QIP	S Martin	**Date Completed**	12.10.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	13.10.15
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	15/10/2015

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