Milesian Manor
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Unannounced Care Inspection
of
Milesian Manor

26 August 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 26 August 2015 from 10.05 to 16.45.

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 Milesian Manor 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 19 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	4	7

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 Selvon Lobin as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Milesian Manor Seamus P. Higgins and Patrick Joseph Forbes	**Registered Manager:** Martha Theresa O'Kane
Person in Charge of the Home at the Time of Inspection: Selvon Lobin	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-I, RC-I, NH-PH, NH-PH(E)	**Number of Registered Places:** 34
Number of Patients Accommodated on Day of Inspection: 33	**Weekly Tariff at Time of Inspection:** £593

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, two care staff, one domestic staff, three nursing staff and four patient's visitors/representatives.

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 monthly monitoring reports;
- policies for communication and end of life care; and
- policies for dying and death and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the Milesian Manor was an unannounced pharmacy inspection dated 21 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 19 November 2014

Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 19.3 **Stated:** First time	It is recommended that regular audits of the management of patients and residents who are incontinent be undertaken and the findings acted upon to enhance already good standards of care.	**Not Met**
	Action taken as confirmed during the inspection: Three records regarding patient's fluid intake and output were reviewed. These records were not considered to be incontinence audits. This recommendation is stated for the second time.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The policy on communication that was reviewed generally related to forms of communication between members of staff. There was no policy regarding how staff should communicate with patients who had a cognitive, language or sensory impairment or on breaking bad news. However, regional guidance on Breaking Bad News was available and discussion with staff confirmed that they were knowledgeable regarding this guidance document.

Training records reviewed did not evidence that formal training on communication had taken place. However, a review of the registered nurse competency and capability assessment confirmed that communication was included and training in the breaking of bad news had been provided to staff as part of recent palliative care training.

Is Care Effective? (Quality of Management)

Care staff consulted stated that they considered the breaking of bad news to be, primarily, the responsibility of the registered nursing staff but felt confident that, should a patient and/or their representative choose to talk to them about a patient's condition, they would have the necessary skills to do so. The nurse in charge was able to demonstrate their ability to communicate sensitively with patients and relatives when breaking bad news and provided examples of how they had done this in the past.
All staff consulted emphasised the importance of building caring relationships with patients and their representatives and the importance of regular ongoing communication regarding the patient's condition. Staff explained that discussions regarding a patient's condition were generally triggered by deterioration in their condition or through the care review process.

One patient was identified as having a significant language and communication barrier. There was evidence that the staff had been using communication tools, however this was not reflected in the patients care plan. Refer to inspector comments in section 5.5.

Is Care Compassionate? (Quality of Care)

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 cheerfully and taking time to reassure patients.

Discussion with four patients individually and with the majority of patients generally evidenced that patients were content living in the home.

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

The policy on communicating effectively should be developed in line with current regional guidance on breaking bad news. The policy should also include communication with patients who have cognitive impairments and sensory, cultural or language barriers.

Number of Requirements:	**0**	**Number of Recommendations**: ***1 recommendation is made under Standard 32 below**	***1**

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)

A policy on the management of palliative and end of life care was in the process of being reviewed on the day of inspection. However, the draft policy which was reviewed did not reflect best practice guidance such as the GAIN Palliative Care Guidelines, November 2013.

There was no formal protocol in place for timely access to any specialist equipment or drugs. However, discussion with two registered nurses confirmed their knowledge of the procedure to follow, should they be required.

A review of the training records evidenced that a number of staff had completed training in respect of palliative/end of life care.

Discussion with two nursing staff and a review of three care records confirmed that:

- there were arrangements in place for staff to make referrals to specialist palliative care services and where instructions had been provided, these were evidently adhered to; 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 specialist equipment, in use in the home on the day of inspection. Training in the use of syringe drivers had been provided and the nurse in charge was aware that update training would be provided through the local healthcare trust nurse.

There was no palliative care link nurse identified in the home, however discussion with the nurse in charge confirmed that plans were in place to nominate and train an appropriate person to undertake this role.

Is Care Effective? (Quality of Management)

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 management and symptom management. However, there was no evidence in the records reviewed that end of life arrangements for patients were discussed with patients and/or their representatives and patients' wishes in relation to their religious, spiritual and cultural needs were not documented.

A key worker/named nurse was identified for each patient approaching end of life care.

Discussion with the nurse in charge, staff and a review of two 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. Through discussion there was evidence that staff had managed shared rooms sensitively. Staff provided an example of patients who had shared a bedroom for many years and how their care was managed when one patient died.

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

Is Care Compassionate? (Quality of Care)

As discussed previously, there was no evidence in the records reviewed that discussion had taken place between staff and patients and/or their representatives regarding end of life care. However, discussion with staff confirmed that patients cultural and spiritual preferences are respected and provided for, when receiving end of life care. All staff consulted demonstrated an awareness of patient's expressed wishes.

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 described how a vacant room would be offered for use, if available and that snacks and refreshments were always provided to relatives during this period.

From discussion with the nurse in charge, staff and relatives there was evidence that arrangements in the home were sufficient to support relatives during this time. The records regarding complaints were not available. However, discussion with the nurse in charge confirmed that there had been no complaints raised in relation to the care provided to patients who were receiving end of life care and relatives consulted commended the management and staff for their efforts towards the family and patients.

All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. From discussion with the nurse in charge, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included support provided by more experienced staff and reflecting on a patient's time spent living in the home. Information regarding support services was available and accessible for staff, patients and their relatives. This information included information leaflets on the last stages of dying and a palliative care directory that provided detailed all services within the Mid-Ulster area.

Areas for Improvement

It is recommended that the policy on end of life care is reviewed and updated to ensure that it is reflective of best practice guidance such as Guidelines and Audit Implementation Network (GAIN) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013.

It is recommended that end of life arrangements for patients are discussed and documented as appropriate and include patients' wishes in relation to their religious, spiritual and cultural needs.

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

5.5 Additional Areas Examined

Complaints

Discussion with the nurse in charge and one registered nurse confirmed that in the absence of the registered manager, complaints were documented in the patient's progress notes and communicated verbally to the registered manager at the next available opportunity. Recent records regarding complaints in the home were not available for inspection. A recommendation is made to address this.

Care Records

Three patient care records were reviewed. Entries in the daily progress notes indicated that patients had taken fluids well on the two days preceding the inspection. However, a review of the fluid intake monitoring records identified that the patients' fluid intake did not meet their fluid targets on these days. The care records reviewed did not evidence that care plans had been developed to address this. Discussion with two registered nursing staff 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. A requirement is made to address this.

The care plans reviewed were not person-centred. As discussed in section 5.3, one patient was identified as having a significant language and communication barrier. There was evidence that the staff had been using communication tools, however this was not reflected in the patients care plan. There was evidence that the patient's pain was being managed effectively. However, there was no pain assessment or care plan in place, to outline the how the patient exhibited signs of discomfort. Discussion with the nurse in charge, one registered nurse and a visiting relative, provided assurances that they had a good awareness of this identified patient's needs.

Four patients' care records were reviewed. One identified patient did not have a continence assessment completed. Three other continence assessments were reviewed. The information identified in the continence assessments was not reflected in the continence care plans. There was also no evidence that patients' normal bowel pattern was ascertained on admission or was recorded in the care plans. Where the goal of the care plan was identified as being for continence to be promoted, there was no indication of the level of each patients' level of participation and the Bristol stool chart was not referenced in the records reviewed.

In view of findings, outlined above, a requirement is made to address this.

The review of patient care records identified that a number of registered nursing staff recorded dates. Entries were observed to be made by the month, rather than the actual date. This was evident in three patient care records. There was one patient assessment that did not indicate the year. This is not in line with professional recording guidelines on record and record keeping. In addition, the bedrail risk assessment did not have a column included to facilitate the entry of the nurses' signature. This was discussed with the nurse in charge who provided assurances that this would be amended. In view of inspector findings, a requirement is made that all registered nursing staff receive training in care planning. This training should also include the legal aspects of care planning and record keeping.

Family Involvement

Discussion with visiting relatives confirmed that they were regularly consulted by the staff with regards to their relatives care. However, a review of four patients care records identified that the family involvement in care planning form had not been updated for two patients and was not present in another care record. Consent forms for the use of restraints had also not been consistently updated in the four care records reviewed. This was discussed with the nurse in charge who provided assurances that these matters would be addressed. Two recommendations are made in this regard.

Training records

Training records were reviewed. There was no information available regarding the content of the training provided. A recommendation is made to address this.

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	9
Patients	5	5
Patients representatives	5	5

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

Staff

'We have a good team working together to improve our care and give the best we can'
'I love the fact that most of the patients know all of the staff by name, which to me shows how well we all work together'
'Everybody seems content with their jobs and responsibilities'
'This is a very happy house'
'It is a good place to be for residents and staff alike'
'The care provided here is very good'
'The home provides a good quality of care and provides them with dignity, help and support'
'We have a great team of carers'.

Patients

'Everybody here is very kind to me'
'It is very good'
'The staff are very good. I am happy here'
'I couldn't be happier'
'I am 99 percent happy here'
'They are good to me here. It is as well as can be expected'
'I treat the patients here like I would treat my own mother'.

Patients' representatives

'I know (my relative) is getting the best care possible'
'Everything possible is being done to keep her safe and I often discuss her care needs with the appropriate staff'
'We have no negative comments and it is a joy to visit. The staff work hard to attend to all needs and they are always happy'
'The staff are excellent. We feel very content with the care'
'It is a very good home'
'I can honestly say that my (relative) is well cared for, happy and all needs are being met'
'It is 100 percent. You could not find better'
'Staff have good banter and there is a good atmosphere here'.

Environment

The home was generally clean and tidy with no malodours present. However, in three identified bedrooms, the door was manually propped open using curtains and another was held open using a bin. This practice is not in keeping with fire regulations. The nurse in charge confirmed that this matter would be addressed as a matter of urgency with all staff. A requirement is made.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Selvon Lobin 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 15 (2) **Stated:** First time **To be Completed by:** 23 October 2015	Where a nursing assessment is made to monitor a patient's daily fluid intake, then the patients daily (24hour) fluid intake must be recorded in their daily progress record to evidence that this area of care is being properly monitored and validated by the registered nurse. **Ref section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: This has been addressed. All staff nurses have been informed of this.
Requirement 2 **Ref:** Regulation 16 (1) **Stated:** First time **To be Completed by:** 23 October 2015	The registered persons must ensure that care plans are developed by registered nurses. **Ref section 5.5**
	Care Plans are always developed by Registered Nurses
Requirement 3 **Ref:** Regulation 20 (1) (c) **Stated:** First time **To be Completed by:** 01 December 2015	Registered nursing staff should receive training in developing care plans. This training should also address the deficits in contemporaneous recording observed in this inspection, in accordance with NMC guidelines for record keeping and should include the legal aspects of care planning and record keeping. **Ref section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: We have sourced training in developing care plans and record keeping.
Requirement 4 **Ref:** Regulation 27 (4) (b) **Stated:** First time **To be Completed by:** 23 October 2015	Precautions must be in place that minimise the risk of fire and protect patients, staff and visitors in the event of a fire. This refers specifically to the observed practice of fire doors being propped open. **Ref section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: All staff are fully aware of the precautions to be taken to prevent fire as they have fire training twice yearly. The Manager has addressed this with all staff.

Recommendations	
Recommendation 1 **Ref**: Standard 19.3 **Stated:** Second time **To be Completed by:** 23 October 2015	It is recommended that regular audits of the management of patients and residents who are incontinent be undertaken and the findings acted upon to enhance already good standards of care. **Ref section 5.2. Follow up on previous issue**
	Response by Registered Person(s) Detailing the Actions Taken: Patients within the Home are regularly assessed as to their requirements and at the time of the inspection audits were in process and are carried out regularly.
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 23 October 2015	The following policies and guidance documents should be developed and made readily available to staff: • A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • A policy on communication which includes communication with patients who have cognitive impairments and sensory, cultural or language barriers. • A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the out of hours procedure for accessing specialist equipment and medication; the referral procedure for specialist palliative care nurses; and the management of shared rooms. • A policy on death and dying in line with current best practice, such as DHSSPSNI (2010) *Living Matters: Dying Matters* which should include the procedure for dealing with patients' belongings after a death. **Ref to section 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Our policy on communication is now further developed to include specific needs of patients with cognitive impairments and sensory, cultural and language barriers There is a policy on on end of life care - this has been further developed to include - out of hours procedure for accessing specialist equipment and medication, the referral proedure for accessing palliative care nurses and the management of a shared room. There is a policy on death and dying which has been developed to include the dealing with patients belongings after death..

Recommendation 3 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 23 October 2015	End of life arrangements for patients should be discussed and documented as appropriate, and include patients' wishes in relation to their religious, spiritual and cultural needs. **Ref section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: End of life arrangements that is their wishes are referenced in the spiritual care plan. An end of life care plan is now implemented for patients that require it in the home. This includes their wishes in relation to their religious, spiritual and cultural needs.
Recommendation 4 **Ref**: Standard 16.11 **Stated:** First time **To be Completed by:** 23 October 2015	Records should be maintained of all complaints and these should include details of all communications with complainants; the result of any investigations; the actions taken; whether or not the complainant was satisfied with the outcome; and how this level of satisfaction was determined. The process for dealing with complaints should be reviewed to include how the staff records complaints in the absence of the registered manager. The complaints record should always made available for inspection. **Ref section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: The complains file was in the Managers office at the time of the inspection. Sorry that staff overlooked it. Recent complaints were received by email and were entered into complaints file. Staff are fully aware of dealing with complaints in my absence.
Recommendation 5 **Ref**: Standard 18.11 **Stated:** First time **To be Completed by:** 23 October 2015	Where restraint and/or restrictive practices are used, the patient and/or their representative should be invited to discuss and regularly review the consent form for continued use. **Ref section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: Forms of restraint will be regularly reviewed and agreed with patient and representative.

Recommendation 6 **Ref**: Standard 4.11 **Stated:** First time **To be Completed by:** 23 October 2015	The process for discussing care plans with patients and/or their representatives should be reviewed to ensure that they are facilitated to participate in all aspects of reviewing outcomes of care, on a regular basis. **Ref section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: We will ensure that care plans are reviewed that the patient and/or representative will be invited to participate in this process.
Recommendation 7 **Ref**: Standard 39 **Stated:** First time **To be Completed by:** 23 October 2015	The content of all training provided should be maintained in the home. **Ref section 5.5**
	Response by Registered Person(s) Detailing the Actions Taken: Information on study days/training is available for inspection in the Managers filing cabinet.

Registered Manager Completing QIP	Mrs Martha O'Kane	**Date Completed**	16/11/2015
Registered Person Approving QIP		**Date Approved**	
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	08/12/2015

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