The Regulation and Quality Improvement Authority

Ballyclare Nursing Home
RQIA ID: 1442
107a Donagh Road
Ballyclare
BT39 9ES

Inspector: Bridget Dougan
Inspection ID: IN22031

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Unannounced Care Inspection of Ballyclare Nursing Home

20 August 2015

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1. Summary of Inspection

An unannounced care inspection took place on 20 August 2015 from 12.00 to 15.30 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying; and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

For the purposes of this report, the term 'patients' will be used to describe those living in Ballyclare Nursing 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 30 September 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	0	2

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

2. Service Details

Registered Organisation/Registered Person: Mrs Janet Montgomery Hutchinson Homes Ltd	**Registered Manager:** Mrs Harriet Dunsmore
Person in Charge of the Home at the Time of Inspection: Mrs Harriet Dunsmore	**Date Manager Registered:** 1 April 2005
Categories of Care: RC-I, RC-MP(E), RC-PH(E), NH-I	**Number of Registered Places:** 34
Number of Patients Accommodated on Day of Inspection: 34	**Weekly Tariff at Time of Inspection:** Nursing - £510 Residential - £405

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)

3. 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 since the previous care inspection
- the returned quality improvement plans (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report.

During the inspection, the inspector met with 12 patients, two nursing, six care staff and two relatives.

The following records were examined during the inspection:

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

- policies for communication, death and dying, and palliative and end of life care
- complaints and compliments records.

4. The Inspection

4.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 30 September 2014. The completed QIP was returned and approved by the care inspector.

Review of Requirements and Recommendations from the last care Inspection

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 16 (2) (b) **Stated:** Second time	The registered person shall ensure that the patients risk assessments and care plans are kept under review.	**Met**
	Action taken as confirmed during the inspection: Six care records were reviewed and evidenced that this requirement had been met	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 5.6 **Stated:** Second time	The registered manager must ensure that contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.	**Met**
	Action taken as confirmed during the inspection: All care records reviewed were contemporaneous and maintained in accordance with NMC guidelines.	

Recommendation 2 **Ref:** Standard 5.5 **Stated:** First time	The registered manager should ensure that copies of the following documents are available in the home for staff to access: • Human Rights Act 1998 • European Convention on Human Rights • (ECHR) DHSSPS • Deprivation of Liberty Safeguards. (DOLS) The content of these documents should be discussed with staff during staff meetings and staff should be aware of their responsibilities in relation to adhering to the Human Rights legislation in the provision of patient care and accompanying records.	**Met**
	Action taken as confirmed during the inspection: Copies of the above documents were available in the home and staff were aware of their responsibilities in relation to adhering to the Human Rights legislation.	
Recommendation 3 **Ref:** Standard 11.3 **Stated:** First time	The registered manager should ensure that where a patient has been assessed as being 'at risk' of developing a pressure ulcer, a care plan is in place to manage the prevention plan and treatment programme.	**Met**
	Action taken as confirmed during the inspection: Review of the care records of two patients who had been assessed as being 'at risk' of developing a pressure ulcer confirmed that a care plan was in place to manage the prevention plan and treatment programme.	
Recommendation 4 **Ref:** Standard 11 **Stated:** First time	The registered manager should ensure there is a policy and procedure for the prevention and treatment of pressure ulcers available in the home for staff to reference.	**Met**
	Action taken as confirmed during the inspection: A policy and procedure for the prevention and treatment of pressure ulcers was available in the home for staff to reference.	

Recommendation 5 **Ref:** Standard 28.4 **Stated:** First time	The registered manager should ensure that training in relation to pressure area care and the prevention of pressure ulcers is provided for all relevant staff.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and review of training records evidenced that six care assistants had attended this training in 2014 and that further training was planned at RCN for October 2015 for the remaining care staff.	
Recommendation 6 **Ref:** Standard 8.3 **Stated:** First time	A recommendation has been made to ensure that, for those patients identified as being at risk of inadequate or excessive food and fluid intake: • a fluid intake target over 24 hours is recorded in the relevant care plan and on fluid balance charts • an effective reconciliation of the total fluid intake against the fluid target established • action to be taken if targets were not being achieved.	**Met**
	Action taken as confirmed during the inspection: Inspection of six patients care records evidenced that food and fluid records were maintained appropriately.	

4.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on breaking bad news. Discussion with eight staff confirmed that they were knowledgeable regarding this policy and procedure.

Discussion with the registered manager and review of training records evidenced that six nurses had completed a Marie Curie palliative care course and this included communicating effectively with patients and their families/representatives regarding the procedure for breaking bad news. Six care assistants had also been booked onto a six week palliative care course commencing 21 August 2015 and further training had been planned for the remaining care assistants and nurses at RCN on 21 October 2015.

Is Care Effective? (Quality of Management)

Six care records evidenced that patients' individual needs and wishes in respect of end of life care were appropriately recorded. Care interventions within records referenced the patient's specific communication needs.

There was evidence within the care records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Nurses demonstrated their ability to communicate sensitively with patients and relatives when breaking bad news by sitting down with the patient and or patient representatives in a private area, speaking in a calm but reassuring tone and providing an opportunity to answer any questions or concerns and where appropriate offering gestures of affection and compassion.

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 as was required from time to time.

Discussion with 12 patients individually evidenced that patients were happy living in the home. Comments received included:

- "Staff are all very good."
- "They couldn't do enough for you."

Two relatives also confirmed that they were happy with standards maintained in the home.

Areas for Improvement

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

4.3 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. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects.

Training records evidenced that nursing staff were trained in the management of death, dying and bereavement. Further training had been booked for care assistants for August and October 2015. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

Discussion with registered 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 other specialist practitioners.

Discussion with the registered manager, registered nursing staff and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

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

A palliative care link nurse had not been identified for the home. A recommendation has been made in this regard.

Is Care Effective? (Quality of Management)

A review of six care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration, nutrition and symptom management. However, two patients on regular analgesia had no assessment or care plans in place for the management of pain. A recommendation has been made.

There was evidence that social, cultural and religious preferences were considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Discussion with the registered manager and a review of a sample 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. Facilities have been made available for family members to spend extended periods with their loved ones during the final days of life. Meals, snacks and emotional support has been provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that all had been reported appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with eight staff and a review of six 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. Two nursing staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plans.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person.

From discussion with the registered manager and staff, relatives 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.

Discussion with the registered manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

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

From discussion with the registered manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included support from management, peer support and also reflections at staff meetings.

Information regarding support services was available and accessible for staff, patients and their relatives.

Areas for Improvement

It is recommended that a palliative care link nurse is identified for the home.

The registered manager should ensure that assessments and care plans are in place for the management of pain for patients who are in receipt of regular analgesia.

Number of Requirements:	0	Number of Recommendations:	2

4.4 Additional Areas Examined

5.4.1 Consultation with patients, their representatives and staff

As part of the inspection process the 12 patients were spoken with. Comments from patients regarding the quality of care, food and in general the life of the home were positive. A number of patients were unable to express their views due to the frailty of their condition. All patients appeared well kempt and comfortable in their surroundings. A few comments are detailed below;

- "Staff are very good."
- "I am happy here."
- "It's not home but it's the next best thing"

Two patients' representatives took the time to speak with the inspector. The relatives were very complimentary regarding the care and services provided. Comments received are detailed below:

- "Excellent."
- "We couldn't speak highly enough of the care and staff in the home."

The general view from staff cited during discussions was that they took pride in delivering safe, effective and compassionate care to patients. Staff confirmed that they were looking forward to the planned training in palliative/end of life care and that this will enhance their knowledge in this area of practice. No concerns were raised with the inspector.

A few comments are detailed below:

- "This is a nice place to work."
- "Our residents are treated with dignity and respect and are well looked after."
- "We have good team work."

5. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Harriet Dunsmore 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.

5.1 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.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

5.3 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 RQIA Office and assessed by the inspector.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 4 **Stated:** First time **To be Completed by:** 01 October 2015	The registered manager should ensure that assessments and care plans are in place for the management of pain for patients who are in receipt of regular analgesia. **Response by Registered Person(s) Detailing the Actions Taken:** Assessments and care plans are now in place for all patients who are in receipt of regular analgesia
Recommendation 2 **Ref:** Standard 32.3 **Stated:** First time **To be Completed by:** 01 October 2015	The registered manager should ensure that a palliative care link nurse has been identified for the home. **Response by Registered Person(s) Detailing the Actions Taken:** We are in the process of identifying a palliative care link nurse. This will be given my immediate attention when staff return from annual leave.

Registered Manager Completing QIP	H: Dunsmore	**Date Completed**	23/9/15
Registered Person Approving QIP	[signature]	**Date Approved**	12·10·2015
RQIA Inspector Assessing Response	Bridget Doyan	**Date Approved**	23/10/15.

Please ensure this document is completed in full and returned to RQIA Office.