Hamilton Care Home
RQIA ID: 1444
The Plantain
168 Ballycorr Road
Ballyclare
BT39 9DF

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Unannounced Care Inspection
of
Hamilton Care Home

8 March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 8 March 2016 from 09.20 to 14.00 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care**, of the DHSSPSNI Care Standards for Nursing Homes (2015).

The inspection also sought to assess progress with the issues raised during and since the previous care inspection on 26 February 2015. Following discussion with senior management, it was agreed that the inspection would also review the recommendations made following a pre-registration inspection on 1 February 2016. The Quality improvement plans (QIPs) from these inspections have been combined in section 5.2.

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 Hamilton 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 QIPs there were no further actions required to be taken following the last care inspection on 26 February 2015 or the pre-registration inspection on 1 February 2016.

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	**2***	**9***

*The total number of requirements and recommendations include two requirements and two recommendations each stated for a second time. In addition, one recommendation has been carried forward until the next inspection, as the compliance date of 1 May 2016 had not been reached.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Lucy Hamilton, 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: Heather Hamilton	**Registered Manager:** Lucy Hamilton
Person in Charge of the Home at the Time of Inspection: Lucy Hamilton	**Date Manager Registered:** 5 June 2008
Categories of Care: NH-I, NH-PH, RC-I, RC-MP(E), RC-PH(E) A maximum of 3 residents in categories RC-I, RC-MP(E) or RC-PH(E). Category NH-PH for 1 identified patient only.	**Number of Registered Places:** 36
Number of Patients Accommodated on Day of Inspection: 27	**Weekly Tariff at Time of Inspection:** £658

3. Inspection Focus

The inspection sought 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)**

The inspection also sought to assess progress with the issues raised during and since the previous care inspection on 26 February 2015. Following discussion with senior management, it was agreed that the inspection would also review the recommendations made following a pre-registration inspection on 1 February 2016.

4. Methods/Process

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

- discussion with the registered manager
- discussion with staff
- discussion with patients
- observation during a tour of the premises
- evaluation and feedback.

The inspector met with five patients individually and with the majority of others in groups, three care staff, one registered nurse and two ancillary staff.

Prior to inspection the following records were analysed:

- notifiable events submitted since the last 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 the previous care inspections
- the care inspection reports for this inspection year.

The following records were examined during the inspection:

- three patient care records and a selection of daily charts
- staff duty rotas from 7 to 13 March 2016
- staff training records
- staff induction records
- complaints records
- a selection of policies and procedures in relation to the theme
- guidance for staff in relation to incontinence and palliative care
- accident and incident records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspections

The previous care inspections of the home were an unannounced pre-registration inspection on 1 February 2016 and an unannounced care inspection on 26 February 2015. The completed QIPs were returned and approved by the care inspector. The QIPs from these inspections have been combined in section 5.2 below.

5.2 Review of Requirements and Recommendations from the Last Care Inspections

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person must ensure that suitable arrangements are made to minimise the risk of infection. This is particularly in relation to the following: • the presence of creams and toiletries in patients' bathrooms which could be potentially shared and increase the risk of cross contamination • Items such as wipes, pads, waste bags and equipment noted to be stored inappropriately in bathrooms • Commode pots in the sluice rack not properly decontaminated or inverted to dry • toileting slings hanging on a hoist with the potential for inappropriate communal	**Partially Met**

	use and cross contamination	
	Action taken as confirmed during the inspection: The home was presented to a good standard of hygiene throughout. Commode pots were appropriately stored and there was no evidence of toileting slings being shared. In one bathroom an unlabelled tub of cream was present and in another some wipes and bags were noted. The manager stated in discussion that she performs a daily walk around the home and highlights these issues to staff. However, the outcome of these walk arounds were not documented and no infection control audits had been completed in recent months. This requirement has been partially met and has not been stated again. However, a recommendation has been made that regular infection prevention and control audits are carried out and documented and any deficits actioned appropriately.	
Requirement 2 **Ref**: Regulation 12 (1) (a) & (b) **Stated:** First time	The registered person shall provide treatment to patients which meets their individual needs and reflects current best practice. This is particularly in relation to: • ensuring that the repositioning schedule is adhered to and records of same are up to date • individualised time frames for repositioning are recorded on the chart and care plan	**Not Met**
	Action taken as confirmed during the inspection: Repositioning charts were in place for patients assessed as “at risk” of pressure ulcers. However, these were inconsistently completed and gaps of up to 12 hours were noted between entries. The individualised time frames for repositioning were recorded in the care plans but not on the repositioning chart. On observation, it was noted that patients were being regularly hoisted, assisted to the toilet and assisted in to bed in the afternoon to enable pressure relief. There was evidence that pressure	

	relieving equipment had been provided to patients. The manager and registered nurse also stated that there were no patients with pressure ulcers in the home. Furthermore, a date for pressure ulcer training had been arranged for March with the trust tissue viability specialist nurse. This requirement has not been met and has been stated for a second time.	
Requirement 3 **Ref**: Regulation 15 (2) **Stated:** First time	The registered person must ensure that the assessment of patient's needs is kept under review, particularly in relation to: • ensuring that fluid balance charts are recorded and totalled accurately and appropriate actions taken as required	**Not Met**
	Action taken as confirmed during the inspection: Fluid balance charts reviewed had not been consistently completed or accurately totalled. This requirement has not been met and has been stated for a second time.	

Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 12, criterion 20 **Stated:** First time	Dining arrangements should be reviewed as patient numbers increase to ensure that patients are enabled to have their meals in the dining room should they so choose.	**Carried forward until next inspection**
	Action taken as confirmed during the inspection: This recommendation has been carried forward until the next inspection, as the compliance date of 1 May 2016 had not been reached.	
Recommendation 2 **Ref**: Standard 47 **Stated:** First time	Oxygen cylinders should be securely stored at all times.	**Not Met**
	Action taken as confirmed during the inspection: Several oxygen cylinders were not securely stored in the treatment room. This recommendation has not been met and has been stated for a second time.	
Recommendation 3 **Ref**: Standard 46 **Stated:** First time	The home should be managed to minimise the risk of infection for staff, patients and visitors. This is particularly in relation to the absence of soap and towel dispensers at hand washing sinks and the location of a bed pan rack in one sluice.	**Met**
	Action taken as confirmed during the inspection: Soap and towel dispensers had been fitted at the handwashing sinks in staff areas and the location of the bed pan rack in the identified sluice had been addressed. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 19.1 **Stated:** First time	Continence assessments should be completed for all patients who require continence management and support.	**Met**
	Action taken as confirmed during the inspection: Continence assessments had been completed in the three patient care records reviewed and corresponding care plans were in place to meet patients' needs This recommendation has been met.	

Recommendation 5 **Ref**: Standard 19.2 **Stated:** First time	The following best practice guidance should be made available to staff and used as required: • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence	**Met**
	Action taken as confirmed during the inspection: Incontinence guidelines had been made available for staff to reference as required. This recommendation has been met.	
Recommendation 6 **Ref**: Standard 25.11 **Stated:** First time	Care records should be regularly audited to ensure they are consistent with the home's policies and procedures and appropriate actions taken to enhance the quality of care.	**Not Met**
	Action taken as confirmed during the inspection: Discussion with the manager confirmed that care record audits had not been completed in recent months. This recommendation has not been met and has been stated for a second time.	
Recommendation 7 **Ref**: Standard 1.1 **Stated:** First time	The term "cot sides", which has the potential to demean patients, should be removed from nursing documentation and the term "bed rails" used instead.	**Met**
	Action taken as confirmed during the inspection: The term "bed rails" was used in the care records reviewed. This recommendation has been met.	
Recommendation 8 **Ref**: Standard 13.5 **Stated:** First time	It is recommended that the registered provider offer a structured programme of varied activities and events and enable patients to participate by providing equipment, aids and staff support.	**Met**
	Action taken as confirmed during the inspection: Activities were being provided on a regular basis for patients and residents. This recommendation has been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was available on breaking bad news. Discussion with staff confirmed that they were knowledgeable regarding this policy. It was recommended that the regional guidelines on breaking bad news were made available for staff to reference.

A sample of training records evidenced that three staff had completed training in relation to communicating effectively with patients and their families/representatives. On discussion with staff it was evident that they were knowledgeable regarding this aspect of care.

Is Care Effective? (Quality of Management)

Records included reference to the patient's specific communication needs such as, cognitive and sensory impairments.

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

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

Is Care Compassionate? (Quality of Care)

Those staff spoken with emphasised the importance of building trusting, professional relationships with patient and their families. The registered nurse confirmed that she provided a private venue for discussion and allowed time for questions when breaking any bad news to patients and their families. The staff were observed welcoming a new patient to the home and conversing with the family to ascertain the patient's preferences and needs.

In discussion, patients confirmed that staff were kind and caring. Staff were observed to be speaking to patients in a kind and patient manner and good relationships were evident between staff, patients and their representatives. Staff were noted to be responding promptly to patients' needs.

There were also a number of thank you cards from relatives and flowers had been sent by one family to express their thanks for the care provided.

Areas for Improvement

A recommendation has been made that the regional guidelines for breaking bad news are made available for staff to reference as required.

Number of Requirements:	**0**	**Number of Recommendations**:	**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 death and dying were available in the home. This reflected best practice guidance such as the Gain Palliative Care Guidelines (2013). Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines (2013) and these were available for staff to reference. Training records evidenced that five staff had undertaken training in grief and loss awareness.

Discussion with staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services where appropriate. Staff also commented positively on the support of the GP as a patient neared end of life.

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

A protocol for timely access to any specialist equipment or drugs was in place and discussion with staff confirmed their knowledge of the protocol. The registered nurse stated that they were proactive in identifying patients' potential need for medications at the end of life and ensured these were in stock for weekends and out of hours.

The registered manager was trained in the use of syringe drivers and the community nurses provided support to staff when required.

Is Care Effective? (Quality of Management)

Care records did not evidence discussion between the patient, their representatives and staff in respect of death and dying arrangements. A review of care records could not evidence that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. The GP had carried out advanced care planning discussions with all patients but the opportunity had not been taken to create care plans to reflect their wishes. A recommendation has been made that end of life care and death arrangements are discussed with patient and a personalised care plan drawn up, as appropriate.

Care plans were in place to manage hydration, nutrition, pain and other symptoms. There was evidence that the social, cultural and religious preferences were also considered. Discussion with the manager, staff and a review of care records evidenced that environmental factors had been considered.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals could be made to the specialist palliative care team if required.

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 evidenced that these had been managed 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. Staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan. A weekly religious service was held in the home.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the person's wishes, for family/friends to spend as much time as they wished with the person. Staff stated that relatives were made welcome and provided with regular drinks and snacks. One care assistant stated that they called in with the family frequently to offer support at this difficult time. Another care assistant commented that they loved to provide palliative care and that they strived to do this well. The registered nurse also stated that the care assistants were excellent and reported any concerns regarding patients promptly.

From discussion with the manager and staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the 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.

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 the support of the team and the manager.

Areas for Improvement

A recommendation has been made that end of life care and death arrangements are discussed with patient and a personalised care plan drawn up, as appropriate.

Number of Requirements:	**0**	**Number of Recommendations: *1 recommendation made is stated under Standard 19 above**	**2 ***

5.5 Additional Areas Examined

5.5.1. Comments of patients, patient representatives and staff

As part of the inspection process patients, their representatives and staff were consulted and questionnaires issued to staff and patients' representatives. Some comments received are detailed below.

Patients

Those patients spoken with commented positively on the staff and the care provided. Comments included:

“I can’t complain. I think the staff are lovely.”
“I am very happy here. I like my room.”

No concerns were raised by patients.

Patients’ representatives

No patients representatives spoke with the inspector. Ten questionnaires were issued but none were returned.

Staff

Those staff spoken with stated that they enjoyed working in the home and that they worked well as a team. No concerns were raised. Ten questionnaires were issued to staff but none were returned.

5.5.2. Mealtime Experience

The lunch time meal was observed. The majority of patients had their meal in the dining room with some others taking lunch in the lounges or in their rooms. The dining room was well presented with tables set and a selection of fluids made available to patients. Clothing protectors and napkins were offered. The atmosphere was calm and organised. Staff were observed to be offering prompt assistance to those patient who required it. Patients were observed to be enjoying their meals.

However, meals were observed to be transported on trays from the kitchen to patients’ rooms uncovered and hot puddings were left uncovered on a trolley in the lounge. This could result in the food being served cold. A recommendation has been made that hot food is served hot.

Food intake charts were also reviewed. These were found to be inconsistently completed and it could not be ascertained what patients had had to eat on a daily basis. This was discussed with the registered manager who acknowledged the deficits in recording. A recommendation has been made that an accurate record is kept of the food consumed or refused by patients who are identified as being at risk of malnutrition or overweight. Where necessary, a referral should be made to the relevant professional.

5.5.3. Records Management

Archived daily charts were requested for review. These were found to be stored loose and disorganised in a large basket for future filing. It was difficult to locate the required information and to evidence the care delivered. A recommendation has been made that clear documented systems are put in place for the management of records in accordance with legislative requirements and best practice guidance.

Areas for Improvement

Number of Requirements:	0	Number of Recommendations:	3

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Lucy Hamilton, registered 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. 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 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.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation 12 (1) (a) & (b) **Stated:** Second time **To be Completed by:** 8 April 2016	The registered person shall provide treatment to patients which meets their individual needs and reflects current best practice. This is particularly in relation to: • ensuring that the repositioning schedule is adhered to and records of same are up to date • individualised time frames for repositioning are recorded on the chart and care plan **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: All staff have had training on the importance of accurate record keeping. New repositioning charts have been commenced after training with the Tissue Viability Nurse and these are being kept up to date by both health care assistants and Staff Nurses. Individualised time frames are clearly marked on the repositioning charts.
Requirement 2 **Ref:** Regulation 15 (2) **Stated:** Second time **To be Completed by:** 8 April 2016	The registered person must ensure that the assessment of patient's needs is kept under review, particularly in relation to: • ensuring that fluid balance charts are recorded and totalled accurately and appropriate actions taken as required **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: This has been fully addressed.

Recommendations	
Recommendation 1 **Ref**: Standard 46, criterion 2 and 3 **Stated:** First time **To be Completed by:** 8 May 2016	Regular infection prevention and control audits should be carried out and documented and any deficits actioned appropriately. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: This has been recommenced by myself and will be completed on a monthly basis.

Recommendation 2 **Ref**: Standard 12, criterion 20 **Stated:** First time **To be Completed by:** 1 May 2016	Dining arrangements should be reviewed as patient numbers increase to ensure that patients are enabled to have their meals in the dining room should they so choose. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: The dining space has been reviewed and additional chairs and tables added to this space to accommodate any new residents.
Recommendation 3 **Ref**: Standard 47 **Stated:** Second time **To be Completed by:** 8 April 2016	Oxygen cylinders should be securely stored at all times. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: This has been fully addressed.
Recommendation 4 **Ref:** Standard 25.11 **Stated:** Second time **To be Completed by:** 8 May 2016	Care records should be regularly audited to ensure they are consistent with the home's policies and procedures and appropriate actions taken to enhance the quality of care. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: This has been commenced and schedule set up so that all care plans are reviewed 3 monthly by another qualified nurse. Please see attached form which has been drawn up to audit care notes.
Recommendation 5 **Ref**: Standard 19 **Stated:** First time **To be Completed by:** 8 April 2016	The regional guidelines for breaking bad news should be made available for staff to reference as required. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: This has been fully addressed.
Recommendation 6 **Ref**: Standard 20, criterion 2 **Stated:** First time **To be Completed by:** 8 April 2016	End of life care and death arrangements should be discussed with patients and a personalised care plan drawn up, as appropriate. **Ref: Section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Care plans have been drawn up for all residents who have made an advanced decision on DNACPR.
Recommendation 7	The mealtime experience of patients should be reviewed to ensure that

Ref: Standard 12 **Stated:** First time **To be Completed by:** 8 April 2016	hot food is served hot. **Ref: Section 5.5.2**
	Response by Registered Person(s) Detailing the Actions Taken: This has been discussed with the kitchen staff and they will serve puddings separately or keep puddings on the heated trolley until they are ready to be served.
Recommendation 8 **Ref**: Standard 12, criterion 27 **Stated:** First time **To be Completed by:** 8 April 2016	An accurate record should be kept of the food consumed or refused by patients who are identified as being at risk of malnutrition or overweight. Where necessary, a referral should be made to the relevant professional. **Ref: Section 5.5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Staff have had further training on the importance of keeping accurate records especially in relation to recording input of food and fluids.
Recommendation 9 **Ref**: Standard 37 **Stated:** First time **To be Completed by:** 8 April 2016	Clear, documented systems should be put in place for the management of records in accordance with legislative requirements and best practice guidance. **Ref: Section 5.5.3**
	Response by Registered Person(s) Detailing the Actions Taken: A new filing system for storing archived notes has been devised and all staff shown how to use this new system.

Registered Manager Completing QIP	Lucy Hamilton	**Date Completed**	17/04/2016
Registered Person Approving QIP	Heather Hamilton	**Date Approved**	17/04/2016
RQIA Inspector Assessing Response	Karen Scarlett	**Date Approved**	20/04/2016

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