Hamilton Court
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Unannounced Care Inspection
of
Hamilton Court

25 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 25 August 2015 from 11.00 to 17.30 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, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to section 1.2 below.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

For the purposes of this report, the term 'patients' will be used to described those living in Hamilton Court 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 09 May 2014.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent actions record regarding pressure care management and records pertaining to same was issued to Hamilton Court Care Home at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	3	2

The details of the Quality Improvement Plan (QIP) within this report were discussed with Heather Murray (regional manager) and Tony Hart (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: Dr Maureen Claire Royston	**Registered Manager:** Anthony Hart
Person in Charge of the Home at the Time of Inspection: Anthony Hart	**Date Manager Registered:** 08 May 2013
Categories of Care: NH-DE, RC-DE	**Number of Registered Places:** 35
Number of Patients Accommodated on Day of Inspection: 30	**Weekly Tariff at Time of Inspection:** £493.00 - £593.00

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

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 (QIP) from inspections undertaken in the previous inspection year
- previous care inspection report.

During the inspection, the inspector met with six patients individually and the majority of others in small groups , the deputy manager, one registered nurse, three care staff, the activity coordinator and four patient's visitors/representatives.

The following records were examined during the inspection:

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

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

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Hamilton Court was an announced estates inspection dated 22 April 2015. The completed QIP was returned and approved by the Estates inspector on 26 June 2015.

5.2 Review of Requirements and Recommendations from the last care inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 14 (2) (c) **Stated:** Third time	The registered person shall ensure as far as reasonably practicable that unnecessary risks to the health or safety of patients/ residents are identified and so far as possible eliminated.	**Met**
	Action taken as confirmed during the inspection: Appropriate actions had been implemented in relation to issues identified.	
Requirement 2 **Ref**: Regulation 19 (1) (b) **Stated:** Second time	The registered person shall ensure that patients' and residents' records are held securely in the nursing home.	**Met**
	Action taken as confirmed during the inspection: At time of inspection records were stored securely in a cupboard. In addition works were in progress to relocate the nurse's station to another area which will further enhance confidentiality and data protection systems.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 25.12 **Stated:** Third time	It is recommended that a sample of staff comments/suggestions be included in reports of unannounced visits undertaken under Regulation 29. A review of regulation 29 visits reports were reviewed and included staff views/opinions.	**Met**
	Action taken as confirmed during the inspection: A review of regulation 29 visits reports for May and July 2015 were reviewed and referenced staff views/opinions.	
Recommendation 2 **Ref**: Standard 1.1 **Stated:** Third time	It is recommended that consideration be given to the provision of one way privacy film on a number of windows including bedroom windows throughout the home to enhance privacy. A suitable alternative may be used.	**Met**
	Action taken as confirmed during the inspection: Privacy blinds have been fitted to bedroom windows throughout the home.	
Recommendation 3 **Ref**: Standard 28.4 **Stated:** First time	It is recommended that staff as appropriate be trained in bed making. Regular audits should be undertaken of patients' and residents' bedrooms.	**Met**
	Action taken as confirmed during the inspection: At time of inspection, bedrooms and beds were presented appropriately.	
Recommendation 4 **Ref**: Standard 30.1 **Stated:** First time	It is recommended that the care staff member rostered for a number of days per week from 16.00 hours to 22.00 hours be rostered daily.	**Met**
	Action taken as confirmed during the inspection: The registered manager and regional manager advised that when occupancy levels are 34 patients / more a care assistant is rostered from 16:00 – 22:00 hours.	

Recommendation 5 **Ref**: Standard 1.1 **Stated:** First time	It is recommended that in order to enhance privacy, thumb turns should be fitted on patients' and residents' bedroom doors with exceptions noted in patients' and residents' care plans.	**Met**
	Action taken as confirmed during the inspection: Bedroom doors have been fitted with thumb turns.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was not available on communicating per se, however information relating to the breaking of bad news was included in a draft policy for palliative & end of life care. The regional guidelines on Breaking Bad News were available in the palliative care resource folder for staff to consult and discussion with staff confirmed they were knowledgeable regarding breaking bad news.

A sampling of training records evidenced that staff had completed training in relation to communicating effectively with patients and their families/representatives. Training on palliative and end of life care included guidance for breaking bad news as relevant to staff roles and responsibilities. Nursing staff consulted were able to demonstrate their skills and knowledge regarding this aspect of care.

Is Care Effective? (Quality of Management)

Care records reflected patient individual needs and wishes in regards to daily living and end of life care. Recording within records included reference to the patient's specific communication needs, including sensory and cognitive impairments.

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.

Two registered nurses consulted demonstrated their ability to communicate sensitively with patients and /or their representatives when breaking bad news. All staff demonstrated a good awareness, relevant to their role, of the need for sensitivity when communicating with patients and or their representatives.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and staff interactions with patients, it was evident 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 the time to offer reassurance to patients as required.

Discussion with six patients individually and with a number of other patients in small groups evidenced that patients were happy living in the home. Some patients were unable to verbally express their views due to the frailty of their condition. These patients appeared comfortable and relaxed in their surroundings. No concerns were expressed by any of the patients. Comments received included:

- "Everybody is the best."
- "I'm being looked after well."

Areas for Improvement

No areas of improvement were identified in regards to this standard.

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 have been recently reviewed and the draft copies 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 staff had completed training in palliative and end of life care via e learning and /or attending training delivered internally. Registered nursing staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

A review of training records evidenced that thirty nine staff had completed training in 2015 in respect of palliative/end of life care. The registered manager confirmed that further training was being scheduled for the remaining staff in 2015. Two registered nurses had also completed training in the use of syringe drivers in February 2015 and additional training was being sourced for other registered nurses.

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 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 two nursing staff confirmed their knowledge of the protocol.

The home was in the process of identifying a palliative care link nurse. The registered manager advised a registered nurse who previously had undertaken the role of palliative care link nurse was still available for staff to consult with, the nurse confirmed this information.

The home had access to syringe drivers through the local Trust and confirmed that they were given the support of the community nursing team as required.

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, in some instances when a patient required additional interventions for example syringe driver / subcutaneous fluids, care plans had not been implemented in regards to same. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

Hamilton Court are also involved with Queens University Belfast in a pilot project, promoting informed decision making and effective communication through advanced care planning for people with dementia and their family / carers. Discussion with a patient representative involved in the project advised this was a positive exercise. The home are to be commended for their efforts in being involved in the project which will further enhance the end of life care for patients.

A 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 manager, nursing and care staff 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. The registered manager advised of proposed works to have a facility for family members to stay overnight.

A review of notifications to RQIA evidenced that the home notified RQIA of any death which occurred in the home in accordance with Regulation 30 of the Nursing Homes Regulations (NI) 2005.

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. From discussion with the manager and staff, and a review of compliments records displayed in the main foyer of the home, there was evidence that arrangements in the home were sufficient to support relatives during this time and 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.

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 for example bereavement support, staff meeting and 1:1 counselling if deemed appropriate.

Information leaflets on palliative care and grief and bereavement were available at the entrance to the home.

Areas for Improvement

The registered person should ensure that care records for patients identified as requiring palliative and /or end of life care are updated to ensure that care plans are relevant and reflect nursing needs and care interventions required at this time. Care plans no longer relevant should be discontinued and archived.

A system should be implemented to ensure that staff are knowledgeable of the updated policy and procedure in respect of palliative and end of life care.

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

5.5 Additional Areas Examined

5.5.1 Consultation with patients, patient representatives and staff

In addition to speaking with patients, staff and visitors, questionnaires were distributed to staff not on duty during the inspection and for patients and patient representatives to complete**.**

Patients

Six patients were spoken with individually and the majority of others in small groups. Patients were complimentary regarding the care delivered, staff, food and activities provided. There were no concerns raised. Comments included:

- "Great people and great food."
- "I have everybody eating out of my hand."
- "Looking after me well a number 1 place."

Staff

The general view from staff cited in completed questionnaires and during discussions was that they took pride in delivering safe, effective and compassionate care to patients. Staff confirmed that they had received training in palliative/end of life care and that this enhanced their knowledge in this area of practice. No concerns were raised with the inspector.
A few staff comments are detailed below:

- "Communication between staff members has improved a lot which makes stronger teamwork and enhancing the quality of care provided to our patients."
- "We have a good team led by our deputy and home manager."
- "Each resident is treated as an individual person first and dementia second."
- "I have recently updated my palliative care training in August 2015 and found it useful and informative."

Patient representatives

One questionnaire was completed and returned. Four patient representatives were spoken with at time of inspection. Overall the comments indicated that the quality of care was good, that staff were attentive and caring and that they were kept informed of changes to their loved one's care. Comments included:

- "The staff are to be commended for dong a great job."
- "I am very happy with the care."
- "The staff are wonderful."
- "Any concerns are always addressed appropriately."

One relative consulted did raise their concerns regarding the laundry service and issues pertaining to personal care. These were discussed at feedback and management gave their assurances these would be followed-up and addressed accordingly.

5.5.2 Care practice and care delivery

During the inspection staff members were noted to communicate with patients in a dignified and respectful manner.

The majority of patients' were observed to be well groomed and appropriately dressed. However, a number of patient's personal care needs had not been adequately met. This observation was discussed with the deputy manager who advised that some of the patients identified were not compliant with this aspect of care. Discussion with one patient representative also highlighted concerns regarding the standard of personal care to their loved one. Information recorded in personal care records did not provide an accurate reflection of care given. There was no evidence that identified care practices had been monitored or reviewed.

Following discussion with management after the inspection, it was agreed that patients preferences regarding personal care would be included in their care plans and that a rationale would be recorded for all personal care delivered /or not delivered in a contemporaneous manner. A requirement is made.

Two patients were observed in bed-rest at the time of inspection. The rationale given for this intervention was attributed to pressure care management. Care records in respect of one of the identified patients were examined and a number of shortfalls were evidenced. No care plan for pressure / wound care management was available and the patient was not receiving the treatment as prescribed in accordance with the Trust tissue viability plan of care. Discussion with the deputy manager advised that an additional review had been completed by the Tissue Viability Nurse and the plan of care was amended subsequently however, no record was available to evidence this communication.

A sample of repositioning records were examined and in most cases were completed to evidence that the patient had been repositioned however; one record examined indicated an occasion when there was a 12 hour period when no repositioning was recorded as being completed.

These issues were very concerning as they could have a direct impact on the delivery of safe effective care and were discussed with management at feedback. On the day of inspection, an urgent actions letter was issued. Following inspection, correspondence was received from the registered manager confirming the actions that had been taken. RQIA are satisfied with the information received and this will be monitored during the next care inspection. A requirement is made.

5.5.3 Environment and infection prevention and Control

A general inspection of the home was undertaken which included inspection of a random sample of bedrooms and bathrooms. The home was found to be warm and well decorated in accordance with best practice guidance for patients with dementia; staff are to be commended for their efforts. The registered manager advised of a number of environmental improvements completed since the last care inspection and an ongoing programme of refurbishment / improvements

However a range of matters were identified that were not managed in accordance with infection prevention and control guidelines:

- over bed tables were worn and unclean in some bedrooms
- commodes in bedrooms had not being cleaned following use for example had talc residue
- hoist frames were unclean
- some radiator covers in bedrooms were worn and could not be cleaned effectively
- low level tiled areas in bathrooms/shower rooms could not be cleaned effectively as seal was broken
- clinical waste bins in some areas were rusted
- care staff were observed wearing nail polish and gel nails.

All of the above was discussed with management at feedback. Some areas identified had been previously acknowledged in Regulation 29 visits and actions identified / taken. A requirement is made for an infection / environmental audit to be undertaken and all matters identified at this inspection and subsequently are required to be actioned in accordance with best practice infection and control guidance.

5.5.4 Activities

The home was noted commendably for the provision of activities both indoors and outdoors. The home has carried out a lot of work to ensure that the home is implementing best practice in regards to Dementia. The majority of patients had life history work completed and the signage on their bedroom doors reflected some areas of their personhood. Corridors have been decorated in various themes and the patients can relate to same. The home has a very special area “The Cottage” which is filled with memorabilia and patients memories. Patients are encouraged to be involved in the activities which meet their ability and this was observed during an activity taking part at time of inspection. Evidence of past activities, for example gardening, photographs, arts and crafts were displayed in the home. The activity therapist has a great understanding of her role and how to apply it to people with dementia type illnesses and this was evidenced during the inspection. The staff and home are commended in this regard.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Heather Murray (regional manager) and Tony Hart (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.

6.1Statutory 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 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 12 (1)(a) **Stated:** First time **To be Completed by:** 25 September 2015	The registered person must ensure that personal care provided is in accordance with the patients identified needs and plan of care. All records should accurately reflect care delivered in this regard and audits should be completed to monitor compliance and actions identified accordingly.
	Response by Registered Person(s) Detailing the Actions Taken: Residents personal care preferences are recorded in their care plan and this has been reassessed. Staff record all personal care delivered daily in a contemporaneous way and this would be audited.
Requirement 2 **Ref:** Regulation 13 (1)(a) & (b) **Stated:** First time **To be Completed by:** 25 August 2015	The registered manager must ensure that all patients with pressure care/ wound management have the relevant risk assessments for pressure care, a care plan for the care required for their identified needs and that all records pertaining to pressure care management are up to date and reviewed as indicated.
	Response by Registered Person(s) Detailing the Actions Taken: Care plans are up to date and reflect the current regime of care. Advice is sought from the TVN and recorded in the appropriate sections of the care file as appropriate. Areas highlighted on day of inspection have been fully addressed.
Requirement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be Completed by:** 23 October 2015	The registered person shall ensure that all issues identified in section 5.5.3 of the report pertaining to infection control are addressed to minimise the risk of infection and spread of infection between patients and staff.
	Response by Registered Person(s) Detailing the Actions Taken: Any worn tables have beeen removed and replaced as new. Decontamination schedules are more robust to ensure commodes are clean following use and that hoist frames are cleaned appropriately. Radiator covers have been identified by the maintenance person and a rolling programme implemented to ensure all are brought up to standard. Current seal replaced with a rolling maintenance programme in place to upgrade all the shower rooms. The two clinical waste bins have been replaced. Staff supervision has been undertaken with the appropriate staff in regards to nail polish and nail gels.

Recommendations	
Recommendation 1 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 23 October 2015	The registered manager should ensure staff are knowledgeable of the reviewed policies and procedures in respect of palliative and end of life care.
	Response by Registered Person(s) Detailing the Actions Taken: The reviewed policy and procedure has been given to staff to read and to sign as read with follow up discussion undertaken at staff meetings and staff supervision to ensure knowledge is retained and understood.
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 23 October 2015	The registered person should ensure that care records for patients identified as requiring palliative/end of life care are reviewed to ensure that the care plans are relevant and reflect current/active nursing needs/interventions. Care plans no longer relevant should be archived.
	Response by Registered Person(s) Detailing the Actions Taken: Audits of the care plans for residents requiring palliative/end of life care have been undertaken and actioned on areas of nursing needs. Care plans that are no longer relevant have been discontinued and archived.

Registered Manager Completing QIP	Tony Hart	**Date Completed**	25.09.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	28.09.15
RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	28.09.15

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