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Unannounced Care Inspection
of
Aughnacloy House

8 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 8 July 2015 from 10.00 to 17.15 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 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.

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 21 October 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 the Ms Connie Mitchell, 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: M D Healthcare/Lesley Catherine Megarity	**Registered Manager:** Connie Mitchell
Person in Charge of the Home at the Time of Inspection: Connie Mitchell	**Date Manager Registered:** 12 February 2015
Categories of Care: NH-DE, NH-I, NH-PH, NH-PH(E)	**Number of Registered Places:** 71
Number of Patients Accommodated on Day of Inspection: 69	**Weekly Tariff at Time of Inspection:** £593.00 - £647.00

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

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

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

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 previous care inspection report and QIP

During the inspection, the inspector met with all of the patients generally, five registered nurses, eight care staff and three patient's visitors/representative.

The following records were examined during the inspection:

- seven patient care records including care charts
- policies and procedures regarding communication, death and dying, palliative and end of life care
- record of complaints and compliments
- staff training records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 21 October 2014. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 13 (1) (a) **Stated:** First time	The registered manager must ensure that appropriate action is taken when significant variances in patients' recorded weights are identified; this should include checking if the recorded weights are accurate.	**Met**
	Action taken as confirmed during the inspection: Review of the record of patients' weights evidenced that where variances were noted the patient weight was rechecked for accuracy. This requirement has been met.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 10.7 **Stated:** Second time	It is recommended that the use of alarm mats is always discussed with patient, where appropriate, and if the patient is unable to give their consent then consultation with relatives and healthcare professionals, if required, in regard to best interest decisions for the patient, should be undertaken and records maintained of the outcome of these discussions.	**Met**
	Action taken as confirmed during the inspection: The use of alarm mats was clearly documented in three care plans examined. There was evidence in the care records of good communication with relatives in regard to care delivery and best interest decisions for patients. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 5.3 **Stated:** First time	The frequency with which patients are required to be repositioned should be recorded in the care plan and consistently recorded on the repositioning chart.	**Met**
	Action taken as confirmed during the inspection: Four care records examined included the frequency with which patients were required to be repositioned. The frequency was consistently recorded on the repositioning chart. This recommendation has been met.	

Recommendation 3 **Ref**: Standard 8.2 **Stated:** First time	The frequency with which patients are weighed should be reviewed if patients are actively losing weight.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff confirmed that patients were generally weighed monthly however any patient who was losing weight would be weighed more frequently. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 12.1 **Stated:** First time	Those patients who are unable to express their views their relatives/representatives should be involved in completing the food preference record.	**Met**
	Action taken as confirmed during the inspection: The deputy manager confirmed that the food preference was now completed as part of the admission procedure and that patients and/or their relatives were involved.	
Recommendation 5 **Ref**: Standard 12.4 **Stated:** First time	The displaying of the menu should be reviewed and displayed in a suitable manner so that patients and their relatives/representatives know what is available at each mealtime.	**Met**
	Action taken as confirmed during the inspection: A pictorial menu was displayed in both dining rooms. This recommendation has been met.	
Recommendation 6 **Ref**: Standard 12.9 **Stated:** First time	Hot food served at any meal should be transported and stored in a heated trolley until served to the patients.	**Met**
	Action taken as confirmed during the inspection: During the serving of lunch hot food was transported and stored in a heated trolley until served to the patients. Notices to remind staff of the importance of this were displayed in both dining rooms. This recommendation has been met.	

Recommendation 7 **Ref**: Standard 12.1 **Stated:** First time	The current method for calculating daily fluid targets should be reviewed and alternative good practice guidance consider to help identify more achievable daily targets.	**Met**
	Action taken as confirmed during the inspection: Registered nurses confirmed that daily fluid targets were now calculated taking into consideration each patient's usual daily intake, reconciled at the end of each 24 hour period and action taken if their intake was deemed to be insufficient. This recommendation has been met.	
Recommendation 8 **Ref**: Standard 17.10 **Stated:** First time	The recording of complaints should be reviewed to ensure that there is a record of all complaints made and action taken available in the home.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that a record of all complaints, including those investigated by the home's human resources department, was maintained in the home. This recommendation has been met.	
Recommendation 9 **Ref**: Standard 32.8 **Stated:** First time	Mattresses which extend beyond the length of the divan bed should be reviewed to ensure that they do not constitute a risk to patient safety.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that a risk assessment was completed of all mattresses which extended beyond the length of the divan bed and that those identified as high risk has been replaced. This recommendation has been met.	

5.3 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. A copy of the DHSSPS regional guidance on breaking bad news was available in the home.

Training had not been provided on breaking bad news. Discussion with the registered manager, registered nurses, care staff and the activity therapist confirmed that staff were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication.

However, further discussion with staff confirmed that whilst staff were knowledgeable, experienced and confident in communicating with patients and their representatives about general issues, some registered nurses reported that they were less confident when approaching relatives to discuss end of life care. Training/development opportunities on communication in this area would be beneficial for registered nurses to allow them to develop confidence in discussing these sensitive, and often emotive, issues.

Is Care Effective? (Quality of Management)

Seven care records evidenced that patient individual needs and wishes in respect of aspects of daily living were appropriately recorded. However, there was limited evidence that end of life issues were discussed with the exception of Do Not Attempt Resuscitation (DNAR) directives.

Care records made reference to the patients' specific communication needs including sensory and cognitive impairment. There was evidence within the care records that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

The registered manager and five registered nurses demonstrated 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. Care staff considered the breaking of bad news to be the responsibility of the registered nursing staff but felt confident that, should a patient choose to talk to them about the diagnosis or prognosis of illness, they would have the necessary skills to do so.

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.

Patients spoken with all stated that they were very happy with the quality of care delivered and with life in the home.

Patients and their representatives consulted were complimentary of staff and the care provided. Good relationships were very evident between staff and the patients and visitors.

Compliment cards and letters are retained by the home. Review of these indicated that relatives were appreciative of the care provided by the home.

Areas for Improvement

A recommendation is made that training for registered nurses in relation to communicating effectively to identify end of life care needs is provided.

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)

Policies and procedures on the management of end of life care and death and dying were available and referenced GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013. A copy of this best practice guidance was also available in the home.

A policy entitled "Death and dying" was available and included the support available for staff and relatives.

Two registered nurses were identified as link workers in palliative care and attended regular palliative care link nurse meetings arranged by the local health care trust.

Review of training records evidenced that 3 registered nurses attended training on the management of syringe drivers in March 2015. This training was provided by the local health and social care trust. Training entitled "Living Matters Dying Matters" was attended by 2 staff in May 2015. The registered manager confirmed that palliative care training will be provided by the local health and social care trust however dates had not been confirmed at the time of the inspection. The registered manager had established systems in place to identify training needs and ensure that all staff have opportunities to attend training.

Advanced care planning had been identified as a topic for staff supervision. At the time of the inspection four staff had received supervision on this topic.

Is Care Effective? (Quality of Management)

A sampling of care records and discussion with the registered manager and registered nurses evidenced that death and dying arrangements were part of the activities of daily living assessment completed for each patient. This physical and psychological assessment contained a section entitled "Dying." Two of the seven care records evidenced that discussion had taken place regarding end of life care with individual wishes identified.

Examples of comments recorded in five care records were:
"Not stated"
"Not yet discussed."

The registered manager and registered nurses acknowledged that, whilst some discussion had taken place regarding the wishes of patients and relatives for end of life care, for example with the DNAR directives, there was a need to create further opportunities to discuss this area in greater detail; in particular in the event of patients becoming suddenly unwell.

As previously discussed in section 5.3 the registered nurses spoken with stated that they were hesitant discussing end of life care with patients and relatives due to the sensitivity of the issue. They admitted to feeling more confident when discussing end of life care when a patient was unwell or identified as approaching end of life but where less confident in approaching the subject at other times.

Whilst the inspector acknowledges there will be occasions when patients and/or their relatives do not wish to discuss end of life care, training on communication in this area would be beneficial for registered nurses to allow them to develop confidence in discussing end of life care issues with patients and their relatives.

Discussion with staff evidenced that environmental factors, which had the potential to impact on patient privacy, had been considered. Staff confirmed that facilities were made available for family members to spend extended periods with their loved ones during the final days of life. Meals, snacks and emotional support were been provided by the staff team.

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

Is Care Compassionate? (Quality of Care)

Discussion with thirteen staff and a review of seven care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences. Only one care record had evidence of consideration of these areas in respect of end of life care. Discussion with staff evidenced that arrangements were in place to meet patients' religious and spiritual needs.

Arrangements were in place to facilitate family and friends to spend as much time as they wish with the patient. Staff discussed openly a number of deaths in the home and how the home had been able to support the family members in providing refreshments and facilitating staying overnight with their loved ones.

From discussion with the registered manager, thirteen staff and a review of the compliments record, there was evidence that there were sound arrangements in the home to support relatives during this time. Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"You'll never truly understand how thankful we are for you all helping her in her final weeks. We really couldn't ask for more in the way she was treated, which gives the whole family great comfort."

"…in terms of the treatment concerning all of us as the family is the way we were looked after on the day that … passed away. We are eternally grateful for how we were cared for."
"Words cannot describe how nice it was to be greeted with a smile on all our visits, even during …last few days. Thanks is not enough."

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 of the 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

Areas for Improvement

As previously identified in section 5.3, training for registered nurses in relation to communicating effectively to identify end of life care needs should be provided.

It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses and that any expressed wishes of patients and/or their representatives are formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.

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 Consultation with patients, their representatives, staff and professional visitors

Discussion took place with the majority patients in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were very positive. Patients did not raise any issues or concerns about care delivery in the home.

Three patients' representatives confirmed that they were happy with the standard of care and communication with staff in the home. One representative spoken with had raised concerns previously with the nurse in charge regarding care delivery and inconsistent communication from staff. The relative was satisfied that the issues had been addressed and was satisfied with the current standard of care. The concerns were discussed with the registered manager who was knowledgeable of the complaint and the action taken to address the issues raised.

Ten patient questionnaires were issued with four returned prior to the conclusion of the inspection. The respondents indicated that they were satisfied or very satisfied that the quality of care, that they could talk to staff if something was wrong and that staff listen to them. They confirmed that their relative had access to religious support. The responses received also confirmed that both they and their relative were treated with dignity and respect, had privacy and could be as independent as possible.

Comments received included:

"Any requests made for comfort and care of patients are usually carried out quickly and effectively."

"It's good to know that staff are always available to help resident and family. Find it a very warm and hospitable environment for all."

One issue was raised regarding the personal laundry of a patient. This was shared with the registered manager who readily agreed to discuss the issue further.

Staff commented positively with regard to staffing and the delivery of care. Staff were knowledgeable regarding their patient's needs, wishes and preferences.

Ten questionnaires were issued to nursing, care and ancillary staff. None were returned prior to the issue of this report.

No professional visitors were available in the home at the time of the inspection.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Connie Mitchell, 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 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 the 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	
Recommendation	
Recommendation 1 **Ref**: Standard 35 **Stated:** First time **To be Completed by:** **30 September 2015**	It is recommended that training for registered nurses in relation to communicating effectively to identify end of life care needs should be provided. **Response by Registered Person(s) Detailing the Actions Taken:** A number of training opportunities are being sourced by the manager, including support from Macmillan Workshops and the SHSCT Bereavement Co-ordinator/Palliative Care Nurse Specialist/Facilatator. Use of the Palliative Care and End of life forum (SHSCT) will continue and staff will cascade this information. Dates are to be confirmed for training.
Recommendation 2 **Ref:** Standard 20.1 **Stated:** First time **To be Completed by:** **19 August 2015**	It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses and that any expressed wishes of patients and/or their representatives are formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients. **Response by Registered Person(s) Detailing the Actions Taken:** The manager has scheduled a facilitation session, 19th August 2015, for all nurses to improve and enhance their confidence in creating opportunities to discuss end of life care and their expressed wishes, with our residents and their representatives. This session will include scenarios/role play to develop staff confidence in discussing difficult situations/breaking bad news. Staff will develop/improve a template for end of life care care plans at this session, to include religious, spiritual and/or cultural needs for our residents.

Registered Manager Completing QIP	Connie Mitchell	**Date Completed**	24/07/2015
Registered Person Approving QIP	Lesley Megarity	**Date Approved**	24/07/15
RQIA Inspector Assessing Response	Lyn Buckley	**Date Approved**	02/09/15

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