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BT66 7HA

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Unannounced Care Inspection
of
Donaghcloney

6 May 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 6 May 2015 from 10 00 to 17 00 hours

This inspection was underpinned by one standard and one theme. **Standard 19 - Communicating Effectively; Theme 'End of Life Care' incorporating criteria from 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 1 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**	**4**

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

2. Service Details

Registered Organisation/Registered Person: Four Seasons Dr Clare Royston	**Registered Manager:** Tracey Palmer Ms Maria Lee Leuterio is acting manager in the absence of the registered manager Tracey Palmer.
Person in Charge of the Home at the Time of Inspection: Ms Maria Lee Leuterio	**Date Manager Registered:** 31 October 2013
Categories of Care: NH-I	**Number of Registered Places:** 45
Number of Patients Accommodated on Day of Inspection: 24	**Weekly Tariff at Time of Inspection:** £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 standard 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 32)**

4. Methods/Process

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

- discussion with management
- 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:

- inspection report and quality improvement plan from the previous care inspection on 1 October 2014
- incident reports submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005
- any written and verbal communication received since the previous care inspection.

The inspector met with eight patients, four care staff, one registered nurse and one patient's relative.

The following records were examined during the inspection:

- care records of four patients
- policies and procedures
- record of complaints and compliments
- repositioning charts
- fluid charts
- accident and incident reports
- 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 1 October 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last care Inspection

<table>
<tr><th colspan="2">Last Care Inspection Statutory Requirements</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Requirement 1

Ref:
Regulation 19(1)(a)
Schedule 3, 2(k)
Stated: Second time</td><td>The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence prescribed care.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of repositioning charts evidenced that this requirement has been met.</td></tr>
</table>

Requirement 2 **Ref**: Regulation 12(1)(a) **Stated: Second time**	The registered person shall ensure that the treatment and other services provided reflect current best practice. RQIA must be notified of pressure ulcers, graded two or above.	**Met**
	Action taken as confirmed during the inspection: Review of notifications sent to RQIA evidenced that this requirement has been met.	
Requirement 3 **Ref**: Regulation 16 (2) b **Stated: First time**	The registered person must ensure that care plans/care records are kept under review in relation to the following: • accurate recording of food / fluid charts • the action to be taken when a patient's fluid intake target has not been met should be included in the care plan • reflect a partnership approach with regard to an identified patient having the opportunity to review menu choice	**Met**
	Action taken as confirmed during the inspection: Review of a selection of care records evidenced that this requirement has been met.	
Requirement 4 **Ref**: Regulation **12(2)** **Stated: First time**	The registered person must ensure that an application for variation is submitted to RQIA in accordance with regulations. A retrospective application should be made in respect of the change made to the identified bathroom.	**Met**
	Action taken as confirmed during the inspection: An application was submitted to RQIA on 20 November 2014 and processed. This requirement has been met.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard **16.2** **Stated: Second time**	It is recommended that induction records are further developed to include a general awareness of the correct use of restraint.	**Met**
	Action taken as confirmed during the inspection: Unsafe practice was included in the induction records and the acting manager explained that this included restraint. The acting manager further explained that restraint was also included during the induction of moving and handling, health and safety and safeguarding vulnerable adults training. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 10.7 **Stated: First time**	It is recommended that alarms mats are managed as a form of restraint.	**Met**
	Action taken as confirmed during the inspection: Alarm mats were not in use with any patient at the time of the inspection. Discussion with a registered nurse evidenced that they were aware that alarm mats should be managed as a form of restraint. The inspector was satisfied that there were systems in place to support this recommendation if an alarm mat was needed.	
Recommendation 3 **Ref**: Standard **5.1** **Stated: Second time**	It is recommended that all patients have a baseline pain assessment completed and an ongoing pain assessment where indicated.	**Met**
	Action taken as confirmed during the inspection: Review of a selection of care records evidenced that this recommendation has been met.	

Recommendation 4 **Ref**: Standard **1.2** **Stated: First time**	It is recommended that all issues identified through the responses in the patient questionnaires/ discussions with patients are further explored by the home manager with the patients generally and the identified care practices are monitored, with appropriate action taken if required. The issues raised relate to: • having access to a buzzer always • the timeliness of the staff response to buzzer calls • choice regarding meeting toilet needs for example, choice regarding use of toilet, commode or bedpan • level of involvement in discussing and planning their care • staff not knocking bedroom door before entering or introducing themselves • frequency of checks to see if patient needs anything • occasions when feels rushed when care being provided • clothing mislaid in the laundry	**Met**
	Action taken as confirmed during the inspection: The acting manager confirmed that following the previous inspection the issues were discussed with the safeguarding team in the local health and social care trust and a decision made not to progress them through safeguarding. The issues were addressed by the management of the home. The acting manager confirmed the following processes were in place to obtain patients' opinions of the care and to allow them opportunities to give their opinions: • Regular patient meetings • day to day contact with patients by the acting manager • monthly monitoring visits undertaken by the regional manager. The inspector was satisfied that there were systems in place for consultation with patients. This recommendation has been met.	

Recommendation 5 **Ref**: Standard **12.12** **Stated: First time**	It is recommended that a record is kept of all food and fluids consumed by an identified patient so that a re-assessment can be made with the patient's GP if any further intervention / referrals are necessary.	**Met**
	Action taken as confirmed during the inspection: Records were in place to evidence patients' food and fluid intake. There was evidence in patient records of contact with their GP regarding fluid management. This recommendation has been met.	
Recommendation 6 **Ref**: Standard **27** **Stated: First time**	It is recommended that the policy relating to nursing records management is updated to reflect only current guidance (not UKCC) and be localised to reflect / reference The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Nursing Homes Minimum Standards (2008).	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that the policy on records management has been reviewed and updated and that the draft issue was awaiting ratification. This recommendation has been met.	
Recommendation 7 **Ref**: Standard **28** **Stated: First time**	It is recommended that all staff are continued to be supported with training commensurate with their roles and responsibilities in relation to the following until 100% compliance is achieved: • Record keeping • Skin care and prevention and management of pressure ulcers • Wound care (registered nurses) • Management of nutrition • Management of dysphagia	**Met**
	Action taken as confirmed during the inspection: Review of training records and discussion with the acting manager and staff evidenced that mandatory training was ongoing with systems in place to support all staff to complete the required training.	

Recommendation 8 **Ref**: Standard **17.10** **Stated: First time**	It is recommended that all complaint records include the name of the patient whom the complaint refers to, in addition to the name of the person who makes the complaint.	**Met**
	Action taken as confirmed during the inspection: Review of the complaints record evidenced that this recommendation has been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Policy guidance for staff was available on communicating effectively. A copy of the DHSSPS Regional guidance on breaking bad news was available in the home.

Discussion with management, nursing and care staff confirmed that staff were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication.

Is Care Effective? (Quality of Management)

Three 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.

A "Needs Assessment" was completed for each patient. Examples of comments recorded in the section entitled "Palliative and End of Life Care." were:
"No wishes expressed"
"Not applicable at present."

Care records included reference to the patient's capacity and ability to make decisions regarding their care. Records also identified patients' communication needs.

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

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 "relieved" when patients and/or relatives stated they had no wishes.

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.

The acting manager and one registered nurse 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.

Discussion with eight patients individually and with the majority of patients generally evidenced that patients were happy living in the home. Comments received included:
"It's a great place…..most caring people."
"We're well looked after."

One patient's representative also confirmed that they were happy with standards maintained in 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 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative end of life care and death and dying were held in the Palliative and End of Life Care Manual which was available in the home. These documents were currently under review by Four Seasons Healthcare to ensure that they are reflective of best practice guidance such as Guidelines and Audit Implementation Network (GAIN) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013.

A policy and procedure on the management of death and dying was available and reflected best practice guidance in the management of palliative care in nursing homes. The management of the deceased person's belongings and personal effects was included in the policy and procedure.

Training records evidenced that 75% of staff had completed the e learning palliative care training. Training entitled "Last days of life" was arranged for 27 May 2015 with staff identified to attend.

There were two identified palliative care link nurses in the home. Both nurses were scheduled to attend palliative and end of life care for link nurses in May, September and November 2015. This training was arranged by the local health and social care trust.

Discussion with the acting manager and a registered nurse confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the acting manager, registered nurse and care staff care evidenced that staff were knowledgeable in identifying when a patient's condition was deteriorating or nearing end of life and the appropriate actions to take. Arrangements were in place for timely access to specialist equipment. Discussion with the acting manager and one registered nurse confirmed their knowledge of the procedure.

Is Care Effective?

A sampling of care records and discussion with the acting manager and registered nurse evidenced that death and dying arrangements were part of the needs assessment completed for each patient. As previously discussed there was limited evidence that end of life issues were discussed.

Discussion with the acting manager, registered nurse and four care staff evidenced that environmental factors, which had the potential to impact on patient privacy, had been considered. Staff gave examples of how patient and family privacy was managed for those patients in shared bedrooms. Staff confirmed that there were reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. 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 staff and a review of four care records evidenced that patients and/or their representatives had been generally consulted in respect of their cultural and spiritual preferences. However this consultation did not consider any cultural or religious wishes in respect of end of life care.

Whilst a number of patients in the home were considered palliative care there were no patients nearing the end of life at the time of inspection. As previously identified there was a need for additional training in relation to communicating effectively to ensure that staff do not avoid discussion of this important area until it is too late for the patient and their family members.

Arrangements were in place in the home to facilitate family and friends to spend as much time as they wish with the patient. Staff discussed openly a number of recent 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.

There was evidence within the compliments records that relatives had commended the management and staff for their care towards the family and patient.

Discussion with the acting 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 acting manager and staff, it was evident that arrangements were in place to support staff following the death of a patient.

Areas for Improvement

To ensure that staff knowledge and care delivery is reflective of best practice in palliative and end of life care it is recommended that when the updated manual is issued staff should receive an induction/training on the content.

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

As previously identified under standard 19 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**	**2** 1 recommendation relating to this theme has been stated in standard 19.

5.5 Additional Areas Examined

5.5.1 Staffing

Discussion with staff identified that on a number of Sundays there were no catering staff rostered for late afternoon to oversee the serving of the evening tea. Staff reported that a buffet style tea was prepared by catering staff with care staff left to serve the meal and wash the dishes. Review of the rota evidenced that there were no additional care staff rostered to work on the Sundays when no catering staff were on duty. The registered manager, who is currently deployed to another home, confirmed she was aware of the staffing on the identified Sundays. It is recommended that the provision of staffing is reviewed to ensure there are catering staff on duty to serve meals and oversee the operation of the kitchen.

5.5.2 Consultation with patients, their representatives, staff and professional visitors

Discussion took place with eight patients individually and with the majority of others in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were very positive. A few comments received are detailed below;
'It's a great place with the most caring people."
"We get good food and we're well looked after."
"We have all our own comforts.

Patients did not raise any issues or concerns raised about care delivery in the home.

One patient's representative confirmed that they were happy with standards maintained in the home.

Staff commented positively with regard to staffing and the delivery of care. Staff discussed the changes in management over the past 12 months and the impact on decision making within the home. These issues were discussed with the registered manager, Tracey Palmer, who although providing management cover in another home, attended Donaghcloney one day a week to provide support to the acting manager and was present in the home for the majority of this inspection.

Six questionnaires were issued to nursing, care and ancillary staff and three were returned following the inspection visit. Staff indicated that they were satisfied or very satisfied that care was safe, effective and compassionate.

One comment received from staff is detailed below:
"Staff of Donaghcloney Care Home are all very caring and compassionate and always show dignity and respect to both residents and their relatives."

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

5.5.3 Environment

The home had undergone refurbishment since the previous inspection. The three lounges had been repainted and new furniture and curtains provided. The dining rooms and foyer had also been redecorated. The vanity units in the bedrooms were replaced. The refurbishment has been tastefully completed and the environment of the home was bright and fresh smelling throughout. The registered manager confirmed that further redecoration was planned.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Tracey Palmer, 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	
Recommendations	
Recommendation 1 **Ref**: Standard 39 **Stated:** First time **To be Completed by:** 6 August 2015	It is recommended that training is provided for registered nurses in relation to communicating effectively to identify end of life care needs. **Response by Registered Person(s) Detailing the Actions Taken:** Two Nurses are Palliative Care Link Nurses, who will attend meetings, bring back infomration and disseminate to staff. All Nurses will receive Supervision with regards to their own indivdual needs, in relation to communicating effectively to identify end of life care needs.
Recommendation 2 **Ref**: Standard 32 **Stated:** First time **To be Completed by:** 6 August 2015	It is recommended that when the updated Palliative and End of Life Care Manual is issued staff should receive an induction/training on the content. **Response by Registered Person(s) Detailing the Actions Taken:** Training on the new policy will be organised for all Registerd Nurses once Palliative and End of Life Care Manual is issued
Recommendation 3 **Ref**: Standard 32 **Stated:** First time **To be Completed by:** 24 June 2015	It is recommended that end of life arrangements for patients are discussed and documented as appropriate, and include patients' wishes in relation to their religious, spiritual and cultural needs. **Response by Registered Person(s) Detailing the Actions Taken:** Discussions are in place at present with resident/relatives in relation to their wishes around religious, spiritual and cultural needs at End of Life.
Recommendation 4 **Ref**: Standard 41 **Stated:** First time **To be Completed by:** 24 June 2015	It is recommended that the provision of staffing is reviewed to ensure there are catering staff on duty to serve meals and oversee the operation of the kitchen. **Response by Registered Person(s) Detailing the Actions Taken:** Kitchen hours have now been addressed

Registered Manager Completing QIP	Tracey Palmer	**Date Completed**	17.06.2015
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	19.06.15
RQIA Inspector Assessing Response	SOM	**Date Approved**	23-6-15