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Unannounced Care Inspection
of
Dungannon

9 October 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 9 October 2015 from 09 40 to 15 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.**

On the day of the inspection, the care 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.

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 5 March 2015.

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**	**6**

The details of the Quality Improvement Plan (QIP) within this report were discussed with the nurse in charge Ms Abigail McFarland as part of the inspection process. Feedback was also provided to Mrs Lorraine Thompson, regional manager, by telephone following the inspection. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four seasons Health Care	**Registered Manager:** See section below
Person in Charge of the Home at the Time of Inspection: Ms Abigail McFarland	**Date Manager Registered:** The post of manager is currently vacant. Please refer to section 5.6.3
Categories of Care: NH-LD, NH-LD(E)	**Number of Registered Places:** 36
Number of Patients Accommodated on Day of Inspection: 34	**Weekly Tariff at Time of Inspection:** £593.00 or £637.00

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)

On 2 September 2015 an anonymous caller raised concerns regarding care practices with the RQIA duty inspector. The registered provider investigated the issues and provided RQIA with a report of the investigation outcomes and action taken. Care practices were reviewed during this inspection and recommendations were made. Please refer to section 5.6.1

4. Methods/Process

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

- discussion with the nurse in charge
- discussion with the regional 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, we met with all of the patients and spoke individually with five of them, two registered nurses, six care staff, one visiting professional and relatives of three patients.

The following records were examined:

- three care records including care charts
- policies and procedures regarding communication, death and dying, palliative and end of life care
- staff training records
- record of complaints and compliments
- medicine management audits

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced medicines management inspection dated 23 July 2015. The completed QIP was returned and approved by the pharmacy inspector. At the request of the pharmacy inspector the progress with the requirement made regarding the close monitoring of co-codamol tablets was reviewed. A review of the medicine records evidenced that running stock balances were now being maintained.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 19(1)(a) Schedule 3, 3(k) **Stated:** Second time	It is required that contemporaneous notes of all nursing provided are maintained. Repositioning charts must evidence regular repositioning and include an assessment of the patients' skin condition at each position change. Changes to patients' positions whilst sitting in their chairs must be included in the repositioning records.	**Met**
	Action taken as confirmed during the inspection: A review of repositioning charts evidenced that patients were being regularly positioned. Records included any concerns identified with skin condition. This requirement has been met.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 5.2 **Stated:** First time	A nutrition risk assessment and a body map should be completed for all patients on admission.	**Met**
	Action taken as confirmed during the inspection: A review of two patients' care records evidenced that a nutrition risk assessment and a body map had been completed on admission. This recommendation has been met.	

Recommendation 2 **Ref**: Standard 25.2 **Stated:** Second time	The dining experience should be reviewed throughout the home to ensure that it is positive for all patients. The review should include the serving of meals in the lounge to the patients in the Killybracken unit.	**Met**
	Action taken as confirmed during the inspection: Staff spoken with were satisfied that there was a good variety of meals served. Observation of the serving of lunch evidenced that the mealtimes were being managed appropriately. The nurse in charge confirmed that a review was being undertaken with view to creating a larger dining room in the Killybracken unit. This would provide patients with an alternative location to have their meals served. The regional manager confirmed that a site visit by senior management and an estates officer from Four Seasons Health Care had recently taken place. The regional manager was aware of the need to submit a variation to the use of rooms to RQIA prior to any work commencing. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 17.10 **Stated:** Second time	It is recommended that complaints record is further developed to evidence how a complaint is assessed as resolved.	**Met**
	Action taken as confirmed during the inspection: A review of the record of complaints 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.

Training had not been provided on breaking bad news. Discussion with the registered nurses, and care staff 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 and confident in communicating with patients and their relatives 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. A recommendation was made.

Is Care Effective? (Quality of Management)

Three care records evidenced that patients' 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. This is discussed further in section 5.5.

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 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 they would have the necessary skills and confidence to talk with patients and relatives following the receipt of bad news.

Is Care Compassionate? (Quality of Care)

Patients were observed to be treated with dignity and respect by staff. There were a number of occasions when patients were assisted by nursing and care staff in a professional and compassionate manner which ensured the patients' dignity was maintained. There was evidence of good relationships between patients and staff.

Patients spoken with all stated that they were 'very happy' living in the home.

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

Compliment cards and letters were retained. Verbal compliments were recorded on a computerised system and in the patients care records. Review of these indicated that relatives were appreciative of the care provided.

Areas for Improvement

A recommendation was 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 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 in draft form. These documents were currently under review by Four Seasons Health Care to ensure that they were 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 recommendation was made.

A copy of the GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013 were available in the home.

A policy and procedure on the management of death and dying was available and reflected best practice guidance. The management of the deceased person's belongings and personal effects was included in the policy and procedure. Staff spoken with were knowledgeable of the procedure and who has responsibility for ensuring the deceased person's belongings were treated with respected.

The regional manager advised that training in palliative and end of life care was scheduled for 6 November 2015 and that staff were identified to attend.

There were arrangements in place for staff to make referrals to specialist palliative care services. Arrangements were in place for timely access to specialist equipment and medication, including syringe drivers. Discussion with the registered nurses confirmed their knowledge of these procedures. Support to manage syringe drivers was provided by the district nurses within the local health and social care trust.

Is Care Effective? (Quality of Management)

Review of care records evidenced that death and dying arrangements were part of the needs assessment completed for each patient. The care records reviewed did not contain details of the patients' assessed needs or wishes with regard to end of life care.

Two care records contained advanced care planning documentation completed by the patients' General Practitioners (GP). The information was generic and did not contain any personal preferences for the patients. The management of "do not attempt resuscitation" directives (DNAR) was discussed with the registered nurses. DNAR directives recorded in hospital should be reviewed with the patient (where appropriate) relatives and relevant healthcare professional on readmission to the home. This is in keeping with best practice guidelines. A recommendation was made.

The registered nurses recognised there was a need to create further opportunities to discuss end of life care in greater detail; in particular in the event of patients becoming suddenly unwell.

Whilst the inspector acknowledges there will be occasions when patients and/or their relatives do not wish to discuss end of life care, opportunities should be created by the registered nurses and any expressed wishes of patients and/or their representatives formulated into a care plan for end of life care. A recommendation was made.

The registered nurses identified that there were a number of patients who did not have any relatives recorded or whose relatives were not active in their care. In these circumstances advice and guidance should be sought from the patient's key worker in the relevant health and social care trust.

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 provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that these were managed appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with the registered nurses and care staff evidenced that they had limited experience of caring for patients in the final days of their life. However, staff were aware of environmental factors which had the potential to impact on patient privacy and how these could be managed. Staff were knowledgeable of the care patients may require in the final days and hours of their life and how they would support patients and their families at this time.

Staff confirmed that when patients were ill facilities were made available for family members to spend extended periods with their loved ones. Meals, snacks and emotional support were provided by the staff team.

The religious, spiritual or cultural need of the patients had been identified in two of the three care records reviewed but there was no evidence of consideration of these areas in respect of end of life care. Discussion with staff evidenced that arrangements were in place on a day to day basis to support patients' to meet their religious and spiritual needs within the home.

The registered nurses and staff confirmed that arrangements were in place to support staff following the death of a patient. Staff gave examples of good team work and how they supported each other.

Areas for Improvement

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

Do not attempt resuscitation directives (DNAR) recorded in hospital should be reviewed with the patient (where appropriate) relatives and relevant healthcare professional on readmission to the home. This is in keeping with best practice guidelines.

Further opportunities, to discuss end of life care, should be created by the registered nurses. Any expressed wishes of patients and/or their representatives should be 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:**	**3**

5.5 Additional Areas Examined

5.5.1. Care practices

During a tour of the premises it was observed that each patient had a supply of personal toiletries. However on further review it was noted that the range of products available was not consistent from patient to patient. For example one patient had shampoo, shower gel, shaving foam and deodorant whilst another patient only had shampoo. The provision of toiletries was discussed with staff who confirmed that patients did not always have an adequate supply available to meet their individual needs. They was an ordering system in place but observations and discussion with staff evidenced that the system was not effective. A recommendation was made to review the current system to ensure that patients have the toiletries available to meet their needs.

Observations confirmed that a supply of continence aids, gloves and aprons were available. Staff reported that occasionally stock of continence aids was low. There were systems in place to acquire additional stock at short notice. The ordering of continence aids was discussed with the deputy manager who confirmed that, due to a recent increase in patients admitted for respite, on occasions the home had to request continence aids at short notice. The deputy manager confirmed that she would review the current ordering arrangements to ensure that there was an adequate stock in the home to allow for patients being admitted at short notice.

The overuse of laxative medication previously raised with RQIA was raised again during this inspection. The deputy manager and registered nurses confirmed how they determined each patient's need, for those patients who were prescribed laxatives on an "as required" basis. However there were no arrangements in place to ensure that registered nurses were consistent in their decision making. It is recommended that the administration of laxative medication prescribed on an "as required" basis is reviewed to ensure that laxatives are only administered in response to patient need. The records of bowel movements should be checked prior to each administration.

5.5.2. Consultation with patients, their representatives and staff.

Discussion took place with five patients individually and with the majority of patients in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were positive.

Three patients' representatives confirmed that they were happy with the standard of care and communication with staff in the home. There were no issues or concerns raised regarding care delivery within the home.

Discussion took place with three registered nurses and eight care staff. Staff commented positively with regard to the delivery of care. Staff were knowledgeable regarding their patient's needs, wishes and preferences. As discussed in section 5.6.1 issues regarding the management of laxatives and supply of toiletries were raised and recommendations have been made.

Ten questionnaires were issued to nursing, care and ancillary staff. Eight were returned. Five staff indicated that they were satisfied or very satisfied that care was safe, effective and compassionate.

Three of the respondents indicated that they were either unsatisfied or very unsatisfied with the training provided in whistleblowing. They also indicated that they were unsatisfied or very unsatisfied that care was compassionate. These opinions were contrary to comments from staff spoken with and observations made during the inspection. The issue of training in whistle blowing and comments regarding compassionate care were shared with the regional manager who, due to the questionnaires being returned anonymously, agreed to discuss the issues generally with staff.

5.6.3 Management arrangements

The position of registered manager was vacant at the time of this inspection. The regional manager, Mrs Lorraine Thompson, confirmed that the recruitment process for a manager was underway. Mrs Thompson also confirmed that day to day management support would be provided by Ms Patricia Graham, registered manager of another facility within Four Seasons Health Care. The registered nurses spoken with were aware of the temporary management arrangements.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Abigail McFarland, nurse in charge and Mrs Lorraine Thompson, regional 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 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	
Recommendations	
Recommendation 1 **Ref**: Standard 39.4 **Stated:** First time **To be Completed by:** 27 November 2015	It is recommended that training for registered nurses in relation to communicating effectively to identify end of life care needs is provided.
	Response by Registered Person(s) Detailing the Actions Taken: Training delivered to all nurses which includes communicate efffectively in identifying end of life care needs
Recommendation 2 **Ref**: Standard 36.2 **Stated:** First time **To be Completed by:** 20 November 2015	It was recommended that when the updated Palliative and end of life care manual is issued by Four Seasons Health Care that staff receive an induction/training on the content to ensure that staff knowledge and care delivery is reflective of best practice in palliative and end of life care.
	Response by Registered Person(s) Detailing the Actions Taken: Updated palliative and end of life care manaual received and training provided
Recommendation 3 **Ref**: Standard 33.2 **Stated:** First time **To be Completed by:** 20 November 2015	It is recommended that do not attempt resuscitation directives (DNAR) recorded in hospital should be reviewed with the patient (where appropriate) relatives and relevant healthcare professional on readmission to the home.
	Response by Registered Person(s) Detailing the Actions Taken: DNAR following re admission from hospital have been discussed with care management and G.P. and updated.
Recommendation 4 **Ref**: Standard 20.2 **Stated:** First time **To be Completed by:** 20 November 2015	It is recommended that further opportunities, to discuss end of life care, should be created by the registered nurses. Any expressed wishes of patients and/or their representatives should be 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: Discussions with a number of clients representives have taken place during care reviews and these discussions have included spiritual, cultural and religious needs of the clients.

Recommendation 5 **Ref**: Standard 6.11 **Stated:** First time **To be Completed by:** 20 November 2015	It is recommended that the current system for ordering patients' toiletries is reviewed to ensure that patients have toiletries available to meet their needs.
	Response by Registered Person(s) Detailing the Actions Taken: System reviewed for ordering toiletries, ensuring that each cleint has sufficient toiletries for their individual needs.
Recommendation 6 **Ref**: Standard 28.1 **Stated:** First time **To be Completed by:** 20 November 2015	It is recommended that the administration of laxative medication prescribed on an "as required" basis is reviewed to ensure that laxatives are administered in response to patient need. The records of bowel movements should be checked prior to each administration.
	Response by Registered Person(s) Detailing the Actions Taken: medications reviewed and as required medications now prescribed on a more regular basis to meet the clients needs. bowel records monitored.

Registered Manager Completing QIP	Pat Graham	**Date Completed**	24/11/15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	24.11.15
RQIA Inspector Assessing Response	Sharon McKnight	**Date Approved**	1-12-15

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