Glencarron
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Unannounced Care Inspection
of
Glencarron

15 September 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 15 September 2015 from 10.30 to 15.00 hours.

This inspection was underpinned by one standard and one theme from the DHSSPSNI Care Standards for Nursing Homes (2015). **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 27 January 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**	**3**

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

2. Service Details

Registered Organisation/Registered Person: Glencarron Homes Limited	**Registered Manager:** Mrs Oonagh Grant
Person in Charge of the Home at the Time of Inspection: Mrs Oonagh Grant	**Date Manager Registered:** 21 December 2011

Categories of Care: NH-DE, NH-PH, NH-PH(E), NH-I Of the 44 residents accommodated there shall be a maximum of 4 assessed as NH-DE and a maximum of 10 in categories NH-PH & NH-PH(E). The home is also approved to provide care on a day basis for a maximum of 9 persons or a maximum of 5 persons of high dependency.	**Number of Registered Places:** 44
Number of Patients Accommodated on Day of Inspection: 43	**Weekly Tariff at Time of Inspection:** £593

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 the registered manager
- discussion with three company directors
- discussion with patients
- discussion with staff
- review of care records
- observation during an inspection of the premises
- evaluation and feedback.

The inspector met with nine patients individually and with the majority of others in groups, two care staff, three nursing staff and one patient's visitors/representative.

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 plan (QIPs) from the care inspection undertaken in the previous inspection year
- the previous care inspection report.

The following records were examined during the inspection:

- staff duty rotas from 31 August to 13 September 2015
- staff training records in relation to the theme
- two staff competency and capability records
- one care staff induction record
- three care records
- a selection of policies and procedures
- incident and accident records
- a selection of care record audits
- the complaints records
- minutes of staff meetings for 2015
- guidance for staff in relation to palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Glencarron was an unannounced care inspection on 27 January 2015. 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 14 (1) (b) **Stated:** First time	The registered manager must ensure that a named patient is referred for specialist tissue viability advice in relation to a pressure ulcer. Confirmation of the assessment and its outcome must be returned to RQIA along with the QIP.	**Met**
	Action taken as confirmed during the inspection: Confirmation of the tissue viability assessment and outcome was received from the manager in relation to the named patient following last inspection. A review of one wound care chart found these records to be well kept with a record of the wound location, the dressing used, the assessment of the wound at each dressing change and the frequency of treatment clearly stated. This requirement has been met.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 19.1 **Stated:** First time	A bowel assessment should be carried out for those patients requiring continence management.	**Not Met**
	Action taken as confirmed during the inspection: A bowel assessment form had been developed to accompany the continence assessment. However, in two of the three care records reviewed this was not completed. This recommendation has not been met and has been stated for a second time.	
Recommendation 2 **Ref**: Standard 35.1 **Stated:** First time	It is recommended that continence pads are stored in a manner which maintains this equipment safely, in accordance with manufacturers' instructions and to ensure effective infection prevention and control.	**Met**
	Action taken as confirmed during the inspection: Continence pads were noted to be stored appropriately in their original packaging. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 26.2 **Stated:** First time	The following policy should be developed in accordance with best practice guidelines: • Catheter care and management.	**Met**
	Action taken as confirmed during the inspection: A detailed catheter care and management guideline had been developed specifically for the home and shared with staff. This referenced current best practice guidelines. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 19.2 **Stated:** First time	The registered person should ensure that the following best practice guidelines are readily available to staff and used as required: • British Geriatrics Society Continence Care in Residential and Nursing Homes • RCN continence care guidelines	**Met**

	• NICE guidelines on the management of urinary incontinence in women • NICE guidelines on the management of faecal incontinence.	
	Action taken as confirmed during the inspection: Relevant guidelines on continence management were available in the home for staff to consult when required. This recommendation has been met.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on breaking bad news which was due for review in October 2015. The regional guidelines on Breaking Bad News were available to staff in the palliative care resource folder.

A sample of training records could not evidence that staff had completed training in relation to communicating effectively with patients and their families/representatives. However, staff spoken with were knowledgeable about this aspect of care.

Is Care Effective? (Quality of Management)

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

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

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

Staff consulted demonstrated their ability to communicate sensitively with patients and/or representatives when breaking bad news by providing a private venue and time to listen and respond. It was clear that staff had kept detailed notes of discussions with the patients' representatives as they approached the end of life.

Is Care Compassionate? (Quality of Care)

Discussion with nursing staff and the manager and a review of the care records evidenced that staff discussed bad news with patients and their family members. There was evidence that the staff had strongly advocated for the best interests of the patient to be respected as they neared the end of life. The nursing staff and the manager also emphasised the importance of building strong, professional relationships with patients' families and representatives as many of the patients were unable to express their own wishes due to cognitive impairment.

One patient's relative consulted confirmed that they were always kept informed in relation to their loved one's condition and were of the opinion that the communication between the staff and the family was very good.

Staff were observed to be responding to patients in a dignified manner. Relationships between staff and patients were observed to be relaxed and cordial.

Areas for Improvement

No requirements or recommendations have been made in relation 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 were under development. The existing policies were not reflective of best practice guidance such as the Gain Palliative Care Guidelines (2013). A recommendation has been made in this regard.

A review of training records evidenced that a number of care staff had completed in-house training in respect of palliative/end of life care. The registered manager and nursing staff confirmed that all nursing staff had received training in the management of syringe drivers. They also received support from the trust in relation to these devices. The deputy manager explained that they had attempted to book more staff on to an RCN course but that this was oversubscribed and they were awaiting further dates to be released. The registered manager had also completed post graduate study in specialist practice in palliative care.

Discussion with staff and a review of the palliative care resource file confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the manager, nursing staff and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken. Staff were observed to be reporting concerns about one particular patient's condition to the manager and appropriate action was taken in response.

A review of one care record identified an issue with timely access to medications out of hours. The medications could not be accessed out of hours despite numerous attempts by the registered manager, resulting in a delay in the set-up of a required syringe driver. A review of records and discussion with the staff evidenced that they had managed to keep the patient comfortable during the night and had contacted a pharmacist first thing next morning. Concerns in relation to this were discussed with the manager who contacted the older people's support team in the commissioning Trust for further advice and guidance. RQIA contacted this team who confirmed that they had advised the home management regarding the out of hours arrangements and they have contacted the out of hours GP manager to identify this issue.

A palliative care link nurse was available in the home and dates of future meetings were displayed on the staff notice board.

Is Care Effective? (Quality of Management)

A review of 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. There was no evidence, however, that the patient's wishes regarding their social, cultural and religious preferences had been considered. Care records documented the patients' religious denominations but no care plan was in place in relation to these needs. The manager confirmed that all patients would have access to spiritual support if they required it. In addition, the manager had identified this as an issue in some to the completed care record audits. A recommendation has been made in this regard.

Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. The manager and deputy manager stated that this discussion was often not possible with the patients but they attempted to broach this subject with patients' families where appropriate. They did state that the GP did not always carry out advanced care planning with patients and their families which they would have found valuable. There was a lengthy discussion with the home management who demonstrated an interest in continuing to improve their practice in this area.

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

Discussion with the manager, staff and a review of care records 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.

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

Is Care Compassionate? (Quality of Care)

Although care records did not evidence that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences staff did confirm in discussion that the priest visited the home regularly and was available to patients. As previously stated, a recommendation has been made in this regard.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the person's wishes, for family/friends to spend as much time as they wished with the person as they neared the end of life. Relatives were offered a comfortable chair in the patient's room or had access to a lounge should they wish to stay overnight. Staff stated that they called in regularly to check on the patient and their relatives and offered beverages and snacks as required.

From discussion with the manager, staff and one relative evidenced that arrangements in the home were sufficient to support relatives during this time. A plaque was on display on the first floor in which family had commended staff for the care and attention paid to their mother.

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.

The remains of a recently deceased patient were observed being taken from the home by the funeral directors. They were accompanied at all times by a member of the senior management team and were treated with the utmost respect throughout.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. From discussion with the manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included the support of the team and the manager.

Areas for Improvement

A recommendation has been made that a policy in relation to palliative care/death and dying is developed with reference to current best practice guidelines and this shared with staff.

A recommendation has been made that the cultural and spiritual needs of patients are assessed and included in their end of life care plan to ensure that these needs are appropriately met.

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

5.5 Additional Areas Examined

5.5.1. Comments of patients, patients' representatives and staff

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

Patients

Patients did not complete questionnaires but comments made to the inspector were very positive in regards to the home and the staff. These included:

"I am very happy and content here. There is nothing I would change."
"The staff are very good here."

Patient representatives

One patient's representative spoke with the inspector and they also completed a questionnaire. They were very happy with the care in the home and described the care as excellent.

They stated that they were always kept informed regarding their loved one's condition. Another patient representative completed a questionnaire following the inspection. They were generally positive about the quality of care and the staff. Concerns raised in the questionnaire were addressed with the manager by email following the inspection.

Staff

Staff spoken with were generally happy working in the home. Six staff completed questionnaires. All staff were either satisfied or very satisfied with the training provided, the support offered to patients who were dying and their relatives and that patients' wishes were respected. One staff member commented that at there were too few care staff on at times. The manager stated that staff would only be short in the event of short notice sickness absence and care staff confirmed this. This was the case on the day of inspection as one care assistant had reported sick. Cover was promptly arranged for that afternoon and staff re-deployed in the morning to compensate for this. A review of the off duty evidenced that appropriate numbers of staff were on duty to meet the needs of patients.

A staff member commented:

"The standard of care provided is of a high standard and the emphasis is placed on residents' human rights and their choices are respected. There is good communication between staff."

5.5.2. Care Records

A review of the care records found these to be well completed with up to date risk assessments and care plans. The care record audits were regularly conducted by the registered manager and there was evidence that these were being returned with the actions completed by the named nurse.

It was noted that two versions of the activities of living assessment were in use. The manager and deputy manager confirmed that they had reviewed an older version of the form and added additional areas including spiritual needs and cognitive needs, for example, to ensure this better met the needs of their patient. The care records were in the process of being updated to include the newer version of the assessment.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Oonagh Grant, registered manager, the deputy manager and three company directors 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.

IN022147

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 19.1 **Stated:** Second time **To be Completed by:** 15 October 2015	A bowel assessment should be carried out for those patients requiring continence management. **Response by Registered Person(s) Detailing the Actions Taken:** These assessments have since been carried out for all patients.
Recommendation 2 **Ref**: Standard 32 **Stated:** First time **To be Completed by:** 15 December 2015	The registered persons should ensure that a policy in relation to palliative care/death and dying is developed with reference to current best practice guidelines and this shared with staff. **Response by Registered Person(s) Detailing the Actions Taken:** Policy has been drafted, is going to print and will be shared with all staff 1 month.
Recommendation 3 **Ref**: Standard 20, criterion 2 **Stated:** First time **To be Completed by:** 15 November 2015	The registered persons should ensure that the cultural and spiritual needs of patients are assessed at end of life and included in their care plan to ensure that these needs are appropriately met. **Response by Registered Person(s) Detailing the Actions Taken:** Where possible these issues have been discussed with patients & outcomes documented. Where this was not possible due to diminished capacity relatives have been consulted

Registered Manager Completing QIP	Grant	**Date Completed**	1.10.15
Registered Person Approving QIP	Bridget Lindy	**Date Approved**	1-10-15
RQIA Inspector Assessing Response	Barrett	**Date Approved**	12-10-15.

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

Please provide any additional comments or observations you may wish to make below: