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Unannounced Care Inspection of Brooklands Kilkeel

28 September 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 28 September 2015 from 11.30 to 17.30 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, 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.

For the purposes of this report, the term 'patients' will be used to described those living Brooklands, Kilkeel, which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 18 November 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	2	1

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

2. Service Details

Registered Organisation/Registered Person: Brooklands Healthcare Ltd Jarlath Conway Therese Elizabeth Conway (Acting)	Registered Manager: Deborah Campbell
Person in Charge of the Home at the Time of Inspection: Deborah Campbell	**Date Manager Registered:** 24 August 2012
Categories of Care: NH-PH, RC-I, NH-LD(E), NH-MP(E), NH-LD, NH-PH(E), RC-DE, NH-DE, NH-I, NH-MP	**Number of Registered Places:** 57
Number of Patients Accommodated on Day of Inspection: Total 53 RC-DE 9 NH-DE 14 NH-PH 29	**Weekly Tariff at Time of Inspection:** £470 to £637

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:

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection;
- the registration status of the home;
- written and verbal communication received since the previous care inspection;
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year; and
- the previous care inspection report.

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with twenty patients, four care staff, two nursing staff, one domestic staff and three patient's visitors/representatives.
The following records were examined during the inspection:

- validation evidence linked to the previous QIP;
- staffing arrangements in the home;
- total of five patient care records, varied units;
- staff training records;
- regulation 29 monthly monitoring reports;
- complaints records;
- policies for communication and end of life care; and
- policies for death, dying and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Brooklands Kilkeel was an announced finance inspection dated 16 February 2015. The completed QIP was returned and approved by the finance inspector.

5.2 Review of Requirements and Recommendations from the last care inspection 18 November 2014

<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 12 (1) (b)

Stated: First time</td><td>Ensure the following policies and procedures are updated to reflect best practice;

• continence management/incontinence management;
• stoma care; and
• catheter care.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of the policy and procedure manual evidenced that the above policies and procedures have been updated to reflect best practice.</td></tr>
<tr><td rowspan="2">Requirement 2

Ref: Regulation 27

Stated: First time</td><td>Ensure the three identified bedrooms are redecorated.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The three identified bedrooms were observed to be redecorated and all have had the floor covering replaced.</td></tr>
</table>

Requirement 3 **Ref: Regulation 12 (4)** **Stated: First time**	Ensure food is served at the correct temperature in accordance with best practice. **Action taken as confirmed during the inspection**: A new heated food trolley has been purchased and in use. The temperature of food is checked prior to service commencing.	**Met**
Requirement 4 **Ref: Regulation 15 and 16** **Stated: First time**	Ensure the following issues are addressed in relation to the care records; • charts are required to be updated contemporaneously in order to reflect the correct delivery of care; • ensure the Malnutrition Universal Screening Tool (MUST) is correctly completed and updated for all patients/residents; • weights should be accurately recorded in care records; • body maps should be kept up to date patients'/residents' skin; • Remove care plans no longer applicable to the patients'/residents' needs; and • ensure all patients who are required to have a fluid balance chart in place have it consolidated at the end of a 24 hour period by a registered nurse and the input and output recorded in the daily evaluation of care. **Action taken as confirmed during the inspection**: Five care records were reviewed throughout the various units in the home. The charts were completed contemporaneously. The MUST chart was correctly completed and was up to date. Weights were accurately recorded in the care records. Body maps were up to date; however old charts no longer in use should be removed from the current records in order to prevent any ambiguity. Old care plans no longer relevant were removed from the current care record.	**Met**

	Fluid balance charts were observed to be consolidated at the end of a 24 hour period by the registered nurse. This information was observed to be transferred to the daily progress notes.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was available on communicating effectively which reflected current best practice, including regional guidelines on 'Breaking Bad News'. Discussion with nursing staff confirmed that they were knowledgeable regarding this policy and procedure. The policy and procedure was endorsed by the registered persons on 25 April 2015 and 26 May 2015. The endorsement included the planned review dates.

Discussion with the registered nurses and care staff confirmed that that they were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication. Palliative care training has been attended by 88% of staff. 85% of staff has received training in Communication. Further training has been arranged for the remainder of staff in Palliative care and Communication the week commencing 12 October 2015. The training programme included training in 'Breaking Bad News'. The registered manager has agreed to confirm to RQIA when all staff have received this training.

Is Care Effective? (Quality of Management)

Two 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. They explained that there were events which would trigger sensitive conversations with patients and/or their families, for example an increase in the number of admissions to hospital, and/or reoccurring symptom with a poor prognosis. They emphasised the importance of building caring relationships with patients and their representatives and the importance of regular, ongoing communication regarding the patient's condition.

Care staff considered the breaking of bad news to be, primarily, the responsibility of the registered nursing staff but felt confident that, should a patient choose to talk to them about a diagnosis or prognosis of illness, they would have the necessary skills to do so. They felt strongly that there role was to empathise and support family members during this period.

The policy on death and dying stated that end of life and after death arrangements are discussed with the patient and their relatives and documented in their care plan. Two care records were reviewed and they reflected patient individual needs and wishes regarding the end of life care. Records included reference to the patients' specific communication needs. A review of both records evidenced that the wishes and feelings were discussed with the patients and/or their representatives, options and treatment plans were discussed. There was also evidence within the records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

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.

We consulted with two visiting relatives who confirmed that staff treated patients with respect and dignity and were always welcoming to visitors.

There were several cards and letters on display complimenting the care that was afforded to patients when they were receiving end of life care.

Areas for Improvement

There were no requirements or recommendations made in regards to Standard 19.

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 care, end of life care, death and dying were available in the home. These documents reflected best practice guidance such as the GAIN Palliative Care Guidelines, November 2013. Registered nursing staff consulted with were aware of and able to demonstrate knowledge of the GAIN guidelines.

The policies reviewed included guidance on the management of the deceased person's belongings and personal effects.

The registered manager has identified a registered nurse who has agreed to undertake the role of palliative link nurse for the home and will attend formal training for this role in the near future and it is envisaged that they will attend the relevant Healthcare Trust meetings regarding palliative care. A recommendation is made in this regard.

Discussion with two nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services and that they were proactive in identifying when a patient's condition was deteriorating and that appropriate actions had been taken.

Discussion with two registered nurses confirmed that they were knowledgeable regarding the procedure to follow if they required access to any specialist equipment or drugs out of normal working hours. One registered nurse described how they would order medicines for symptom relief, in anticipation of need. Discussion with one registered nurse confirmed that they had a good awareness of the procedure to follow, in the event of a patient suddenly becoming unwell or dying unexpectedly. There was no specialist equipment, in use in the home on the day of inspection. Discussion with two registered nurses confirmed that training in the use of syringe drivers had been provided previously and that updates can be accessed through the local Healthcare Trust nurse if required.

Is Care Effective? (Quality of Management)

A review of two 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 and symptom management. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A key worker/named nurse were identified for each patient approaching end of life care.

Discussion with the registered manager and staff evidenced that environmental factors had been considered when patients were diagnosed as requiring palliative care or were at the end of life stage of care. Registered nurses described that in the past 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 all notifications were submitted appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of five care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. All staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. Overnight stays were facilitated if there was a vacant room and staff described how catering and snack arrangements were provided to family members during this period.

From discussion with the registered manager, staff and a review of the compliments records, there was evidence that arrangements in the home were sufficient to support relatives during this time. There were numerous cards on display, within which relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the registered manager and staff evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home. All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with the manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included more experienced staff offering support to new staff and time spent reflecting on a patients time spent living in the home. One staff member described how difficult it was for staff when there was a sudden deterioration in a patient's health. It was evident that there were supportive relations within the home.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included information on the Health and Social Care Bereavement Network on caring at end of life, how to cope with bereavement and a guide for talking with and supporting children following a death.

Areas for Improvement

A recommendation is made that the identified a registered nurse who has agreed to undertake the role of palliative link nurse for the home and will attend formal training.

Number of Requirements:	0	Number of Recommendations:	1

5.5 Additional Areas Examined

5.5.1 Questionnaires and comments

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	10	3
Patients	5	5
Patients representatives	2	1

All comments in the returned questionnaires were very positive. Some comments received are detailed below:

Staff

- "Satisfied that I have received training in safeguarding vulnerable adults and how to report poor practice."
- "Very satisfied that patients are afforded privacy, dignity and respect at all times."
- ""Satisfied that there are supportive systems in place to enable staff to pay their respects following the death of a patient."
- "I am very happy here, we all work well as a team, and Deborah is very approachable."
- "The care is good here, I think patients are well looked after."

There were no concerns raised by staff during the inspection process.

Patients

- "Satisfied that staff takes time to listen to me."
- "The quality is very good, I think nothing needs to change, the manager is very good she listens to me."
- "I can talk to the staff about anything."
- "Very satisfied that my relatives/friends are made welcome by staff."
- "Very satisfied that I receive my medicines on time."
- "Very satisfied that I feel I have as much independence as possible."
- "I couldn't ask for better, the staff is so attentive."
- "Everyone is always so busy, but they always have time for me."

There were no concerns raised by patients during the inspection process.

Patients' representatives

- "Very satisfied that my relative has access to religious support if required."
- "Staff are very friendly and kind, but they have so much work on."
- "I have no worries, I think my relative is very well looked after here, it is home from home."
- "It's all good, I am very satisfied with everything, if I had a worry I would go to the nurses or the manager."

There were no concerns raised by patients' representatives during the inspection process.

5.5.2 Environment

A general inspection of the home was undertaken which included inspection of a random sample of bedrooms, bathrooms shower and toilet facilities, sluice rooms, storage rooms and communal areas were examined. All areas examined were found to be clean, tidy and were warm and welcoming throughout. However, there are some areas in the home which are required to be refurbished. Various areas in the home have been refurbished due to re-registration as the category of care has changed in the residential unit and the dementia nursing unit. The environment in these units was nicely presented. Some identified bedrooms in the frail elderly nursing unit are required to be refurbished as the wardrobes and furniture was observed to be chipped scraped and marked. A refurbishment plan should be prepared with timescales as to when this furniture is planned to be replaced. A copy of the refurbishment plan should be forwarded to RQIA alongside the returned QIP. A requirement is made in this regard.

5.5.3 Care Records

Five care records were reviewed from various units throughout the home. All units were following a process of assessment, planning, implementation and evaluation. They were all generally reflective of the current needs of patients as discussed with staff on duty. The care records examined were specific, individualised and easily perused.

One care record of a patient who had a head injury was well detailed in term of assessment, reassessment and care delivery. However, the care record was required to be updated to include a care plan in place to manage the injury. There was a daily entry describing the injury, however the care plan and monitoring arrangements was not formalised to guide staff of the care required. A requirement is made to ensure this identified care record is updated in keeping with best practice.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager, Deborah Campbell, 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

Statutory Requirements	
Requirement 1 **Ref: Regulation 27 2 (c)** **Stated: First time** **To be Completed by: 13 November 2015**	The registered persons shall ensure that a refurbishment plan is prepared. The timescales as to when the furniture is planned to be replaced should be forwarded to RQIA alongside the returned QIP. **Ref 5.5.2** **Response by Registered Person(s) Detailing the Actions Taken:**
Requirement 2 **Ref: Regulation 15 2 (b)** **Stated: First time** **To be Completed by: 13 November 2015**	Ensure the identified care record is updated to reflect their current needs. **Ref 5.5.3** **Response by Registered Person(s) Detailing the Actions Taken:**
Recommendations	
Recommendation 1 **Ref: Standard 32** **Stated: First time** **To be Completed by: 30 November 2015**	The registered persons shall ensure that the identified a registered nurse who has agreed to undertake the role of palliative link nurse for the home will attend formal training. **Ref 5.4** **Response by Registered Person(s) Detailing the Actions Taken:**

Registered Manager Completing QIP		**Date Completed**	
Registered Person Approving QIP		**Date Approved**	
RQIA Inspector Assessing Response		**Date Approved**	

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

A completed Quality Improvement Plan from the inspection of this service is not currently available. However, it is anticipated that it will be available soon.

If you have any further enquiries regarding this report please contact RQIA through the e-mail address info@rqia.org.uk