Corkhill Care Centre
RQIA ID: 1483
27 Coolmaghery Road
Donaghmore
Dungannon
BT70 3HJ
Tel: 028 8776 7362
Email: lodge.corkhill@btopenworld.com

Inspector: Sharon Loane
Inspection ID: IN021876

Unannounced Care Inspection
of
Corkhill Care Centre

11 November 2015

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 11 November 2015 from 11.00 to 17.00 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 in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in this report.

For the purposes of this report, the term 'patients' will be used to described those living in Corkhill Care Centre 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 01 December 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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Corkhill Care Centre Mr Thomas & Mrs Margaret Potts	**Registered Manager:** Ms Una McTaggart
Person in Charge of the Home at the Time of Inspection: Ms Una Mc Taggart Ms Hayley Jordan	**Date Manager Registered:** 24 September 2014
Categories of Care: RC-I, RC-PH, NH-LD, NH-LD(E), RC-DE, NH-DE, NH-I, NH-PH	**Number of Registered Places:** 48
Number of Patients Accommodated on Day of Inspection: 44	**Weekly Tariff at Time of Inspection:** £470.00 - £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 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

Prior to inspection the following records were analysed:

- notifiable events submitted since January 2015
- the registration status of the home
- any communication/information received by RQIA regarding the home since the last care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

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

- discussion with Ms Una Taggart, (registered manager) and Ms Hayley Jordan (residential manager)
- discussion with Mr Thomas Potts, responsible individual
- discussion with patients, staff and patient representatives
- review of a selection of records
- observation during a tour of the premises
- evaluation and feedback

The following records were examined during the inspection:

- three patient care records
- staff training records
- policies and procedures in relation to the standards and theme of inspection
- a record of compliments

During the inspection, eleven patients were consulted individually and the majority of others in smaller groups; five staff and four relatives were also spoken with. Questionnaires for staff not on duty during the inspection were provided along with five relative/representatives questionnaires for distribution. Please refer to section 5.5.3 for details.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Corkhill Care Centre was an unannounced finance inspection dated 16 July 2015. The completed QIP was returned and approved by the finance inspector on 10 September 2015.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 01 December 2014

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 28.4 **Stated:** First time	It is recommended that registered nurses as appropriate are trained in male catheterisation.	**Met**
	Action taken as confirmed during the inspection: A review of training records confirmed that nine registered nurses had completed training in male catheterisation on 09 March 2015. The training was facilitated by the Clinical Education Centre (HSC).	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was currently being developed on communicating effectively to include the breaking of bad news. A final copy of the policy was forwarded to RQIA post inspection and was reflective of the regional guidelines on Breaking Bad News. Discussion with staff confirmed that they were knowledgeable regarding breaking bad news.

A sampling of staff training records evidenced that staff had completed training, June 2015 in relation to communicating effectively with patients and their families/representatives. This training included the procedure for breaking bad news as relevant to staff roles and responsibilities.

Staff had also completed sensory training, August 2015 which focused on barriers to communication for example hearing problems, eyesight and cognitive impairment and the impact that these can have on a person's ability to communicate their needs and wishes.

Is Care Effective? (Quality of Management)

A review of three care records evidenced that reference had been made to the patients specific communication needs such as, when a patient required spectacles or a hearing aid or if a patient would have difficulty understanding.

There was 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.

Two registered nurses consulted demonstrated their ability to communicate sensitively with patients and/or representatives when breaking bad news. All staff demonstrated a good awareness, relevant to their role, of the need for sensitivity when communicating with patients and /or their representatives. However, this was dependent on the staff member's experience; for example some of the care staff spoken with said they would refer the patient or relatives to

the registered nurse, while others said they would feel confident to reassure the patient or relative before referring them to the registered nurse.

Is Care Compassionate? (Quality of Care)

Patients were observed to be treated with dignity and respect by all grades of staff. There were a number of occasions observed 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, management and staff.

Patients spoken with all stated that they were very happy with the quality of care received and with all aspects of life in Corkhill Care Centre. Patients confirmed that all staff were kind, caring and courteous and that they felt safe in the home.

Relatives/visitors spoken with confirmed that communication between them and the home was effective, that management and all staff were compassionate, empathetic and caring in their approach.

Areas for Improvement

No areas of improvement were identified 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 available in the home. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects. A copy of the GAIN Palliative Care Guidelines, November 2013 were available and registered nurses and care staff were aware of and able to demonstrate knowledge of these guidelines.

A review of staff training records evidenced that the majority of staff had completed training in respect of palliative and end of life care. Staff had attended a number of training events to include; Living Matters Dying Matters, May 2015, a Palliative Care Master Class, September 2015, Oral Health Care and Palliative and End of Life Care and Spiritual Care, September and November 2015. A record was also available to evidence that staff had also completed training in palliative care via e learning. The registered manager advised that supervision sessions had been completed with staff in relation to the standards and theme of inspection, a record was available to confirm this information. Four staff were scheduled to attend the RCN conference on palliative and end of life care on the 12 November 2015. The home are commended for the level and scope of training opportunities afforded to staff to enhance their knowledge and practice in this area of practice.

Discussion with registered nurses and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the registered manager, two registered nurses and a review of three 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.

A protocol for timely access to any specialist equipment, drugs and all specialist services available was in place and discussion with staff confirmed their knowledge of the protocol.

There was no specialist equipment in use in the home on the day of inspection. A review of training records confirmed that two registered nurses had received a training update in the use of the McKinley syringe driver, September 2015.

The home had an identified palliative care link nurse who was available for discussion at time of inspection. The link nurse discussed their role and advised that they attended the Trust link meetings when scheduled and availed of all training opportunities to enhance their knowledge and all learning is shared with the staff team.

Is Care Effective? (Quality of Management)

A review of three 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. One of the records reviewed was for a patient identified as having palliative care needs. The records reviewed had been updated to reflect all changes in accordance with the patients identified needs. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements. The information recorded was very detailed in this regard and management and registered nurses are commended.

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

Discussion with the registered manager and staff 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 confirmed that they were submitted appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of three 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. Staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

Management and staff confirmed that arrangements for relatives/representatives to be with patients who had been ill or dying were in place. Staff described arrangements with ease and had confidence in their ability to support and provide comfort at this time.

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

Discussion 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.

Staff confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with the registered manager and staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included for example, bereavement support; staff meeting and 1:1 counselling if deemed appropriate.

Information regarding support services were available and accessible for staff, patients and their relatives.

Areas for Improvement

No areas for improvement were identified in regards to this theme.

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

5.5 Additional Areas Examined

5.5.1. Categories of Care

A review of the certificate of registration and categories of care was undertaken. Discussion with management and a review of the patient list evidenced that the home were compliant with the categories of care for which they were registered. Temporary care arrangements for two identified patients were discussed. Assurances were given by management, that additional measures had been taken to ensure the health and welfare of the identified patients and that there was no significant impact on other patients. A review of records confirmed that the Trust had agreed with the temporary care arrangements in place.
Following the inspection, this information was discussed with senior management at RQIA.

5.5.2 Environment

A general inspection of the home was undertaken which included inspection of a random sample of bedrooms and bathrooms. The home was found to be warm, beautifully decorated and the level of cleanliness observed was to a very high standard. The home had recently celebrated a 30 year business anniversary and there were photographs, cards and letters available to mark this celebration and achievement.

5.5.3 Consultation with Patient, Staff and Relatives

In addition to speaking with patients, staff and relatives/visitors, five questionnaires were distributed to staff not on duty during the inspection and five questionnaires were issued for relatives to complete.

Patients

Eleven patients were spoken with individually and the majority of others in smaller groups. Patients spoken with were complimentary regarding the care delivered, staff, quality of food and life in the home. There were no concerns raised. Four questionnaires were completed and returned. Some comments included;

“for the past six months I have found Corkhill to be “a home from home”, I am comfortable about approaching the staff and management with any problems that I have”.

“I am very well cared for and comfortable in Corkhill, the staff are pleasant at all times and the food is very good”.

“this is treated as the very next best thing to my home. Each and every one of the staff are so helpful- couldn’t speak highly enough, they do their very best”.

“I am treated with dignity and they are very kind to me. I have a choice when I get up when I want, watch T.V when I want. It’s a perfect home to me I wouldn’t leave it for the world – I am content and feel safe and it’s near my friends who come to visit me”.

Relatives

Four relatives were spoken with during the inspection. Relatives spoken with and responses recorded in the returned questionnaires (four) indicated that the standard of care was excellent, food was exceptional with an extensive menu, staff were very attentive and caring and that they were kept fully informed of changes to their loved one’s care. Relatives recorded the following comments;

“we find staff very caring and easy to talk to … has been in Corkhill for 6 years and has received excellent care during that time”.

“in five years we have no complaints about care and staff. … show absolute dedication and set a very high standard. Thank you”.

“spirituality discussed with me in depth with staff nurse”.

Staff

Five questionnaires were left for staff, and three were returned. Respondents indicated that they had received mandatory training and additional training relating to their role and function in the home. Staff spoken with demonstrated great pride in being a member of the team at Corkhill Care Centre. Staff stated that they were satisfied or very satisfied with the standards of care provided and patients and their representatives were respected and treated with dignity. No concerns were raised.

Comments recorded on the returned questionnaires, by staff included:

"I love my job and feel that we all work well as a team".

"I feel positive that the patients of this home are well cared for and any needs that they have staff provide for them well. There is good support and the training is very good".

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Una McTaggart	**Date Completed**	02/12/15
Registered Person	Margaret Potts	**Date Approved**	02/12/15
RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	10/12/15

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

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

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.