Inspector: Sharon McKnight
Inspection ID: IN023416

Dunlarg Care Home
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Unannounced Care Inspection of Dunlarg Care Home

1 October 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 1 October 2015 from 10.00 to 16.15 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 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 in Dunlarg Care Home 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 12 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	**0**	**2**

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

2. Service Details

Registered Organisation/Registered Person: Four Seasons (Bamford) Ltd	**Registered Manager:** Patricia Graham
Person in Charge of the Home at the Time of Inspection: Patricia Graham	**Date Manager Registered:** 30 May 2012
Categories of Care: RC-I, RC-MP(E), NH-LD, NH-PH, NH-PH(E), NH-DE, NH-I	**Number of Registered Places:** 58
Number of Patients Accommodated on Day of Inspection: 48	**Weekly Tariff at Time of Inspection:** Residential £470.00 – £528.00 Nursing £593.00 - £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)

In September 2015 RQIA received a complaint regarding care issues and the management of medicines. It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. The caller was advised to contact the health and social care trust who commission care to raise their concerns.

If RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. Following discussion with senior management, it was agreed that the focus of the planned inspection would include a review of the governance arrangements for medicine management and general care delivery in the home.

4. Methods/Process

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

- discussion with registered 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, the inspector met with 16 patients individually and with the majority generally, three registered nurses, five care staff and two patient's visitors/representative.

The following records were examined during the inspection:

- six care records
- 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 care inspection dated 12 November 2014. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care (Same specialism) Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 19.4 **Stated:** First time	It is recommended that registered nurses competency and capability assessments be reviewed and updated to include male catheterisation.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that competency and capability of registered nurses to carry out male catheterisation was assessed by the district nursing service of the local and health and social care trust. Records were maintained of competency. Whilst the Four Seasons Heath Care competency and capability assessment had not been updated RQIA were satisfied that evidence was maintained of staff competency. 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.

A sample of training records evidenced that staff had not completed formal training in relation to communicating effectively with patients and their families/representatives. However, the registered manager, nursing and care staff confirmed during discussion that staff were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication. Staff spoken with, were knowledgeable and experienced in communicating with patients and their representatives.

Is Care Effective? (Quality of Management)

Six 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 5.4.

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 manager and registered nurse demonstrated their ability to communicate sensitively with patients and relatives when breaking bad news and provided examples of how they had done this in the past. Care staff considered the breaking of bad news to be the responsibility of the registered nursing staff but felt confident that, should a patient choose to talk to them about the diagnosis or prognosis of illness, they would have the necessary skills and confidence to do so.

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 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' with the quality of care delivered and with life in the home.

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

Compliment cards and letters are retained. Review of these indicated that relatives were appreciative of the care provided.

Areas for Improvement

There were no areas for improvement identified with 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 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 and DHSSPS Living Matters Dying Matters, A Palliative and of Life Care Strategy for Adults in Northern Ireland, March 2010 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 are treated with respected.

Three registered nurses were identified as link workers in palliative care and attended regular palliative care link nurse meetings arranged by the local health and social care trust. The link nurses attended a conference entitled "End of Life Care" organised by the Irish Hospice Foundation on 10 September 2015. This training enabled them to support staff in this area of care.

Training records evidenced that staff had received training in palliative and end of life care on 27 May 2015. The registered manager advised that this programme was being run again on 16 October 2015 and that staff were identified to attend. Registered nurses had received training in the management of syringe drivers in February and March 2015; support to manage this equipment was provided by the district nurses within the local health and social care trust.

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. Discussion with the registered manager and registered nurses confirmed their knowledge of these procedures.

Discussion with staff evidenced that they were knowledgeable in identifying when a patient's condition was deteriorating or nearing end of life and the appropriate actions to take.

Is Care Effective? (Quality of Management)

Review of care records evidenced that death and dying arrangements were identified as part of the needs assessment completed for each patient. The care records did not contain specific details of the patients' assessed needs or wishes with regard to end of life care. Examples of comments recorded in the section entitled "Palliative and end of life needs" included:

"no needs identified"
"DNAR signed"
"none identified".

Some patients had palliative care plans in place but the interventions were generic and were not personalised.

The registered manager and registered nurse recognised that, whilst some discussion had taken place regarding the wishes of patients and relatives with the DNAR directives, 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, to discuss end of life care, 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.

Discussion with three registered nurses and five care staff evidenced that environmental factors, which had the potential to impact on patient privacy had been considered. 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 room formerly used as an activity room had recently been refurbished as a relatives' room with tea and coffee making facilities. A range of information and support leaflets were displayed and available for relatives to take away.

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

Is Care Compassionate? (Quality of Care)

The religious, spiritual or cultural need of the patients had been identified in their care records but there was no evidence of consideration of these areas in respect of end of life care. Discussion with patients and 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.

Arrangements were in place in the home to facilitate family and friends to spend as much time as they wish with the patient who was ill or dying. Staff discussed openly a number of deaths in the home and how the home had been able to support the family members in providing refreshments and facilitating staying overnight with their loved ones.

From discussion with the registered manager, eight staff and a review of the compliments record, there was evidence that there were sound arrangements in the home to support relatives during this time. Numerous compliments had been received from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"Sincere thanks for all your care for … and for the kindness shown to us all especially during the last couple of weeks."

"…to all the wonderful staff who looked after my uncle … over the weeks he stayed at Dunlarg…as a family we appreciate how good you all were to us all and especially on the night/morning of his passing."

"The staff of Dunlarg Care Centre have always gone over and beyond the expected both during her stay and after her death. Thank you."

Staff gave a number of examples of how they were given an opportunity to pay their respects after a patient's death. Examples included forming a guard when the patients were being taken out of the home by the undertaker, sending a floral tribute and representation by staff at the funeral.

The registered manager 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 and the support provided by the registered manager.

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.

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:	2

5.5 Additional Areas Examined

5.5.1 Medicines management

The registered manager confirmed that medications were supplied by two local pharmacies and that arrangements were in place to cover weekends and bank holidays. The registered nurses confirmed their knowledge of these arrangements.

A system of medication audits was in place with audits undertaken weekly and monthly by the registered manager. Records evidenced that any areas identified for improvement were re-audited to ensure they were brought into compliance. The registered manager confirmed that, generally there were no issues with out of stock medication. A number of weeks ago there was an issue with the receipt of a prescription but the issue was with the GP practice and was addressed at the time. RQIA were satisfied that there were governance arrangements in place to ensure that the management of medicines was safe.

5.5.1. Care practices

During a tour of the building it was noted that patients were well presented with their clothing suitable for the season. Staff were observed to respond to patients' requests promptly. Patients spoken with were aware of the nurse call system and reported that generally staff would remind them of it before leaving the room.

There was no inappropriate storage of equipment in patients' bedrooms. Staff confirmed that there were good supplies of continence aids, gloves, wipes and toilet roll.

Protective equipment on one bed was noted to be extensively damaged. The replacement of this equipment was discussed with the registered manager and confirmation that a replacement had been ordered was received by RQIA on 6 October 2015 via electronic mail.

A range of activities was observed throughout the day. Armchair exercises took place in one lounge. Other patients participated in a quiz. Patients in another lounge were assisting staff to paint large cartoon characters for the fun day which was scheduled to take place in a few weeks. All of the patients were enthusiastic about the range of activities provided.

5.5.3 Consultation with patients, their representatives and staff.

Discussion took place with 16 patients individually and with the majority of others in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were very positive. Patients did not raise any issues or concerns about care delivery.

Two patients' representatives confirmed that they were happy with the standard of care and communication with staff.

Staff commented positively with regard to staffing and the delivery of care. Staff were knowledgeable regarding their patient's needs, wishes and preferences.

Ten questionnaires were issued to nursing, care and ancillary staff. One was returned. The staff member indicated that they were satisfied or very satisfied that care was safe, effective and compassionate. The following comments were included:

"I feel that the home has great staff and because it is in a small area most of the staff will know the clients and their families."

"We have a great team of GPs who give us great support with end of life care."

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Patricia Graham, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that 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 36.2 **Stated:** First time **To be Completed by:** 12 November 2015	It is 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:** Copy of new manual given to staff and 4 training sessions arranged for all care staff and nurses to attend
Recommendation 2 **Ref**: Standard 20.2 **Stated:** First time **To be Completed by:** 12 November 2015	It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan. 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:** New care plans formulated and these include residents/relatives wishes for end of life care.

Registered Manager Completing QIP	Pat Graham	**Date Completed**	09/11/15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	11.11.15
RQIA Inspector Assessing Response	Sharon McKnight	**Date Approved**	23-11-15

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