Nightingale Care Home
RQIA ID: 1492
34 Old Eglish Road
Dungannon
BT71 7PA

Inspector: Aveen Donnelly
Inspection ID: IN021834

Tel: 02887752666
Email: nightingale@fshc.co.uk

Unannounced Care Inspection
of
Nightingale Care Home

01 September 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500   Fax: 028 9051 7501   Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 01 September 2015 from 11.15 to 19.00.

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 in Nightingale 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 22 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	4

The total number of requirements and recommendations above includes both new and those that have been 'restated'.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the 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/ Dr Maureen Claire Royston	Registered Manager: Hazel Margaret Black
Person in Charge of the Home at the Time of Inspection: Hazel Margaret Black	**Date Manager Registered:** 18 June 2012
Categories of Care: NH-PH, RC-PH, NH-I, NH-MP, RC-I	**Number of Registered Places:** 48
Number of Patients Accommodated on Day of Inspection: 40	**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;
- the previous care inspection report; and
- pre inspection assessment audit.

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with five patients, three care staff, three nursing staff and two patient's visitors/representative.

The following records were examined during the inspection:

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

The Inspection

4.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the Nightingale Care Home was an announced finance inspection dated 5 February 2015. The completed QIP was returned and approved by the finance inspector.

4.2 Review of Requirements and Recommendations from the last care inspection on 22 January 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 13 (7) **Stated:** First time	The registered manager shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff. The following issues were identified which require to be addressed: • a number of bedroom vanity units with veneer were worn and had visible areas of bare wood exposed • a number of toileting seats, toileting equipment were unclean and did not meet infection prevention and control guidance • a number of radiator covers were in poor state of repair and had bare wood exposed • wheelchairs were observed being stored in a linen store	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that 17 radiators had been replaced and that there was a refurbishment plan in place to address the number of vanity units that were in need of replacement. All toilet seats/equipment were observed to be clean and the home was free of malodours. Store rooms were observed being uncluttered and wheelchairs were stored appropriately.	

<table>
<tr><th colspan="2">Last Care Inspection Recommendations</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 5.1

Stated: Second time</td><td>It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of two patients care records confirmed that baseline pain assessments were completed and were reviewed on a regular basis.</td></tr>
<tr><td rowspan="2">Recommendation 2

Ref: Standard 6.2 & 19.1

Stated: First time</td><td>The registered manager should ensure that all assessment documentation is fully completed, signed by the assessing registered nurse and dated.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Three patient care records were reviewed. Two patients had continence assessments completed.

We were unable to locate the continence assessment of one identified patient. However, there was evidence that the patient’s continence assessment had been reviewed. This was discussed with the registered manager who agreed to address this.

Following the inspection the registered manager confirmed to RQIA that this assessment was in place.</td></tr>
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<tr>
<td rowspan="2">Recommendation 3

Ref: Standard 19.1

Stated: First time</td>
<td>The registered manager should ensure accurate records in keeping with schedule 3 are maintained.

Records such as;
bowel function referencing Bristol Stool should be recorded and effectively monitored and recorded in the individuals patient’s progress notes.
fluid intake and output records must be maintained for all patients who have a catheter. Entries should be totalled and the information transferred into daily progress records.</td>
<td rowspan="2">Partially Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
A review of two patient care records identified that registered nursing staff were not consistently recording patients’ bowel function in the progress notes, using the Bristol Stool Chart.

This was discussed with the registered manager who stated that bowel function had been recorded in a bowel book. This was reviewed and there was evidence that the Bristol Stool Chart had been referenced. The registered manager provided assurances that the system of recording bowel function in the progress notes would be discussed at the upcoming staff meeting.

This element of the recommendation has been met.

Inspector confirmed that fluid intake and output records were maintained for two patients who had urinary catheters in place.

However, a review of total fluid intake for two identified patients, for a one week period, evidenced that fluid intake was inadequate. There was no evidence in the progress notes reviewed that action had been taken by the registered nurses, to address this.

Entries on the fluid recording charts were totalled. However, the information was not consistently transferred into daily progress records and there was no evidence that the patients fluid intake had been validated by a registered nurse.

This element of the recommendation has not been met and is stated for the second time.</td>
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Recommendation 4 **Ref**: Standard 40.4 **Stated:** First time	The registered manager should ensure prescribed medicines are only administered to the patient for whom they are prescribed. **Action taken as confirmed during the inspection**: There was no evidence that prescribed creams had been used for patients other than those for whom they had been prescribed.	**Met**

4.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The policies and procedures on the management of palliative and end of life care and death and dying were under review on the day of inspection. However, a review of the draft policy confirmed that the document currently reflected best practice guidance such as the regional guidelines on Breaking Bad News. Discussion with the registered nursing staff confirmed that they were knowledgeable regarding this policy and procedure.

Training records reviewed confirmed that registered nursing staff had received training in palliative care. This training included the procedure for breaking bad news as relevant to staff roles and responsibilities. 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.

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 or increased visits by the general practitioner. 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 relative choose to talk to them about a patient's condition, they would feel comfortable in doing so.

The policy on end of life care stated that if the patients or their advocates have not expressed any views in relation to palliative or end of life care, there should be an effort made to establish the patients preferences and that for patients who do not wish to discuss this, a record should be entered in the needs assessment section of the care records. A review of patient care records did not evidence that these discussions had taken place.

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 taking time to reassure patients as was required from time to time.

Discussion with four patients individually and with the majority of patients generally evidenced that patients were content living in the home.

Discussion with staff and a review of compliments records evidenced that patients' relatives/representatives were appreciative of the care provided to them, when their loved one was dying.

Areas for Improvement

Registered nursing staff should record the efforts made to establish patients' preferences in respect of end of life care and that for patients who do not wish to discuss this, a record should be also be maintained in line with the policy on end of life care.

Number of Requirements:	**0**	**Number of Recommendations**: ***1 recommendation made is stated under Standard 32 below**	***1**

4.4 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)

The policies and procedures on the management of palliative and end of life care and death and dying were under review. However, a review of the draft policy confirmed that the current document reflected best practice guidance such as the GAIN Palliative Care Guidelines, November 2013. The GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013 were available in the home and all registered nursing staff stated that they were aware of where to access the policies and guidance documents should they need to.

There was no formal protocol for timely access to any specialist equipment or drugs in place, however discussion with three registered nursing staff confirmed their knowledge of the procedure to follow should these be required.

The policy reviewed stated that that the e-learning module on palliative and end of life care was mandatory for registered nursing staff and acknowledges that it is good practice for this training to be extended to all grades of staff. Discussion with the registered manager confirmed that the e-learning component of training has not commenced yet. However, there was evidence in the training records reviewed that eight registered nursing staff had completed training in palliative care, three nurses had attended training in respect of the care of the deteriorating patient and four had attended end of life resource training. Plans for all grades of staff to receive training in end of life care were in place.

Three patient care records were reviewed, two of whom were recently deceased. There was no evidence that care plans were in place in respect of patients' palliative and end of life care needs. As previously discussed, registered nursing staff 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 or increased visits by the general practitioner. However, one of the care records reviewed related to a patient who had died suddenly and the inspector could not locate in their care record any evidence that end of life discussions had taken place.

Discussion with three nursing staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services and 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.

Discussion with the manager, three registered nursing staff 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.

There was no specialist equipment, in use in the home on the day of inspection. Discussion with the registered manager and three registered nursing staff confirmed that staff had received training in the use of the McKinley syringe driver. Update training would be accessed through the through the local healthcare trust nurse, if required.

A palliative care link nurse has been identified and there was evidence that this staff member attended training for this role. Discussion with the registered manager confirmed that the home had good relationship with the Macmillan team and that there was one identified staff member, who also worked with the Macmillan team.

Is Care Effective? (Quality of Management)

A review of three care records evidenced that patients' needs were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management.

The policy on end of life care stated that the registered nurse/senior carer was responsible for any specific cultural arrangements which may include religious or cultural beliefs and that these should be included in the patients' care plans. However, there was no evidence in the care records reviewed that these were considered or that discussions between the patient, their representatives and staff in respect of death and dying arrangements had taken place. As previously discussed, the registered nurses explained that discussions and care planning regarding end of life care were generally triggered by a deterioration in the patient's physical condition. For patients who suddenly became unwell, there was no evidence that their wishes had been established.

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

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)

As discussed previously, there was no evidence within the records reviewed that arrangements were in place to support patients' with their religious and spiritual needs, however discussion with patients and staff demonstrated that the staff had a strong awareness of the patient's expressed wishes and needs

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. Staff consulted with described how refreshments and catering/snack arrangements were provided to patients' relatives during this period.

From discussion with the manager, staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during 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 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.

All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. Staff members described how they would form a guard of honour at the front of the home, when a patient was leaving the home and that they would ensure that appropriate music was played as this was happening. Discussion with the registered manager confirmed that a number of patients had been waked in the home at the request of the patients' family members.

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 supporting newer staff and reflecting on the patients' time spent living in the home.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included leaflets from the Health and Social Care board that provided information for patients and carers on palliative and end of life care and on Macmillan services.

Areas for Improvement

As previously stated, registered nursing staff should record efforts made to establish patients' preferences in respect of end of life care and that for patients who do not wish to discuss this, a record should be also be maintained in line with the policy on end of life care.

A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; and palliative and end of life care.

Where a decision is made regarding end of life care, a care plan should be developed and should include identified religious, spiritual and cultural needs.

Number of Requirements:	**0**	**Number of Recommendations:**	**3**

4.5 Additional Areas Examined

Complaints

A review of the complaints in the previous inspection year confirmed that records were appropriately maintained

Staffing

Review of duty rotas for nursing and care staff confirmed that staffing levels were generally in keeping with the planned staffing levels discussed with inspectors. Staff spoken with confirmed that short notice absences were managed as per the home's protocol. Staff comments are detailed below.

Questionnaires

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	10
Patients	5	4
Patients representatives	5	5

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

Staff

'Nightingale have an excellent knowledge of end of life care and have received a lot of excellent feedback over the years'
'When there is annual leave, the domestic staff often have to work short'
'We cannot get our care plans done within our contracted hours. It is very busy''
'The atmosphere in the home is caring and cordial'
'I feel this is an excellent home, residents are happy and well looked after. It has often been recommended (to people) for its homely atmosphere'
'Residents feel secure and happy. We have been recommended by many families'
'If there are any issues, they are communicated effectively, in order to deliver a high standard of care'

Three staff raised concerns regarding the practice of one care staff leaving the floor for 90 minutes in the mornings, to supervise the patients having breakfast. They stated that due to the high dependency levels of the patients that they were under pressure in the mornings. This was discussed with the registered manager who confirmed that dependency levels were reviewed on a regular basis and that the demarcation of both units can be adjusted accordingly. We did not observe any impact on patient care and the registered manager provided assurance that deployment of the carer was for one hour and that this practice facilitated patients being supervised, whilst eating. The registered manager agreed to provide staff with the opportunity to discuss the impact of this deployment at the upcoming staff meeting.

Two registered nursing staff stated that they had difficulties in completing their care plans during their contracted hours. This was discussed with the registered manager, who stated that the registered nurses were not allocated any 'protected' time to complete their documentation. Other than the matters identified in section 5.3 and 5.4, that are addressed in the quality improvement plan appended to this report, there was no evidence that assessment and care plans had not been completed and/or reviewed. The registered manager provided assurances that staff would be provided with the opportunity to discuss this matter at the upcoming staff meeting.

One member of the domestic staff stated that during periods of annual leave, that there are times when there is only one cleaner designated to clean the whole home. This was discussed with the registered manager, who agreed to address this. A recommendation is made to address this.

Patients

‘Everything is first class. I couldn’t praise enough’
‘Staff are willing and it is a home from home’
‘Having wi-fi is excellent. It gives me email access to friends and family, which I find very good. There is nothing to improve here’
‘No complaints. They are very good to me here’
‘This is a wonderful place. The manager is magnificent’
‘My family are delighted with me being here. It is peace and tranquillity. I have gone from independence to needing assistance with everything and the staff help me’
‘It is lovely here’.

Patients’ representatives

‘I am very highly pleased. My (relative) is very comfortable and content’
‘The staff have given my (relative) a comfortable and safe environment and a happy contentment’
‘All staff have a pleasant and cheery disposition’
‘This is a great home with excellent nursing and care staff, who provide an excellent service’.

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. In general the areas examined were found to be clean, reasonably tidy and well decorated and warm throughout.

5. 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 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.

5.1 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.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015 and the Residential Care Homes Minimum Standards, August 2011. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

5.3 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 19.1 **Stated:** Second time **To be Completed by:** 29 October 2015	The registered manager should ensure accurate records in keeping with schedule 3 are maintained Records such as: • Fluid intake and output records must be maintained for all patients who have a catheter. Entries should be totalled and the information transferred into daily progress records.
	Response by Registered Person(s) Detailing the Actions Taken: Residents' GP's only require output records and staff will monitor for signs of dehydration. Manager audits will ensure alll entries are being totalled and transcribed to daily progress notes.
Recommendation 2 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 29 October 2015	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively; and palliative and end of life care. **Ref section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Staff meetings, supervisions, and a file for new/policy of the month will evidence staff knowledge of new policies and promote effective communication
Recommendation 3 **Ref**: Standard 32.1 **Stated:** First time **To be Completed by:** 29 October 2015	It is recommended that registered nursing staff record efforts made to establish patients' preferences in respect of end of life care and that for patients who do not wish to discuss this, a record should be also be maintained in line with the policy on end of life care. Where a decision is made regarding end of life care, a care plan should be developed and should include identified religious, spiritual and cultural needs. **Ref section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: . A record is made in the assessed needs whether or not a resident wishes to discuss preferences in respect of end of life care. Any information given is included in a care plan to reflect religious, spiritual and cultural needs
Recommendation 4 **Ref**: Standard 41.2 **Stated:** First time	The registered persons should review the provision of hours, dedicated to domestic staff, to ensure that appropriate levels of domestic staff are maintained during periods of annual leave. **Ref section 5.5**

To be Completed by: 29 October 2015	**Response by Registered Person(s) Detailing the Actions Taken:** Provision has been made to employ bank staff to cover annual leave for domestic staff.

Registered Manager Completing QIP	Hazel Black	**Date Completed**	08.10.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	08.10.15
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	15.10.2015

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