St Josephs
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Unannounced Care Inspection
of
St Josephs

06 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 6 July 2015 from 10:00 to 16:30.

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.

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 16 October 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	**1**	**2**

The details of the Quality Improvement Plan (QIP) within this report were discussed with Jacqueline Rooney, registered manager and Peggy O'Neill, registered provider as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Peggy O'Neill	**Registered Manager:** Jacqueline Rooney
Person in Charge of the Home at the Time of Inspection: Jacqueline Rooney	**Date Manager Registered:** 31 October 2013
Categories of Care: NH-LD, NH-I, NH-LD(E), NH-PH, NH-PH(E), RC-I, RC-PH, RC-PH(E)	**Number of Registered Places:** 50
Number of Patients Accommodated on Day of Inspection: 50	**Weekly Tariff at Time of Inspection:** £593

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were examined:

- 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 (QIP) from inspections undertaken in the previous inspection year;
- the previous care inspection report; and
- pre-inspection assessment audit.

During the inspection, care delivery/care practices and a review of the general environment of the home was undertaken. Approximately 25 patients, six care staff, three registered nurses, two domestic staff and three relatives were spoken with. There were no visiting professionals available during the inspection.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP;
- the staff duty rota;
- five patient care records;
- accident/notifiable events records;
- staff training records;
- staff induction records; and
- policies for communication, death and 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 the home was an unannounced care inspection dated 16 October 2014. The completed QIP was returned and approved by the nursing inspector.

Review of Requirements and Recommendations from the last care Inspection 16 October 2014

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref: Regulation 15 (2)** **Stated: Second time**	The registered person shall ensure that the assessment of the patient's needs is kept under review; and revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually, by ensuring: The date of admission and the signature of the person completing the admission records should always be recorded. A fluid balance chart should be in place, accurately recorded and the overall total fluid intake and output recorded and consolidated over the 24 hour period. All records including repositioning charts, fluid balance charts and nutritional intake charts should be dated and signed and completed in an accurate and contemporaneous manner.	**Met**
	Action taken as confirmed during the inspection: A review of five care records evidenced that the admission records were appropriately recorded. Where appropriate fluid balance charts were completed and they included the overall total fluid intake and output record was recorded and consolidated over the 24 hour period. All records were observed to be completed contemporaneously.	

Requirement 2 **Ref: Regulation 12 (1)** **Stated: First time**	Ensure care plan audits are completed on patients with wounds/pressure ulcers to ensure they are appropriately completed in keeping with best practice guidelines. **Action taken as confirmed during the inspection**: Two or three Care plan audits were observed to be completed every week. Records are maintained.	**Met**
Requirement 3 **Ref: Regulation 20 (1) (c) (1)** **Stated: First time**	Ensure that when training is provided to staff that it is embedded into practice and where shortfalls are identified that they are actioned through formal supervision. **Action taken as confirmed during the inspection**: The registered manager confirmed that when training is provided for staff that it is embedded into practice, this is evidenced by supervision of staff and periods of discreet observation.	**Met**
Requirement 4 **Ref: Regulation 16 (2) (b)** **Stated: Second time**	The registered person shall ensure that – (b) the patient's plan is kept under review by ensuring that • a care plan is put in place for all actual or potential problems (including the prevention of pressure ulcers) requiring nursing care. • care plans are updated when there changes in the patients' needs. • best practice regarding the record keeping of wound/pressure ulcer care should be in keeping with best practice guidelines. **Action taken as confirmed during the inspection**: A review of two patients identified with wounds were reviewed they were observed to be appropriately recorded. There was evidence of audits of wounds on a monthly basis. Confirmation was received that all registered nurses have received training in wound/pressure ulcer care and staff confirmed that they are aware of the NICE guidelines.	**Met**

Requirement 5 **Ref: Regulation 13 (7)** **Stated: First time**	The registered manager shall ensure that the management of staffing in the laundry is reviewed to ensure that laundry is completed in a timely manner and that infected and soiled linen should be cleared daily in accordance with best practice.	**Met**
	Action taken as confirmed during the inspection: It was confirmed that there are an additional two hours allocated to laundry duties daily. New members of staff have been employed and the laundry is regularly checked by the registered manager.	
Requirement 5 **Ref: Regulation 13 (7)** **Stated: First time**	Ensure the identified care records are updated to ensure the following issues are addressed; Ensure weights are recorded at least monthly or more often if required. Details of how often the patient should be weighed should also be included. Ensure the care record refers to the pressure relieving equipment in place. Ensure the care plan in relation to nutritional supplements is updated and recorded in a clear manner. Ensure the repositioning chart, fluid balance chart and nutritional intake chart is completed in accordance with the care plan. Ensure the fluid target is recorded in the fluid balance chart. Ensure the daily care record reflects accurately the care delivered. Ensure the Braden risk assessment includes the date that it is carried out. Ensure the current state of wounds/pressure ulcer care is clearly recorded in relation to each wound. Ensure there is an initial assessment is in place in relation to each wound. Ensure there is an ongoing wound care assessment in place and that it is updated each	**Met**

	time the wound is dressed. Ensure care records in relation to nutritional intake charts and food fluid intake and output charts should be reflective of the food and fluids offered and taken and are completed contemporaneously.	
	Action taken as confirmed during the inspection: A review of five care records evidenced that weights are appropriately recorded. Care records referenced pressure relieving equipment where appropriate. Where nutritional supplements were required they were appropriately recorded with a plan of care in place. Repositioning charts, fluid balance charts and nutritional intake/output charts were observed to be appropriately recorded. The fluid target where appropriate was recorded on the fluid balance chart. The daily care records were observed to be recorded contemporaneously. Wounds were appropriately recorded when there was a change in condition.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref: Standard 30.1** **Stated: First time**	The registered manager shall ensure that a review of the staffing levels and the deployment of staff are carried out in order to ensure that records are maintained in accordance with best practice. Registered nurses should be able to complete care records in a timely way. Time should be included in the care hours to ensure that fluid balance, nutritional intake and repositioning charts are completed in a contemporaneous manner.	**Met**
	Action taken as confirmed during the inspection: A review of the staffing levels and the deployment of staff was carried out since the previous inspection. Staff spoken with stated they felt the staffing and routine in the home was satisfactory and staff felt they were meeting the needs of the patients in a timely way. All records to be completed by nursing and care staff were observed to be appropriately completed in a timely way.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The registered manager informed the inspector that there are currently updated policies and procedures in place regarding the regional guidelines on Breaking Bad News, Communication and Pastoral Care. The registered manager stated management were currently updating policy information on palliative and end of life care.

The registered manager informed the inspector that there are plans in place to hold a training programme for staff in breaking bad news and bereavement and palliative care. Two staff have already attended this training on 9 June 2015 and it is planned that a further 9 staff will receive their training on 17 July 2015.

Staff spoken with during the inspection demonstrated that they were aware of the importance of good communication in the home and the importance of being able to break bad news appropriately to both patients and their representatives.

Is Care Effective? (Quality of Management)

Two care records reflected patients' individual needs and wishes regarding the end of life care. Records included reference to the patient's specific communication needs.

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

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

Care staff were consulted and discussed their ability to communicate sensitively with patients and/or representatives. When the need for breaking of bad news was raised care staff felt this was generally undertaken by nursing staff. However, staff were aware of communication aids/cues, for example, non-verbal cues and gestures. They also felt their role was to empathise and to support patients and their representatives following sensitive or distressing news.

Is Care Compassionate? (Quality of Care)

Discussion was undertaken with staff regarding how they communicate with patients and their representatives.

All staff presented as knowledgeable and had a strong awareness of the need for sensitivity when communicating with patients and their representatives.

A number of communication events were observed throughout the inspection visit which validated that staff embedded this knowledge into daily practice. These observations included staff assisting patients with meals, and speaking to patients with a cognitive or sensory impairment. There was a calm, peaceful atmosphere in the home throughout the inspection visit.

Staff recognised the need to develop a strong, supportive relationship with patients and their representatives from day one in the home. It was appreciated by staff that this relationship would allow the delivery of bad news more sensitively and with greater empathy when required.

The inspector consulted with five visiting relatives. Relatives confirmed that staff treated patients with respect and dignity and were always welcoming to visitors.

A number of letters complimenting the care afforded to patients were viewed. Families stated their appreciation and support of staff and the care afforded in Lisburn Intermediate Care Home.

Areas for Improvement

The registered manager shall ensure that staff receives the planned training in breaking bad news, bereavement and palliative/end of life care. This training should be cascaded to all staff in keeping with their roles and responsibilities.

Number of Requirements:	**0**	**Number of Recommendations**:	**1**

5.3 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)

As previously stated there were policies and procedures which included End of Life Care, Pastoral Care and Breaking Bad News. These documents reflected best practice guidance, and included guidance on the management of the deceased person's belongings and personal effects. There were no policies or procedures in place regarding Palliative Care or The Management of an Unexpected/Sudden death.

Training records evidenced that two staff were trained in the management bereavement. As previously stated there are plans that a further 9 staff receive this training and it is cascaded down to the remaining staff in keeping with their roles and responsibilities. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

A review of the competency and capability assessments for registered nurses evidenced end of life care was included and the assessments had been validated by the registered manager. The review of staff induction training records also confirmed that end of life care was included.

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

Discussion with the nurse manager, four staff and a review of two 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 or drugs was in place and discussion with nursing staff confirmed their knowledge of the protocol.

There was no specialist equipment, for example syringe drivers is in use in the home at the time of the inspection.

Is Care Effective? (Quality of Management)

Whilst there were no patients identified as requiring end of life care in the home at the time of the inspection, the care records of one patient who was in receipt of palliative care was reviewed. The care plan included the management of hydration and nutrition, pain management and symptom management. A key worker/named nurse was identified for each patient in the home. There was evidence that referrals are made if required to the specialist palliative care team and close contact was evidenced in the records to be maintained with the patient's General Practitioner.

Discussion with the registered manager, four staff and a review of one care record 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. There is a relatives/family room available and patients' representatives enabled to stay for extended periods of time without disturbing other patients in the home if required.

A review of notifications of death to RQIA during the previous inspection year, evidenced they were appropriately submitted.

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 care. Staff gave examples from the past, of how they supported the spiritual wishes of patients and of how staff stayed and gave emotional support to patients at the end of life. Staff stated they were able to sit with patients, if family members were not available so as no patient passed away with no one present.

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

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 for example, bereavement support; and staff meetings if appropriate.

Areas for Improvement

A policy and procedure should be in place to guide staff on the arrangements of Palliative Care and The Management of an Unexpected/Sudden Death.

Number of Requirements:	**0**	**Number of Recommendations:**	**1**

5.4 Additional Areas Examined

5.4.1 Questionnaires

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

Questionnaire's issued to	Number issued	Number returned
Staff	10	7
Patients	4	2
Patients representatives	6	5

All comments on the returned questionnaires were in general positive.

Patients' views

There were 4 questionnaires completed by patients, comments made and those received on the day of inspection. There were no negative comments made to the inspector. Some comments returned are detailed below:

- "I am satisfied that staff treats me with dignity and respect."
- "I am happy here in St Joseph's. I appreciate the staff they are very caring and obliging."
- "I feel very safe in the home."
- "Staff are pleasant and kind."
- "I feel we are well looked after."
- "I like the food."
- "Staff are kind."

Patients' representatives' views

There were three relatives visiting at the time of the inspection. All comments made were very positive regarding care and communication in the home. All representatives were positive regarding the staff in the home.

There were 5 questionnaires completed by patients representatives, comments received are detailed below:

- "I feel satisfied that the quality of care is good."
- "I feel very satisfied that my relative has privacy in the home."
- "We are generally happy with the patients care and occasionally when problems arise we are happy that they will be sorted."
- "Care is very good and additional bonus is the religious support which is very important to my relative."
- "The home always feels welcoming, I come to the home regularly and am treated well."

Staff views

Staff spoken during the inspection expressed high level of satisfaction with care and services provided in the home. All were complimentary of the management in the home and felt communication and palliative/care of the dying was a theme which they were well trained in and were confident that they delivered well. They were all complimentary of the management arrangements in the home. There were no negative comments made to the inspector during the inspection.

There were 7 questionnaires completed by staff, comments received are detailed below:

- "The management of distressing symptoms at the end of life are well managed."
- "I am very satisfied with the arrangements regarding whistleblowing."
- "I feel St Joseph's meets the needs of the elderly and their care."
- "St Joseph's meets the requirements of care to all residents."
- "Care assistants couldn't do enough for residents very attentive."
- "The morale in the home is good, we are well supported."
- "I love working here, I love my job."
- "We are all a happy family here."

5.4.2 The environment

There was a good standard of cleanliness and hygiene standards evident during the inspection. The home was spacious and communal areas were comfortable. Infection control procedures were also maintained to a good standard. One issue was raised in relation to the management overflowing of the general waste bins outside the home. The registered manager agreed to ensure this issue was addressed a requirement is made in this regard.

5.4.3 Care records

Five care records were reviewed during the inspection. They were generally found to be individualised and were reflective of the care needs of patients. They are audited monthly.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Jacqueline Rooney, registered manager and Peggy O'Neill, registered provider, 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.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref: Regulation 18 (k)** **Stated: First time** **To be Completed by: 17 August 2015**	The registered persons shall ensure that the management of bins in the general waste area is reviewed to ensure they are managed in keeping with Health and Safety Regulations.
	Response by Registered Person(s) Detailing the Actions Taken: The management of bins and waste area has been reviewed and are checked daily by Maintainence.they are also routinley checked by Manager
Recommendation	
Recommendation 1 **Ref: Standard 19** **Stated: First time** **To be Completed by: 5 October 2015**	The registered persons shall ensure that staff receives the planned training in breaking bad news, bereavement and palliative/end of life care. This training should be cascaded to all staff in keeping with their roles and responsibilities.
	Response by Registered Person(s) Detailing the Actions Taken: Training ongoing with staff through RCN website ,which is being cascased to all Grades of staff in the home.End Of Life awareness information delivered to staff through supervision sessions
Recommendation 2 **Ref: Standard 20** **Stated: First time** **To be Completed by: 28 September 2015**	The registered persons shall ensure that a policy and procedure is in place to guide staff on the arrangements of Palliative Care and The Management of an Unexpected/Sudden Death.
	Response by Registered Person(s) Detailing the Actions Taken: New policy developed and forwarded to Inspector .

Registered Manager Completing QIP	Jacqueline Rooney	**Date Completed**	20th Aug 15
Registered Person Approving QIP	Peggy O Neill	**Date Approved**	20th Aug 15
RQIA Inspector Assessing Response	**Donna Rogan**	**Date Approved**	**03/09/2015**

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