Kilbroney House
RQIA ID: 1553
83 Kilbroney Road
Rostrevor
BT34 3BL

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Unannounced Care Inspection
of
Kilbroney House

22 June 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 22 June 2015 from 10:30 to 16:00.

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.

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 25 November 2014.

1.2 Actions/Enforcement Resulting from this Inspection

Other that those actions dated in the QIP there were no further actions required following this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**2**	**0**

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

2. Service Details

Registered Organisation/Registered Person: Jacqueline Ann Campbell	**Registered Manager:** Jacqueline Ann Campbell
Person in Charge of the Home at the Time of Inspection: Pauline Campbell (nurse manager)	**Date Manager Registered:** 01 October 2009
Categories of Care: NH-PH, NH-PH(E), NH-MP, NH-MP(E), NH-DE, NH-I	**Number of Registered Places:** 19
Number of Patients Accommodated on Day of Inspection: 19	**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, delivery of care/practices was observed and a review of the general environment of the home was undertaken. Discussions were held with ten patients, three care staff and one registered nurse. 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;
- three 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 25 November 2014. The completed QIP was returned and approved by the nursing inspector.

5.2 Review of Requirements and Recommendations from the last care inspection 25 November 2014

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref: Regulation 15(2)** **Stated: First time**	The registered person shall ensure that the identified care plan is updated to reflect the direct care required in accordance with the homes' policies and procedures.	**Met**
	Action taken as confirmed during the inspection: The identified care record was updated following the previous inspection to reflect the direct care required in accordance with the home's policies and procedures.	

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 2 **Ref: Regulation 27** **Stated: First time**	The registered person shall ensure the identified bedroom has a privacy curtain put in place. The registered person shall ensure that the identified bed is reviewed to ensure the mattress is appropriate in size to fit the bed and appropriate to meet the needs of the patient.	**Met**
	Action taken as confirmed during the inspection: A privacy curtain has been put in place in the identified bedroom. All mattresses were observed to be appropriate in size to fit the beds and were appropriate to meet the needs of the patients.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The nurse manager informed the inspector that there are currently no updated policies and procedures in place regarding the regional guidelines on Breaking Bad News. The nurse manager stated management were currently updating policy information on communicating effectively and 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. There is currently one patient identified in the home currently undergoing bereavement. The registered manager is a qualified counsellor and there is a plan of care in place regarding the care required. The care plan is individualised an appropriate to meet the need of the patient. All staff spoken with were aware of the contents of the plan of care.

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 two 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 Kilbroney Nursing Home.

Areas for Improvement

Following the development of the new policy documentation in respect of on communicating effectively and palliative and end of life care, a system should also be implemented to ensure and verify staff are knowledgeable of the policy documentation and regional guidelines. Staff should also receive the planned training in breaking bad news, bereavement and palliative/end of life care.

Number of Requirements:	**2**	**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)

Arrangements are in place to ensure that staff are trained in the management of death, dying and bereavement. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013. The registered manager is the link nurse in respect of palliative care and attends the oncology and palliative care link nurse meeting in the local Healthcare Trust on an annual basis.

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.

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, discussion took place regarding the management of two patients who had been in receipt of end of life and palliative care. Discussion with staff confirmed that patient's needs for palliative care were assessed and reviewed on an ongoing basis and documented in patient's care plans where appropriate. This included the management of hydration and nutrition, pain management and symptom management. A key worker/named nurse was identified for each patient. There was evidence that referrals would be made if required to the specialist palliative care team and close contact was evidenced to be maintained with the patient's GP.

Discussion with the nurse manager, four staff and a review of two care records evidenced that environmental factors had been considered. Discussion with staff confirmed that management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying and patients representatives were enabled to stay for extended periods of time without disturbing other patients in the home.

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 two 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. Staff also confirmed that they are always given an opportunity to attend patients' funerals.

From discussion with the nurse 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 nurse 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 nurse 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 appropriate.

Areas for Improvement

There were no areas for improvement observed during the inspection in relation to this standard.

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

5.5 Additional Areas Examined

Questionnaires

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

Questionnaire's issued to	Number issued	Number returned
Staff	6	5
Patients	3	3
Patients representatives	4	4

All comments on the returned questionnaires were in general positive.

Patients' views

There were 3 questionnaires completed by patients, comments received are detailed below:

"I am very well cared for, I'm happy here."
"I feel safe in the home I feel I can talk with staff if something is wrong."
"I am treated with dignity and respect."
"I am very happy with all the care I get."
"It is so homely here; I can come and go as I please."
"Staff are so friendly and welcoming, this is my home."
"Everyone from the top down is lovely."

Patients' representatives' views

There were two 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 4 questionnaires completed by patients representatives, comments received are detailed below:

"Mummy receives the highest standard of nursing care. As a family we feel blessed to have a placement in Kilbroney Nursing Home."
"I am very satisfied that the care is good."
"Very happy with care in the home."
"Staff listen and are knowledgeable about meeting the needs of my relative."

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.

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

"Very satisfied patients receive timely support from the multi-disciplinary team."
"Very satisfied that there are supportive systems in place to meet patients' spiritual, psychological and cultural needs."
"This is a great home, I love working here."
"I can go to the management for anything, I'm never afraid to ask they are so accommodating."
"I am very happy in my position and am privileged to be working with a good caring team."
"The residents are very well cared for and all appear very happy."

5.5.2 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 generally maintained to a good standard.

5.5.3 Care records

Three care records were reviewed. They were found to be of a good standard, they were detailed, individualised and clearly reflective of the care needs of patients. They are regularly updated and audited monthly by senior management in the home.

6. Quality Improvement Plan

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

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.

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.

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 the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref: Regulation 12 (1) (b)** **Stated: First time** **To be Completed by: 10 August 2015**	The registered person shall ensure that the policies and procedures in relation to communicating effectively and palliative care are updated and implemented. Following the development of the new policy documentation in respect of on communicating effectively and palliative and end of life care, a system should also be implemented to ensure and verify staff are knowledgeable of the policy documentation and regional guidelines. **Response by Registered Person(s) Detailing the Actions Taken:** A Revised & updated Policy in relation to Palliative Care has been Completed in full'
Requirement 2 **Ref: Regulation 20 (1) (c) (i)** **Stated: First time** **To be Completed by: 07 September 2015**	The registered manager shall ensure that staff receive the planned training in breaking bad news, bereavement and palliative/end of life care. **Response by Registered Person(s) Detailing the Actions Taken:** Staff training will take place Tue 15th Sept 15 - all staff will be invited to attend scheduled training.

Registered Manager Completing QIP	Campbelle	**Date Completed**	17th July '15
Registered Person Approving QIP	Campbell	**Date Approved**	17th July 15
RQIA Inspector Assessing Response	Donna Logan	**Date Approved**	22/7/15

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

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

Ref. Kilbroney House Nursing Home, Rostrevor.