The Regulation and Quality Improvement Authority

Inspector: Donna Rogan
Inspection ID: IN022071

REGULATION AND QUALITY
19 JAN 2016
IMPROVEMENT AUTHORITY

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Unannounced Care Inspection of Faith House

25 November 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 25 November 2015 from 11.00 to 17.30.

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.

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 27 April 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	6	3

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

2. Service Details

Registered Organisation/Registered Person: Mervyn Wishart	**Registered Manager:** Jane Moore
Person in Charge of the Home at the Time of Inspection: Jane Moore, registered manager	**Date Manager Registered:** 09 January 2015
Categories of Care: RC-I, NH-I, NH-PH, NH-TI	**Number of Registered Places:** 65
Number of Patients Accommodated on Day of Inspection: 33 Nursing care 25 Residential care	**Weekly Tariff at Time of Inspection:** £514 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; and
- the previous care inspection report.

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with twenty five patients, four care staff, two registered nurses, two senior carers, the residential manager and two patient's visitors/representatives.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP;
- staffing arrangements in the home;
- four patient care records;
- staff training records;
- policies for communication and end of life care; and
- policies for dying and death 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 Faith House was an announced estates inspection dated 10 November 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 27 April 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref: Regulation 12 (4)** **Stated: First time** **To be Completed by: 25 May 2015**	Review the serving of the lunch time meal to ensure all patients receive their meals in a timely way and assisted as necessary in keeping with their needs. **Action taken as confirmed during the inspection:** The dining room is currently being extended to improve the dining room experience. Work is currently on-going with minimal disruption to meals and meal times. Observation evidenced the lunch time meal was served in a timely way and was served in keeping with patients' needs.	**Met**
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref: Standard 21 Criteria 11** **Stated: First time** **To be Completed by: 25 May 2015**	Ensure bladder and bowel continence assessments are completed for all patients. **Action taken as confirmed during the inspection:** A review of four patients' care records evidenced that bowel and continence assessments are completed for patients.	**Met**
Recommendation 2 **Ref: Standard 21 Criteria 9** **Stated: First time** **To be Completed by: 25 May 2015**	The identified care record of a patient with a catheter should have the care plan reviewed to include the type and size of catheter used. **Action taken as confirmed during the inspection:** Care records have been updated for those patients with a catheter, the type and size of catheter is included in the care record.	**Met**

Recommendation 3 Ref: Standard 4 Criteria 8 Stated: First time To be Completed by: 25 May 2015	The registered manager shall ensure when care plans are no longer recommended that they are clearly discontinued. The registered manager shall ensure when care to be delivered changes that the care plan is rewritten to avoid confusion.	
	Action taken as confirmed during the inspection: A review of care four care records evidenced that when care records are no longer relevant that they are discontinued. There was evidence that care plans were re-written as changes occur. There was no over writing evident in the care records reviewed.	**Met**

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was available on communicating effectively, however it required to be updated as it had not been reviewed since September 2011 and was no longer relevant and did not include the current management arrangements. However, discussion with nursing staff confirmed that they were knowledgeable regarding effective communication.

There was no policy or procedure available to advise staff regarding breaking bad news. Discussion with the registered nurses and care staff confirmed that that they were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication. Palliative care training has been attended by 25 February 2015, 16 April 2016 and 9 September 2015, the training programme included training in communication and breaking bad news. A recommendation is made that the policy regarding communication is updated and that management prepares and introduces a policy and procedure regarding the breaking of bad news.

Is Care Effective? (Quality of Management)

The 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. 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, and/or reoccurring symptom with a poor prognosis. 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 or to the senior carers in the residential unit, but all felt confident that, should a patient choose to talk to them about a diagnosis or prognosis of illness, they would have the necessary skills to do so. They felt strongly that there role was to empathise and support family members during this period.

The policy on actions to be taken in the event of a death stated that end of life and after death arrangements are discussed with the patient and their relatives and documented in their care plan. Two nursing care records were reviewed and they did not reflect patient individual needs and wishes regarding the end of life care. A requirement is made to ensure that these details are included in the care record. Records included reference to the patients' specific communication needs. Neither of the two nursing care records evidenced that the wishes and feelings were discussed with the patients and/or their representatives. There was no evidence that options and treatment plans were discussed. The two nursing care records reviewed did not indicate that patients and/or their representatives were involved in the assessment, planning and evaluation of care. A recommendation is made to ensure that discussions with patients and their representatives' wishes and feelings are held and the outcomes of these communications are recorded in the care records. Further information of the findings of the care records can be viewed in the additional areas examined section of the report.

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 cheerfully, and taking time to reassure patients as was required from time to time.

We consulted with three visiting relatives who confirmed that staff treated patients with respect and dignity and were always welcoming to visitors.

There were several cards and letters on display complimenting the care that was afforded to patients when they were receiving end of life care.

In accordance with the Faith House's Statement of Purpose the home seeks to provide care for patients within a Christian Ethos, this is reflected throughout the homes environment and day to day service provision. All patients are informed of the ethos prior to their admission and all patients are provided with an opportunity to express and practice in accordance with their religious and spiritual beliefs. It is the primary nurses' role to ensure that the care plan is specific regarding patients pastoral care. Details are included in the care record of the patients' spiritual advisor and the record also includes details of the patients' denomination where relevant.

Areas for Improvement

A requirement and a recommendation was made in regards to this standard. It is required that patient individual needs and wishes regarding the end of life care are reflected in care records. It is recommended that the policy and procedure regarding communication should be updated to reflect the current management arrangements. A record of all communication with patients and their representatives should be included in the care record. As previously stated it is also recommended that management prepares and introduces a policy and procedure regarding the breaking of bad news.

Number of Requirements:	1	Number of Recommendations:	2

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

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home; however they have not been reviewed since June 2013 they are required to be updated to reflect best practice guidance such as the GAIN Palliative Care Guidelines, November 2013. The GAIN guidelines were available in the home. Registered nursing staff consulted with were aware of the guideline content and were able to demonstrate knowledge of the GAIN guidelines.

The policies reviewed included a policy on spirituality and guidance on the management of the deceased person's belongings and personal effects.

There are currently no trained palliative care link nurses appointed in the home. Training records evidenced that training had taken place for 9 staff members in relation to palliative care on 25 February 2015, 16 April 2015 and 9 September 2015.

Discussion with the registered nurses and senior carers confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services and that they were proactive in identifying when a patient's condition was deteriorating and that appropriate actions had been taken.

There was a formal protocol for timely access to any specialist equipment or drugs. Discussion with the registered nurses confirmed that they were knowledgeable regarding the procedure to follow if required. The registered nurses described how they would order medicines for symptom relief, in anticipation of need. Discussion with the registered nurses also confirmed that they had a good awareness of the procedure to follow, in the event of a patient suddenly becoming unwell or dying unexpectedly. There was no specialist equipment, in use in the home on the day of inspection. The training records confirmed that training in the use of syringe drivers had been provided to registered nursing staff on 3 March 2015 and 17 September 2015.

Is Care Effective? (Quality of Management)

A review of two care records evidenced that patients' needs for palliative and end of life care were not assessed nor reviewed on an ongoing basis. However the care records did include the management of hydration and nutrition, pain and symptom management.

Staff confirmed that a key worker/named nurse/senior carer was identified for each patient and in particular when they were approaching end of life care.

Discussion with the registered nurse and staff evidenced that environmental factors were always considered. Discussion evidenced that management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying.

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

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of four care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. All staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

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. Overnight stays were facilitated if there was a vacant room and staff described how catering and snack arrangements were provided to family members during this period.

From discussion with staff and a review of the compliments records, there was evidence that arrangements in the home were sufficient to support relatives during this time. There were numerous cards on display, within which relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with staff 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.

From discussion with staff, it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included more experienced staff offering support to new staff and time spent reflecting on a patients time spent living in the home. One staff member described how difficult it was for staff when there was a sudden deterioration in a patient's health. It was evident that there were supportive relations within the home.

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

Areas for Improvement

It is required that care records are reviewed and updated in relation to palliative care needs. The palliative care policy and procedure should be updated to reflect the GAIN Palliative Guidelines November 2013.

It is recommended that a palliative link nurse is appointed and suitably trained to guide and direct staff regarding palliative care, the palliative link nurse should attend the support meetings arranged by the local Healthcare Trust.

Number of Requirements:	1	Number of Recommendations:	1

5.5 Additional Areas Examined

5.5.1 Care records

Four care records were reviewed. Two care records reviewed in the residential unit were observed to be comprehensive and reflective of the care delivery. However both care records reviewed in the nursing unit required to be reviewed as a matter of urgency. Issues were raised regarding the overall quality of the information provided in the care records. They were not comprehensive and did not provide specific detail as to the care required or delivered. In one care record the Malnutrition Universal Screening Tool (MUST) had been incorrectly totalled with the result that the nutritional assessment was not accurate. The term "all care as planned" was frequently used and did not provide sufficient enough information as to the care the patient may have received. One care record evidenced a safeguarding issue which was not appropriately recorded. Details of the action taken or the outcome was not evident in the care record. One care record lacked detail regarding the timely taking of blood and urine samples and a request to see a General Practitioner, (GP). The records were not clear and did not follow a sequential record of the treatment or care provided. The issues identified throughout the care records were discussed at length with the registered manager who agreed to immediately follow up on the issues raised and provide further information to RQIA by e-mail. RQIA can confirm that correspondence has been received that whilst the two identified care records did not accurately reflect care delivery in accordance with best practice that there was evidence in other correspondence in the home that care was delivered as it should. The registered manager also confirmed in correspondence received by RQIA that there has been a complete audit of all nursing care records in the home and an action plan has been devised with the staff involved to address any issues raised within the audit. RQIA will validate the quality of care records during the next inspection. Requirements have been made in relation to care records.

5.5.2 Questionnaires and comments

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	11	11
Patients representatives	2	2

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

Staff

- "Generally the residents get the necessary support from multi-disciplinary teams, though at times they are slow to visit."
- "Very satisfied that patients are well supported and enabled to have a dignified death."
- "The quality of care provided is of a high standard and is always patient centred."
- "I feel the care we require is very good."
- "I love working at Faith House, brilliant staff and care."

- "Happy environment for residents and staff."
- "I welcome any support and change needed to deliver the service more effectively and efficiently."
- "Unsatisfied that patients receive timely support from the multi-disciplinary team."
- "I feel the home is continually improving according to patients' needs, very well run and enjoy working in a positive and caring atmosphere."

There were no concerns raised by staff during the inspection.

Patients

- "It is a wonderful place."
- "I could not be happier."
- "We are so well looked after."
- "Staff often make phone calls to my daughter on my behalf to inform her of my condition when necessary."
- "Staff are overstretched."
- "Staff do the utmost to do what they can do to help."
- "I would recommend this home to anyone."
- "I feel very much at home here, have found peace here."
- "I am very happy here, I have recommended the home to others."
- "Very happy to be a resident in this home."
- "All my friends are made welcome."

There were no concerns raised by patients during the inspection.

Patients' representatives

- "My …… has been so well looked after since their admission."
- "I am so confident that when I leave that my …. Is so well cared for."
- "My family are very happy with the loving homely atmosphere in Faith House."
- "Find the staff very kind and respectful of all residents every time I visit."
- "….. always enjoys the activities, especially the music and chair exercises."

There were no concerns raised by patients' representatives during the inspection process.

5.5.3 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. All areas examined were found to be clean, tidy and were warm and welcoming throughout.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Jane Moore, 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 RQIA's office 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 in this report do not absolve the registered provider/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 provider/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:** 31 December 2015	The registered persons shall ensure that patient individual needs and wishes regarding the end of life care are reflected in care records. **Response by Registered Person(s) Detailing the Actions Taken:** All named nurses are aware of need for careful and sensitive discussion with patients re their wishes regarding end of life care. These discussions must be reflected in care plans. Policies on Death and Dying and Spirituality implemented to aid staff in their recording
Requirement 2 **Ref:** Regulation 15 (2) (b) **Stated:** First time **To be Completed by:** 31 December 2015	The registered persons shall ensure that care records are reviewed and updated in relation to palliative care needs. **Response by Registered Person(s) Detailing the Actions Taken:** All care records re palliative care needs have been reviewed and actioned as necessary in line with newly updated palliative care policies within Faith House and in line with Gain Guidelines.
Requirement 3 **Ref:** Regulation 12 (1) (b) **Stated:** First time **To be Completed by:** 31 December 2016	The registered persons shall ensure all safeguarding issues are appropriately followed up and recorded. **Response by Registered Person(s) Detailing the Actions Taken:** Staff are aware of the importance of ensuring any concerns voiced by any party are fully investigated. Management has addressed issues re documentation with all nursing staff. All concerns are shared with management and appropriate action taken as needed. All staff will be partaking in update training re safeguarding Feb 2016
Requirement 4 **Ref:** Regulation 15 (1) **Stated: First time** **To be completed by:** 31 January 2016	The registered persons shall ensure that a complete an audit of all care records and ensure they are reviewed to reflect the care delivered to patients. **Response by Registered Person(s) Detailing the Actions Taken:** All care records within nursing wing fully audited by management completed on 4/12/15. Full audit reports shared with named nurses with action required highlighted. Management will continue to audit weekly to ensure actions completed. Residential wing care records will be fully audited by end of 01/16.

Requirement 5 **Ref:** Regulation 15 (2) **Stated:** First time **To be completed by:** 31 December 2015	The registered persons shall ensure that the term, "All care given", is not used to describe care delivery, the actual care delivered should be specifically recorded. **Response by Registered Person(s) Detailing the Actions Taken:** Action plan was completed following inspection report - this included advising staff of the importance of ensuring documentation of actual care given, management will monitor during weekly audits.
Requirement 6 **Ref:** Regulation 12 (1) (b) **Stated:** First time **To be completed by:** 31 December 2015	The registered persons shall ensure that all records are maintained contemporaneously. **Response by Registered Person(s) Detailing the Actions Taken:** Management have advised staff of importance of ensuring all documentation is recorded in a timely manner, that records are clear and follow a logical order re the treatment of care provided. Management will monitor during weekly audits
Recommendations	
Recommendation 1 **Ref:** Standard 19 **Stated:** First time **To be Completed by:** 25 January 2016	The registered persons should ensure that the policy regarding communication is updated and that management prepares and introduces a policy and procedure regarding the breaking of bad news. The policy and procedure regarding palliative care should be updated to reflect the GAIN Guidelines November 2013. **Response by Registered Person(s) Detailing the Actions Taken:** Policies have been reviewed and updated. Policy re breaking bad news has been implemented.
Recommendation 2 **Ref:** Standard 19 **Stated:** First time **To be Completed by:** 31 December 2015	The registered persons should ensure that a record of all communication with patients and their representatives should be included in the care record. **Response by Registered Person(s) Detailing the Actions Taken:** Communication sheets are now found within each patients care file. An individual communication is available for GP/NOK/multidisciplinary team.
Recommendation 3 **Ref:** Standard 32 **Stated:** First time **To be Completed by:** 31 January 2016	The registered persons should ensure that a palliative link nurse is appointed and suitably trained to guide and direct staff regarding palliative care, the palliative link nurse should attend the support meetings arranged by the local Healthcare Trust. **Response by Registered Person(s) Detailing the Actions Taken:** Management are currently reviewing this and are linking with local trusts re support meetings. Training is being sourced through the Trust and Hospice.

Registered Manager Completing QIP	Jane Poole	Date Completed	18/01/16
Registered Person Approving QIP	[signature]	Date Approved	
RQIA Inspector Assessing Response		Date Approved	

Please ensure this document is completed in full and returned to RQIA's Office from the authorised email address

RQIA Inspector Assessing Response	Donna Rogan	**Date Approved**	20/01/2016