Rosemount Care Centre
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Portadown
BT62 1QL

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Unannounced Care Inspection
of
Rosemount Care Centre

16 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

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

This inspection was undertaken in both the nursing and residential units and is 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 relation to the above theme was found to be effective and compassionate. However, on the day of the inspection, concerns in relation to the management of fire safety were identified and are required to be addressed to ensure that care in the home is safe. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to section 1.2 below.

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 Rosemount Care Centre 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 13 November 2014.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent action record regarding fire safety was issued to Ms Claire McKenna, registered manager, at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients in the home. RQIA received an e mail from the registered manager on 17 July 2015 confirming that an update of the fire risk assessment would be completed by 24 July 2015 and that the items stored under the stairs had been removed.

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 the registered manager, Claire McKenna, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Zest Care Homes	**Registered Manager:** Claire McKenna
Person in Charge of the Home at the Time of Inspection: Claire McKenna	**Date Manager Registered:** 12 September 2011
Categories of Care: NH-I, NH-DE, RC-DE	**Number of Registered Places:** 71 – 39 nursing 32 residential
Number of Patients Accommodated on Day of Inspection: 38 nursing 29 residential	**Weekly Tariff at Time of Inspection:** Nursing - £628 Residential - £495

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:

- discussion with the registered manager
- discussion with staff
- discussion with patients
- discussion with relatives
- review of records
- observation during a tour of the premises
- evaluation and feedback.

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report.

During the inspection, the inspectors met with 22 patients individually and with the majority generally, two registered nurses, eight care staff and seven patient's visitors/representative.

The following records were examined during the inspection

- 11 patient care records including care charts
- policies and procedures regarding communication, death and dying, palliative and end of life care
- record of complaints and compliments
- staff training
- fire risk assessment and record of weekly fire checks.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced finance inspection dated 2 June 2015. The completed QIP was returned and approved by the finance inspector.

5.2 Review of Requirements and Recommendations from the last care inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref: Standard 19.1** **Stated: First time**	Care needs should be clearly and consistently recorded across care records. The type of continence pad and size of pants should be recorded in the patients' care records.	**Met**
	Action taken as confirmed during the inspection: Patients' continence needs were clearly and consistently recorded in the care records examined. This recommendation has been met.	
Recommendation 2 **Ref: Standard 19.2** **Stated: First time**	Publications on the management of bladder and bowel continence and catheter and stoma care should be readily available in the home to inform and guide staff on best practice.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that publications on the management of bladder and bowel continence and catheter and stoma care were available in the home. This recommendation has been met.	

Recommendation 3 **Ref: Standard 32.1** **Stated: First time**	It is recommended that the management of odours in the identified area is reviewed and eliminated. Carpets which cannot be effectively cleaned and maintained odour free should be replaced.	**Met**
	Action taken as confirmed during the inspection: Observations confirmed that the flooring in the identified rooms had been replaced. There were no odours detected in the home. This recommendation has been met.	
Recommendation 4 **Ref: Standard 9.2** **Stated: First time**	Ensure that fluid intake is recorded for all residents who cannot comprehend the necessity to drink adequate daily fluids and for residents with potential urinary tract infection needs and those with urinary catheters in situ. Detail of identified need / goal and intervention should be reflected within the care plan of residents. (Section 10.2)	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that their current policy is to maintain fluid balance charts for those residents who are on antibiotic therapy. The inspector observed a fluid balance chart which was currently maintained. Drinks were also in place in the day rooms of both residential suites.	

Recommendation 5 **Standard 8.4** **Stated: First time**	Continence garments supplied by the commissioning trust for specific residents are not to be accepted when a resident is no longer accommodated in the home. (Section 10.3)	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that continence garments for residents who no longer reside in the home were discontinued.	
Recommendation 6 **Ref: Standard 6.6** **Stated: First time**	It is recommended that the care plan of one resident is reviewed and revised to reflect the management of suprapubic catheterisation (Section 10.4)	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that this resident's care plan was revised to reflect the management of suprapubic catheterisation. This resident no longer resides in the home.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was available on communicating effectively. A copy of the DHSSPS regional guidance on breaking bad news was available in the home.

Training had not been provided on breaking bad news. However, discussion with the registered manager, 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. Staff spoken with were knowledgeable, experienced and confident in communicating with patients and their representatives.

Is Care Effective? (Quality of Management)

Seven care records evidenced that patient individual needs and wishes in respect of aspects of daily living were appropriately recorded. However, there was limited evidence that end of life issues were discussed with the exception of Do Not Attempt Resuscitation (DNAR) directives.

Care records made reference to the patients' specific communication needs including sensory and cognitive impairment. There was evidence within the care records that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

The registered manager and 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. Care staff considered the breaking of bad news to be the responsibility of the registered nursing staff but felt confident that, should a patient choose to

talk to them about the diagnosis or prognosis of illness, they would have the necessary skills to do so.

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.

Patients spoken with all stated that they were very happy with the quality of care delivered and with life in the home.

Patients and their representatives consulted were generally complimentary of staff and the care provided. Consultation with relatives is further discussed in section 5.4.2. Good relationships were very evident between staff and the patients and visitors.

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

Areas for Improvement

There were no areas for improvement identified with this standard.

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

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)

Policies and procedures on the management of end of life care and death and dying were available in the home. The policies were dated January 2013. Guidelines and Audit Implementation Network (GAIN) issued Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes in December 2013. The relevant policies should be reviewed and updated to reflect this best practice guidance.

The GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013 were available in the home.

Records evidenced that three registered nurses had attended training in the management of syringe drivers delivered by the local health and social care trust in February 2015. Registered nurses had also attended training in the administration of intravenous (IV) medication in May 2015. Eight registered nurses completed the Regional Palliative and End of Life care Learning and Development Programme for nurses in January 2015. The registered manager confirmed that five residential care staff had also undertaken training in this area of care. The registered manager advised that this programme was being run again and that staff were identified to attend.

Training programmes on dying, death and bereavement and understanding cancer and the role of the Macmillan nurse were available to staff via the e learning system within the home. The registered manager had established systems in place to monitor staff compliance to ensure that staff complete the required training.

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

The registered manager confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services through the local health and social care trust. Procedures for timely access to any specialist equipment or drugs were in place.

Is Care Effective? (Quality of Management)

A sampling of care records and discussion with the registered nurses evidenced that death and dying arrangements were part of the activities of daily living assessment completed for each patient. This physical and psychological assessment contained a section entitled "Dying". Only two of seven assessments evidenced that discussion had taken place regarding end of life care. Examples of comments recorded in the five care records were:

"Not discussed"
"Contented"

Two care records contained an advanced care planning documentation completed by the patient's General Practitioner (GP). However, the information recorded in this record had not been formulated into a comprehensive plan of care. Four care records had a care plan in place for end of life care but the interventions were generic and did not contain any personal preferences for the patients.

The registered manager and registered nurses acknowledged that, whilst some discussion had taken place regarding the wishes of patients and relatives for end of life care, for example with the DNAR directives, there was a need to create further opportunities to discuss this area in greater detail; in particular in the event of patients becoming suddenly unwell.

Whilst the inspector acknowledges there will be occasions when patients and/or their relatives do not wish to discuss end of life care, opportunities, to discuss end of life care, should be created by the registered nurses and any expressed wishes of patients and/or their representatives formulated into a care plan for end of life care.

Staff confirmed that facilities were made available for family members to spend extended periods with their loved ones during the final days of life. Meals, snacks and emotional support were been provided by the staff team.

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

Is Care Compassionate? (Quality of Care)

The religious, spiritual or cultural needs of the patients reviewed had been recorded for four of the seven patients, but there was no evidence of consideration of these areas in respect of end of life care. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs on a regular basis.

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

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

"Many thanks for all your care, kindness and professionalism shown to mum, during her time in Rosemount. Particular thanks to the nursing team whom not only nursed and cared for mum but were so kind and considerate to the family."

"It is difficult to express in words how much your kind attention and devotion to mum meant to us. We will always be indebted to you and in particular your support on Tuesday evening when mum passed away."

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.

All of the staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. From discussion with the registered manager and staff, it was evident that arrangements were in place to support staff following the death of a patient.

Areas for Improvement

The policies regarding end of life care should be reviewed and updated to ensure that are reflective of best practice guidance.

To ensure that staff knowledge and care delivery is reflective of best practice in palliative and end of life care it is recommended that when the policy is updated staff should receive an induction/training on the content.

It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.

Number of Requirements:	0	**Number of Recommendations:**	2

5.4 Additional Areas Examined

5.4.1 Fire safety

Numerous items of clothing were stored under the stairs to the first floor. This inappropriate storage was a potential fire hazard. On further review of fire safety in the home it was identified that the fire risk assessment had not been updated and the weekly fire safety checks had not been completed since June 2015. It is required that adequate precautions are taken against the risk of fire. Therefore it is required that:

- The fire risk assessment is updated to ensure that it is current
- the clothing stored under the stairs is removed
- the weekly fire safety checks are recommenced and arrangements put in place to ensure that they are completed when identified staff are on annual leave.

5.4.2 Consultation with patients, their representatives, staff and professional visitors

Discussion took place with 22 patients individually and with the majority of others in smaller groups in both units. Comments from patients regarding the quality of care, food and in general the life in the home were very positive. Patients did not raise any issues or concerns about care delivery in the home. One comment made was:

"The food is good, I am well looked after."

Seven patients' representatives were spoken with. Six confirmed that they were happy with the standard of care and communication with staff in the home. In particular they all referred to the good communication and feedback between the staff and families. One relative noted that there was always plenty of staff on duty and the staff were very courteous to relatives. One comment made was:

"This is a brilliant environment. The staff are very approachable and are overly keen to help. There is brilliant communication. This is home from home."

One patient's relatives raised concerns regarding care delivery. They had not previously raised these with the registered manager. The issues were discussed with the registered manager who agreed to contact the relatives for further discussion. Another relative expressed dissatisfaction with the provision of equipment. Review of the care records and discussion with the registered manager evidenced that the home were liaising closely with the health and social care trust and the family to reach a safe outcome.

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

Twenty questionnaires were issued to nursing, care and ancillary staff. One was returned prior to the issue of this report. The responses indicated that they were satisfied or very satisfied that care was safe, effective and compassionate. Comments included:

"For all residents at end stages of their life, we not only care for the resident but for their family members at this very sad, troubled time endeavouring to make their end days with their loved ones enjoyable and peaceful."

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Claire McKenna, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

6.1 Statutory Requirements

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

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that 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 27(4)(b) **Stated:** First time **To be Completed by:** 24 July 2015	The registered person must ensure that adequate precautions are taken against the risk of fire. It is required that: • The fire risk assessment is updated to ensure that it is current • the clothing stored under the stairs is removed • the weekly fire safety checks are recommenced and arrangements put in place to ensure that they are completed when identified staff are on annual leave.
	Response by Registered Person(s) Detailing the Actions Taken: The fire risk assessment was updated on 22/07/15. The clothing under the stairs was removed immediately on 16/07/15. The weekly fire safety checks were recommenced immediately on 17/07/15 and these will be delegated to an appropriate staff member during any periods when the Maintenance person is on annual leave.
Recommendations	
Recommendation 1 **Ref**: Standard 36, criterion 2. **Stated:** First time **To be Completed by:** 27 August 2015	It is recommended that the policies regarding end of life care should be reviewed and updated to ensure that are reflective of best practice guidance. To ensure that staff knowledge and care delivery is reflective of best practice in palliative and end of life care it is recommended that when the policy is updated staff should receive an induction/training on the content.
	Response by Registered Person(s) Detailing the Actions Taken: In conjunction with our sister home the policies regarding end of life care have been reviewed and updated to reflect current guidance and best practice. Particular attention has been paid to developing the area of communicating bad news. The revised policies have been circulated for all current staff to familiarise themselves with and will be highlighted during the induction of any new staff employed.
Recommendation 2 **Ref**: Standard 20 criterion 2. **Stated:** First time	It is recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.

To be Completed by: 27 August 2015	**Response by Registered Person(s) Detailing the Actions Taken:** All Named nurses have been advised to review their resident's care plans in relation to end of life care regardless of illness stage. Care plans will be developed in sufficient detail to meet Standard 20. Future auditing of care files will focus on the detail within end of life care plans to ensure compliance with meeting the current standards.		
Registered Manager Completing QIP	CLAIRE McKENNA	**Date Completed**	04/09/15
Registered Person Approving QIP	PHILIP SCOTT	**Date Approved**	0409/15
RQIA Inspector Assessing Response	Laura O'Hanlon	**Date Approved**	11.9.15

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