Park Manor
RQIA ID: 11120
6 Thornhill Road
Dunmurry
Belfast
BT17 9EJ

Inspector: Lyn Buckley
Inspection ID: IN022000

Tel: 02890 307700
Email: parkmanor@macklingroup.com

# Unannounced Care Inspection
# of
# Park Manor

## 26 November 2015

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

## 1. Summary of Inspection

An unannounced care inspection took place on 26 November 2015 from 11:10 to 16:45 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Park Manor 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 25 February 2015.

### 1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

### 1.3 Inspection Outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 0 | 1 |

The details of the Quality Improvement Plan (QIP) within this report were discussed with the manager, Ms Claire Black, the regional manager and the registered person as part of the inspection process. The timescales for completion commence from the date of inspection.

## 2. Service Details

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| **Registered Organisation/Registered Person:**<br>Macklin Group<br>Mr Brian Macklin and Mrs Mary Macklin | **Registered Manager:**<br>See box below |
| **Person in Charge of the Home at the Time of Inspection:**<br>Ms Claire Black – acting manager | **Date Manager Registered:**<br>Ms Claire Black – acting manager– application not yet submitted<br>Refer to section 5.5.5. |
| **Categories of Care:**<br>NH-DE, I and PH<br>RC- I and PH<br>Maximum of 26 persons in category NH - DE<br>Maximum of 26 persons in category NH – I and PH<br>Maximum of 26 persons in category RC- I and PH | **Number of Registered Places:**<br>78 |
| **Number of Patients Accommodated on Day of Inspection:**<br>76 | **Weekly Tariff at Time of Inspection:**<br>£533- £689 |

## 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 manager
- discussion with the regional manager
- discussion with the Mrs M Macklin - registered person
- discussion with a selection of staff on duty
- consultation with patients and relatives
- observation of care delivery
- observation of patient and staff interactions
- tour of the home and review of a random selection of patient bedrooms, bathrooms and communal areas
- evaluation and feedback.

Prior to inspection the following records were analysed:

- notifiable events submitted since 1 January 2015
- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the returned quality improvement plans (QIP) from the last care inspection
- the previous care inspection report.

During the inspection, the inspector spoke with the nine patients individually and met others in smaller groups. The inspector also spoke with two relatives, two catering/housekeeping staff, one member of administration team, four care staff and three registered nurses.

The following records were examined during the inspection:

- evidence required to validate the previous care inspection QIP
- policies and procedures pertaining to the inspection themes
- nursing and care staff duty rotas from 16 – 29 November 2015
- training records
- induction templates for nursing and care staff
- compliment records
- complaint records
- two patient care charts relating to repositioning and fluid intake/output charts
- three patient care records.

## 5. The Inspection

### 5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Park Manor was an unannounced care inspection dated 25 February 2015. The completed QIP was returned and approved by the care inspector.

## 5.2 Review of Requirements and Recommendations from the Last Care (Same specialism) Inspection

| Last Care Inspection Recommendations | | Validation of Compliance |
|---|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 19.1 & 13.9<br><br>**Stated:** First time | It is recommended that the following record keeping issues are addressed:<br><br>• information from communal records is transcribed to patients' individual records<br>• every record (including loose pages) contains the patient's details and other relevant information regarding the purpose of the record<br>• a record is maintained of all activities that patients/residents participate in. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of patient records and discussion with the manager and staff confirmed that this recommendation had been met. | |
| **Recommendation 2**<br><br>**Ref**: Standard 19.2<br><br>**Stated:** First time | It is recommended that:<br><br>additional evidence based guidelines in in relation to bowel / bladder care are sourced and made available to staff<br><br>that policies / procedures in relation to continence / incontinence management include stoma care and are further developed /reviewed to include additional evidence based references | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Guidelines on bladder and bowel care were available to staff.<br><br>Policies and procedures pertaining to continence/incontinence and stoma care, dated January 2015, were available to staff. | |

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| **Recommendation 3**<br><br>**Ref**: Standard 19.4<br><br>**Stated:** First time | It is recommended that:<br><br>all remaining registered nurses receive an update on male and female catheterisation and management of stoma care until 100% compliance is attained. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of training records, discussion with registered nurses confirmed that catheter training had been delivered, therefore this recommendation has been met. | |
| **Recommendation 4**<br><br>**Ref**: Standard 30.1<br><br>**Stated:** First time | Confirm the arrangements regarding the recruitment additional registered nurses. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The manager evidenced that additional hours for registered nurses (RN) had been made available and the posts filled. | |

### 5.3 Standard 19 - Communicating Effectively

**Is Care Safe? (Quality of Life)**

A policy and procedure on communicating effectively was available dated April 2015.

Regional guidelines on Breaking Bad News were available and staff spoken with were aware of the polices/procedures, guidelines and the Minimum Care Standards for Nursing Homes; standard 19.

The manager confirmed that training in communicating effectively with patients had taken place October/November 2015. This training included the home's core values and culture as well as communicating effectively.

Discussion with staff confirmed that they were knowledgeable of how to communicate effectively. Staff confirmed that they were aware of the importance of communicating effectively through their training and experience of caring for patients.

**Is Care Effective? (Quality of Management)**

Care records reviewed, included reference to the patient's specific communication needs and actions required to manage barriers such as, language, cognitive ability, or sensory impairment.

Care records reviewed evidenced that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs. Relatives spoken with confirmed they were kept informed.

Staff consulted clearly demonstrated their ability to communicate sensitively with patients and their families. It was evident that staff were aware of the individual needs of their patients. This was commended by the inspector.

**Is Care Compassionate? (Quality of Care)**

Observation of the delivery of care and interactions between patients and staff clearly evidenced that communication was compassionate and considerate of the patient's needs. Patients were treated with dignity and respect.

Patients who could verbalise their feelings on life in Park Manor commented very positively in relation to the care they were receiving from staff and the attitude of staff. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff.

Positive comments were also provided by the two relatives spoken with and in letters and cards received by the home from relatives.

**Areas for Improvement**

There were no areas for improvement identified.

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| **Number of Requirements:** | **0** | **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)**

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home dated April 2015. Polices were reflected of best practice guidance in palliative and end of life care.

Records reviewed and discussion with the manager and staff evidenced that training in palliative care and end of life had been delivered in April 2015. Additional training was to be disseminated to all staff, by the manager, in December 2015 and January 2016.

GAIN Palliative Care Guidelines, November 2013 were available in the home. Staff spoken with were aware of the guidance and the minimum care standards for nursing homes; standards 20 and 32.

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

Discussion with the manager, nursing staff and a review of 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 medications was in place and discussion with nursing staff confirmed their knowledge of the protocol.

**Is Care Effective? (Quality of Management)**

A review of care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered.

Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Staff were able to describe clearly how the families would be supported during this time and enabled to stay overnight in the home when their loved ones were dying.

A review of notifications of death to RQIA since the 1 January 2015 confirmed that any death occurring in the home was notified appropriately.

**Is Care Compassionate? (Quality of Care)**

Discussion with staff and a review of 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. Staff demonstrated an awareness of patients' expressed wishes and needs as identified in their care plan.

Staff consulted demonstrated clearly their compassion for the patients, their relatives and friends. The inspector commended how staff interacted with patients and the detailed knowledge demonstrated to ensure patients were afforded privacy, dignity and respect.

Staff confirmed that they were given an opportunity to pay their respects after a patient's death.

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. All staff spoken with informed the inspector of how they could provide support to families who were 'sitting with loved ones' who were dying.

Discussion with the manager, staff and a review of the compliments record, evidenced that arrangements in the home supported relatives when their loved one was dying. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Some examples of comments made by relatives included:

"We cannot thank you enough for all the care and consideration you provided for…"

"Thank you so very much for the kindness and care you have all displayed in looking after our … who told us [they] loved you all".

"The family are so grateful for the attention and kindness of all the staff to … in making [their] final days so peaceful and comfortable".

"We very much appreciated the care and attention, to say nothing of the endless cups of tea and slices of toast with marmalade…"

Discussion with the manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

**Areas for Improvement**

There were no areas for improvement identified.

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

## 5.5 Additional Areas Examined

### 5.5.1 Consultation with Patients, Staff and Patient Representative/Relatives

**Patients**

Nine patients were spoken with individually and others in smaller groups. Patients were very complimentary regarding the standard of care they received, the attitude of staff and the food provided. Patients who could not verbalise their feelings appeared, by their demeanour, to be relaxed and comfortable in their surroundings and with staff. There were no concerns raised with the inspector.

Eight questionnaires for patients were left with the manager for distribution and six were returned. Patients indicated that they were satisfied (x1) or very satisfied (x6) with the care and supported they received from staff and that the home delivered safe, effective and compassionate care. Comments recorded included:

"Would like to say thanks for the care".

"Staff are approachable at all times and very caring".

"All aspects of care are exceptionally well catered for from the highest to the lowest levels".

**Staff**

In addition to speaking with staff on duty, eight questionnaires were provided for staff not on duty. The manager agreed to forward these to the staff selected. At the time of writing this report five had been returned.

Staff indicated that they had received training in relation to safeguarding, reporting poor practice/whistleblowing and patient consent. In addition the staff indicted that they were satisfied or very satisfied that patients were treated with dignity and respect and that patients' needs and wishes were respected and met.

Additional comments recorded included:

"I am happy to say we have great staff across the whole home… We all care and that's very important in my view."

"I love that the atmosphere is so homely and welcoming, its like a home from home, run well, brilliant management and staff team work."

"I feel the quality of care given in Park Manor nursing home is to a very high standard. The staff and management are all very caring and I'm proud to be part of that team."

"I feel the care provided in the home is extremely good for residents and to family members especially when the residents are near to end of life."

**Representatives/Relatives**

Two relatives spoken with during this inspection confirmed that they were happy with the care their loved one received, that the staff were attentive, caring and kind and that the manager was well known and available to them at any time.

Eight questionnaires were also provided for patient representatives/relatives and three were returned. Comments recorded evidenced that relatives/representatives were either satisfied or very satisfied with the care provided for their loved one.

Additional comments recorded included;

"I am very satisfied with the care that …receives and the kindness of all the staff to … and myself."

"It has been my experience that the staff at Park Manor, both caring and nursing; have always been tireless and assiduous in treating their patients with respect and dignity; in tending to their needs."

"from management, nursing, carers, kitchen and housekeeping, every aspect has been excellent."

### 5.5.2 Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms, bathrooms lounge and dining rooms and sluices on each floor.

The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients were observed relaxing in their bedroom or in one of the lounge areas available. Patients were complimentary in respect of the home's environment.

### 5.5.3 Care Records

Review of care records, including care charts for repositioning of patient and fluid intake/output, evidenced that care records were maintained in accordance with, regulatory, professional and minimum standards. The records also reflected the recommendations made by other healthcare professionals such as dieticians and GPs.

However, concern was raised in relation to the recording of decisions around resuscitation and advance care planning.

Following discussion with the manager, regional manager and registered person a recommendation has been made to ensure this matter was considered and addressed.

### 5.5.4 Staffing

The manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met.

Review of duty rotas from 16 – 29 November 2015 confirmed that the planned staffing levels were maintained.

During discussion, with staff, patients and relatives, there were no concerns regarding staffing levels made.

### 5.5.5 Registration of the manager

During feedback, discussion took place regarding the acting manager's registration with RQIA. The manager and registered person confirmed that an application to register would be submitted to RQIA within the next few weeks.

**Areas for Improvement**

It was recommended that management review the recording of do not attempt resuscitation/cardio pulmonary resuscitation orders in accordance with national and regional guideline such as the Resuscitation Council Guidelines for the United Kingdom.

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

## 6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the manager, Ms Claire Black, the regional manager and the registered person 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 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

| Recommendations | |
|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 33<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 January 2016 | Management should review the recording of do not attempt resuscitation/cardio pulmonary resuscitation orders to ensure records are maintained in accordance with national and regional guidelines.<br><br>**Ref: Section 5.5.3**<br><br>**Response by Registered Person(s) Detailing the Actions Taken:**<br>DNAR form Reviewed & Replaced with new form from Resuscitation council website, which is in line with Resuscitation council guidelines. |

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|---|---|---|---|
| **Registered Manager Completing QIP** | Claire Black | **Date Completed** | 23-12-15 |
| **Registered Person Approving QIP** | | **Date Approved** | |
| **RQIA Inspector Assessing Response** | | **Date Approved** | |

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

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|---|---|---|---|
| **RQIA Inspector Assessing Response** | Lyn Buckley | **Date Approved** | 12/01/2016 |