Unannounced Care Inspection Report
8 December 2016

Bannview House Care Home

Address: 23 Bannview Road, Banbridge, BT32 3RL
Tel No: 028 4066 0110
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Bannview House Care Home took place on 8 December 2016 from 09.30 to 17.20 hours.

The inspection was conducted as a result of two separate whistleblowing concerns to RQIA regarding staffing arrangements in the home. This unannounced inspection was conducted to review the staffing arrangements and assess any impact of these arrangements on patient care within the home.

Deficits in staffing levels were identified following a review of duty rotas and discussion with staff. Deficits on patient care in respect of the management of patient's assessment of need, risk assessments and care plan development and review were also identified. During the inspection four patient care records were reviewed. One patient had recently been admitted to the home. The patient's admission assessments and care plans had not been recorded when and since the patient was admitted into the home. A second patient admitted in October 2016 had assessments completed on risk of falls, mobility and continence. However, corresponding care plans had not been developed. A Braden risk assessment on the second patient had been incorrectly recorded on admission and not reviewed from admission. Three patients wound management records had not been recorded in accordance with best practice guidelines.

Following the inspection a meeting was held at RQIA on 9 December 2016 and it was decided to invite the registered persons to attend a serious concerns meeting at RQIA to discuss the inspection findings. This meeting was held on the 14 December 2016. At this time, an action plan was provided which outlined the actions from the registered persons taken since the inspection and the proposed actions to ensure compliance with legislation and improve the delivery of care, the management of care records and the staffing arrangements. Following consideration of the information and assurances provided by the registered persons RQIA decided to allow a period of time in which to implement this action plan. A further unannounced inspection will be planned to validate that improvements have been made and sustained.

This inspection was underpinned by The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5*	1

*The total number of requirements includes one requirement which has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Karen McElherron, regional manager; Roberta Wilson, registered manager and Cherith Rogers, deputy manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 19 and 20 April 2016. Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Priory (Warrenpoint) Ltd Caroline Denny	**Registered manager:** Roberta Wilson
Person in charge of the home at the time of inspection: Cherith Rogers (Deputy manager)	**Date manager registered:** 22 December 2015
Categories of care: NH-PH, NH-I, RC-I, NH-DE 15 patients in category NH-I 41 patients in category NH-DE 2 patients in category NH-PH 22 residents in category RC-I	**Number of registered places:** 80

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- 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 and the returned QIP
- pre inspection assessment audit

During the inspection we met with six patients individually and others in small groups, three patient representatives, four care staff, three registered nurses and one ancillary staff member.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- four patient care records
- staff training records
- Incidents / accidents records
- duty rotas for the period 31 October to 4 December 2016

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 and 20 April 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 19 and 20 April 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13 (1) **Stated:** First time	The registered persons must ensure the afternoon routine is immediately reviewed to ensure that the safety, health and welfare of patients are maintained at all times.	**Not Met**
	Action taken as confirmed during the inspection: During a review of the environment, three patients were observed seated in their wheelchairs within a lounge. Discussion with staff confirmed that they had been there from 15.00 hours and would remain in the wheelchairs until dinner was over at around 17.30 hours.	
Requirement 2 **Ref:** Regulation 27 (2) (c) **Stated:** First time	The registered persons must ensure that equipment provided for use in the nursing home for use by patients or persons who work at the home is in good working order, properly maintained in accordance with the manufacturer's guidance, and suitable for the purpose for which it is to be used.	**Met**
	Action taken as confirmed during the inspection: All equipment observed during the inspection was in good working order and used for the purpose it was designed for.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 21 **Stated:** First time	The registered persons should ensure that all care records including supplementary records are dated and signed by the person completing them.	**Met**
	Action taken as confirmed during the inspection: All records reviewed on inspection had been signed and dated appropriately.	

4.3 Inspection findings

4.3.1 Staffing arrangements

Discussion with staff and a review of duty rotas evidenced that the home regularly did not meet the assessed staffing levels required to meet the needs of the patients. Discussion with staff evidenced that staff were regularly moved from the units in which they normally worked to other units within the home. The staffing level in the Downshire Unit has a planned reduction of one staff member at weekends. A requirement was made to ensure staffing arrangements within the home met the assessed needs of patients at all times.

4.3.2 Care Records

During a review of patients care records it was observed that a patient ‘A’ admitted recently did not have any assessments completed for some 10 days post admission. This patient was also evidenced to have not had any care plans established to direct staff in the delivery of required care for 10 days post admission.

Patient ’B’ had a Braden risk assessment completed on admission , however following a review of the patient’s nursing care records, it was identified that this risk assessment was not fully reflective of patient need on two assessed areas. The Braden assessment had not been reviewed from the time of admission. A requirement was made to ensure all assessments are completed as required on admission and reviewed when required or when the patients’ needs change.

A review of Patient ‘B’ nursing care records evidenced that care plans had not been completed in response to identified needs within continence, mobility and a falls risk assessment.

Patient ‘C’ wound care plan was not updated to reflect the changed frequency of wound management. A requirement was made to ensure that patients’ care plans were developed following identification of assessed needs; reviewed regularly and updated accordingly to meet the current needs of patients.

During the review of wound management records, Patient 'C' records did not contain a written record of any monitoring of wound progression other than a recording in the daily progress records. Patient 'D' wound observation chart did not include any monitoring of wound dimensions as measured on assessment. Patient 'D' had three separate wounds and did not have each individual wound monitored appropriately. A requirement was made to ensure all wounds in the home were monitored appropriately and that record keeping in relation to wound management was maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.

Supplementary care records had not been recorded consistently. Indications of care provision had been recorded by the use of abbreviations by some staff and a tick by other staff. Furthermore, one staff consulted did not recognise the abbreviations used and a key indicating the meaning of abbreviations used was not available on the chart used.

Deficits in achieving goals had been identified within the progress notes in patients care records. However, any actions taken in response to the recorded deficits were not recorded. A recommendation was made.

4.3.3 Consultation

On inspection three registered nurses, four carers and one ancillary staff member was consulted to ascertain their views of life in Bannview. Staff consulted confirmed that when they raised a concern, they were happy that the home's management would take their concerns seriously.

Some staff comments were as follows:

"It is a lovely nursing home."
"I love it here."
"I really enjoy working here."
"We are frequently short staffed."
"We are under severe pressure with staff shortages."
"When we are fully staffed I love working here."
"I sometimes think management don't appreciate the workload at weekends."

On inspection nine patients were consulted and the patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Some patient comments were as follows:
"You won't find nothing wrong in this nursing home."
"It is a very good home."
"I find it very good here."
"The care here is very good."

Three patient representatives were consulted with on the day of inspection.

Some relative comments were as follows:
"The care here is brilliant."
"I find the care given here is very good."
"I think the care here is great and the staff are very friendly."

4.3.4 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

4.3.5 Staff Training

Discussion with the deputy manager and a review of training records evidenced that staff had achieved 94 percent compliance with mandatory training requirements. Information sent to RQIA confirmed the majority of staff had completed training on moving and handling, fire safety, adult safeguarding, first aid and infection prevention and control.

Areas for improvement

The areas for improvement within this report are with regards to staffing arrangements, assessment of patients' needs, care planning, wound management, recording of supplementary records and recording of actions taken in response to identified deficits.

Number of requirements	4	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Karen McElherron, regional manager; Roberta Wilson, registered manager and Cherith Rogers, deputy manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13 (1) **Stated:** Second time **To be completed by:** 9 December 2016	The registered persons must ensure the afternoon routine is immediately reviewed to ensure that the safety, health and welfare of patients are maintained at all times. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Afternoon routine addressed with staff on the day. Followed up with verbal and formal written supervisions with all care and nursing staff. Manager and Deputy Manager are monitoring on a regular basis.
Requirement 2 **Ref:** Regulation 20 (1) (a) (b) **Stated:** First time **To be completed by:** 9 December 2016	The registered person must ensure that staffing arrangements within the home meet the assessed needs of the patients accommodated within at all times. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: Planned staffing arrangements ensure that the assessed needs of the residents are met on a day to day basis. There are enhanced planned staffing levels for the Bronte, lisnaree and Downshire units. Rotas are monitored on a daily basis. All efforts are made to ensure the needs of the residents across all areas of the home are safely met on a day to day basis Rotas are completed four weeks in advance and staff are allocated to vacant shifts on their request and bank staff are used.Agency staff nurses have been block booked in advance from 08 11 2016. Permissions to bring in Agency care staff were in place from 07 12 16 to cover staff leavers in December. Even with all the above measures in place there may be times that a shift cannot be covered at short notice. There is difficulty in filling half shifts at short notice when staff call in sick. There is now a protocol in place for what steps to take when a member of staff calls in absent. A Nurse in charge phone has been purchased with staff group numbers allocated (carers, bank Nurses)

Requirement 3 **Ref:** Regulation 15 (2) (a) (b) **Stated:** First time **To be completed by:** 15 December 2016	The registered person must ensure that assessments are completed as required on admission and reviewed when required or when the patients' needs change. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: This has been addressed with the resident highlighted. In addition to this all residents monthly assessments have been reviewed to ensure they reflect the residents current needs. This has been reinforced with all staff verbally and will be followed up with a series of formal supervisons regarding individual accountability, assessment and care planning.
Requirement 4 **Ref:** Regulation 16 (1) (2)(a)(b) **Stated:** First time **To be completed by:** 15 December 2016	The registered person must ensure that patients' care plans were developed following identification of assessed needs; reviewed regularly and updated accordingly to meet the current needs of patients. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: This has been addressed with the resident highlighted. In addition to this all residents monthly care plan assessments have been reviewed to ensure they reflect the residents current needs. There has been an increased focus on the resident of the day procedures to ensure the relevant systems are in place moving forward. This has been reinforced with all staff verbally and will be followed up with a series of formal supervisons regarding individual accountability, assessment, care planning and reviewing of same .
Requirement 5 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 15 December 2016	The registered person must ensure that all wounds in the home are monitored appropriately and that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: This has been addressed with the residents highlighted, all wounds have been reassessed, new photographs taken and clear instructions included in revised wound plans. In addition to this all other residents wound assessments have been reviewed to ensure they reflect the residents current wounds status. This has been reinforced with all staff verbally and will be followed up with a series of formal supervisons regarding individual accountability, wound management and documentation.

Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 15 December 2016	The registered person should ensure that supplementary records in the home are recorded consistently by all staff and in a format which is understood by all staff. A reference should be made within patient care records to identify any actions taken in response to any variances identified. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: A key for the supplementary records is included in the supplementary records file. It is the responsibility of all staff including registered nurses to be familiar with all aspects of supplementary documentation used. This has been reinforced with all staff verbally and will be followed up with a series of formal supervisons regarding individual accountability, and documentation. Registerred Nurses have been made aware.

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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