Unannounced Enforcement Compliance Inspection Report
3 September 2020

Drumary House

Type of Service: Residential Care Home
Address: 44 Knockmore Road, Derrygonnelly, BT93 6GA
Tel No: 028 6864 1736
Inspector: Jane Laird

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for

2.0 Profile of service

This is a residential care home registered to provide residential care for up to 17 residents.

3.0 Service details

Organisation/Registered Provider: Potensial Ltd **Responsible Individual:** Nicki Stadames	**Registered Manager and date registered:** Julie Murphy – pending registration
Person in charge at the time of inspection: Julie Murphy	**Number of registered places:** 17
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 10

4.0 Inspection summary

An unannounced enforcement compliance inspection took place on 3 September 2020 from 08.45 hours to 14.20 hours.

The inspection sought to assess the level of compliance achieved in relation to two Failure to Comply (FTC) Notices issued to the Responsible Individual (RI) on 20 July 2020; FTC Reference: **FTC000104** and **FTC000105**. The date of compliance with both FTC notices was 3 September 2020.

Significant improvements were evident since the previous care inspection on 9 July 2020 in relation to the governance of care records, audits, the duty rota, monthly monitoring reports, management of complaints, accidents/incidents, weight management, modified diets, registration checks of staff with NISCC, restrictive practice, risk management and infection prevention and control (IPC).

An evidence folder of all actions taken to address each point within the two notices had been maintained by the manager with a separate memo folder evidencing all information shared with staff regarding the outcome of the inspection on the 9 July 2020 and actions required to address the issues. Evidence was available during this inspection to validate compliance with the Failure to Comply Notices.

There were three new areas for improvement identified as a result of this inspection in relation to policies and procedures, urinary catheter care and care records.

During the inspection residents discussed their involvement in the homes plans for redecoration and provided the inspector with a description of paint colours and floor coverings which had been ordered for their bedrooms. Compassionate delivery of care was observed throughout the inspection and residents stated they were very happy living in Drumary House and were well looked after.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	*4

*The total number of areas for improvement includes one standard which has been carried forward for review at the next care inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Julie Murphy, manager and Mike Barton, area manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Further enforcement action did not result from the findings of this inspection.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- the FTC notices: FTC000104 and FTC000105.

During the inspection the inspector met with nine residents and four staff.

The following records were examined during the inspection:

- a sample of duty rotas for all staff for weeks commencing 3 August 2020, 10 August 2020 and 31 August 2020
- records confirming staff registration with the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- three residents' care records
- a sample of governance audits/records
- complaints record
- staff supervision records

- a sample of policies and procedures
- a sample of monthly monitoring reports from April 2020.

One area for improvement identified at the last care inspection was reviewed and assessment of compliance recorded as met; one area for improvement was not reviewed and has been carried forward for review at the next care inspection.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 9 July 2020

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 12.4 **Stated:** Second time	The registered person shall ensure a daily menu is displayed in an area and format which residents can see and understand.	**Met**
	Action taken as confirmed during the inspection: On observation of the environment it was evidenced that a daily pictorial menu was on display within the dining room with a choice of two main meals.	
Area for improvement 3 **Ref**: Standard 27.1 **Stated:** First time	The registered person shall ensure the building is decorated to a standard acceptable for the residents.	**Carried Forward to next care inspection**
	Action taken as confirmed during the inspection: Due to the restrictions on contractors entering care homes during the COVID-19 pandemic the action required to ensure compliance with this standard was not reviewed as part of this inspection and has been carried forward to the next care inspection.	

6.2 Inspection findings

The inspection focussed on the actions detailed within the two FTC notices issued on 20 July 2020.

FTC Ref: FTC000104

Notice of failure to comply with regulation 10 of The Residential Care Homes Regulations (Northern Ireland) 2005.

Regulation 10.—
(1) *The registered provider and the registered manager shall, having regard to the size of the residential care home, the statement of purpose, and the number and needs of the residents, carry on or manage the home (as the case may be) with sufficient care, competence and skill.*

In relation to this notice the following 15 actions were required to comply with this regulation:

- there are effective systems in place to monitor staff compliance with good infection prevention and control practices
- systems are in place to monitor the use of restrictive practices to ensure these are kept current and under review
- systems are in place to ensure that accident and incidents are recorded, reported and actioned appropriately
- accidents and incidents are audited on a monthly basis to identify any trends and patterns
- complaints are recorded and audited on a monthly basis to ensure they are appropriately managed and facilitate learning and improvement
- a system is in place to audit care records to ensure that these are reflective of residents' needs
- a system is in place to identify potential hazards to residents' safety and any deficits identified are promptly addressed
- a robust system is in place to ensure that staff are registered with NISCC
- there is clear evidence where deficits are identified through the audit process, an action plan is put in place to ensure the necessary improvements are made
- staff duty rotas contain the full names of staff, their job role and hours worked
- staff are deployed in sufficient numbers to meet the assessed needs of the residents with specific reference made to night duty
- all staff working in the home can demonstrate their knowledge of the mental capacity act (NI) 2016 and deprivation of liberty safeguards (DoLS) to reflect the regional guidance for Northern Ireland commensurate with their role and function in the home
- the home's policies, procedures and guidance are reviewed to reflect the Northern Ireland context
- the registration of staff with NISCC is reviewed and managed in accordance with regulation to ensure the safety of residents
- quality monitoring reports are completed in accordance with regulation 29 of the residential care homes regulations (Northern Ireland) 2005 and forwarded to RQIA by the fourth day of each month.

Evidence was available to validate compliance with the Failure to Comply Notice.

We reviewed a sample of audits carried out by the manager in relation to infection prevention and control and hand hygiene. The manager had recorded any deficits observed via the audit and implemented an action plan with timeframes. All staff were wearing face masks and observed applying and removing personal protective equipment (PPE) appropriately.

Since the previous care inspection on the 9 July 2020 the manager had reviewed all residents' care plans and risk assessments. Relevant care management reviews had been completed and restrictive practice reviewed. There was evidence within one resident's care records that the care manager had submitted a deprivation of liberty safeguards (DoLS) application to the trust panel for use of restrictive interventions. A record of lap strap use and bedrail checks was maintained as necessary and monthly audits had been implemented on all restrictive practices to ensure that relevant documents are maintained.

We were advised that all accidents/incidents are documented on the computerised system within the home which are printed off and stored in a folder. On review of the folder we evidenced that a system had been implemented to monitor the frequency of falls and any trends through monthly audits by the manager and during monthly monitoring visits by the area manager.

A system for recording complaints had been initiated following the care inspection on 9 July 2020. We evidenced two folders; one containing template forms, including a pictorial format and the other folder contained the details of the complaint, the investigation and the outcome. Complaints are then audited monthly by both the manager and area manager.

The manager advised that all care folders had been updated to reflect the residents' current needs with a schedule of monthly audits to be completed by the manager and senior care assistants. The manager further advised that person centred care, record keeping and care plans training is scheduled on various dates for September 2020 for all care staff which was evident via the memo folder.

We reviewed the most recent health and safety audit completed in August 2020 which evidenced that a system was in place to identify potential hazards to residents' safety with an action plan to address the issue, including the person responsible and the time frame for completion.

A system for monitoring all care assistants with the Northern Ireland Social Care Council had been implemented following the previous care inspection on 9 July 2020 to ensure that all care staff working within the home and who are recorded on the staff duty rota are also included on a spreadsheet and reviewed monthly by the manager and area manager as part of the monthly monitoring system.

We reviewed a sample of audits maintained within the home which evidenced that where deficits had been identified an action plan with time frames and the person responsible for completing the task had been implemented.

Staff duty rotas contained the full name, job role and hours worked of all staff which evidenced a clear system to establish the number of staff on duty. The manager advised that staffing levels are kept under review to ensure that the assessed needs of the residents are met and that the staffing levels at night are adequate to meet the residents' current needs, but that this would be kept under continuous review.

We reviewed an evidence folder which had been implemented by the manager with information that had been distributed to staff regarding the Mental Capacity Act (NI) 2016 and Deprivation of Liberty Safeguards. On discussion with staff they were knowledgeable regarding restrictive practice and DoLS but had not completed training specific to Northern Ireland. This was discussed with the manager and during the inspection four members of staff completed DoLS training via the Department of Health (DoH) website and evidence of a memo was shared with the inspector which had been circulated to all staff requesting them to complete the training as detailed above.

Policies and procedures were reviewed which evidenced that they had been updated to reflect the Northern Ireland context. Although this action had been addressed, we identified deficits in relation to the organisation of the folder which was not indexed and a number of policies such as consent and pre-admission assessment which had not been reviewed within the three year period. The area manager advised that new policies for Potens as a group had been updated and were on an electronic system that had not been printed off or forwarded to the manager. We discussed the importance of ensuring that policies and procedures are made available for staff and/or residents and an area for improvement was made.

Quality monitoring reports were completed and forwarded to RQIA by the fourth day of each month. The reports evidenced that where deficits had been identified an action plan with timeframes was implemented with the person responsible for completing the task.

FTC Ref: FTC000105

Notice of failure to comply with regulation 13 of The Residential Care Homes Regulations (Northern Ireland) 2005.

Regulation 13.—
(1) *The registered person shall ensure that the residential home is conducted so as –*
(a) to promote and make proper provision for the health and welfare of residents;
(b) to make proper provision for the care and where appropriate, treatment and supervision of residents.

In relation to this notice the following 12 actions were required to comply with this regulation:

- a robust system is in place to monitor residents' weights with clear evidence of actions taken where weight loss has been identified
- care records are reviewed upon admission of a resident to ensure that these are up to date and reflective of the resident's current needs
- where restrictive practices are in place, care records are reflective of the resident's assessed needs, are kept under review and there is clear evidence of consultation with the multi-disciplinary team
- care records in relation to residents' moving and handling needs are reflective of their assessed needs and are kept under review
- care records in relation to nutrition and modified diets are reflective of the residents' assessed needs, are kept under review and are reflective of the advice of the multi-disciplinary team
- staff are able to demonstrate their knowledge in relation to best practice in the modification of food and fluids
- falls are managed in accordance with best practice and regional guidelines

- care records in relation to the management of residents' urinary catheters are maintained to evidence the care delivered
- the assessed needs of residents are kept under regular review and referrals are made to relevant professionals in a timely manner
- all staff working in the home can demonstrate their knowledge of infection prevention and control measures commensurate with their role and function in the home
- the home's environment is managed to reduce risks to patients' health and wellbeing for example, storage of hazardous chemicals, exposed pipework and securing of wardrobes to the walls
- fire exit doors are kept clear at all times.

Evidence was available to validate compliance with the Failure to Comply Notice.

A folder containing a record of monthly weights for residents was available with a template for recording any weight loss/gain and the action taken where necessary. Additional information such as; nutritional guidelines and advice regarding when to refer a resident to other health care professionals if concerned re: weight loss, was also included within the folder to direct care staff. The inspector commended the manager for making these necessary improvements.

There had been no admissions since the previous inspection. On discussion with the manager we were advised that prior to any new admissions and/or residents returning for respite care, updated information would be requested from the care manager and a pre-admission assessment would be arranged with the resident and their next of kin where appropriate, to ensure that all relevant care records are updated to reflect any change in care needs.

A review of one resident's care records specific to restrictive practice evidenced that a care management review had been completed following the inspection on the 9 July 2020, with input from the occupational therapist (OT). Care plans and risk assessments had been reviewed to reflect the resident's assessed needs and an application for deprivation of liberty safeguards had been submitted to the trust panel for consideration.

On review of three residents' care records specific to: moving and handling; nutrition and modified diets, evidenced that input had been received from the OT and speech and language therapist (SALT) and care plans and risk assessments were updated to reflect the residents' assessed needs.

We discussed modified diets with the cook who described the different textures and the process involved to ensure that food and fluids are prepared to the correct consistency. The manager provided an evidence folder with a training session that had been completed with all staff regarding modified diets and the International Dysphagia Diet Standardisation Initiative (IDDSI) chart was displayed on the notice board within the kitchen. The manager also advised that she completes spot checks to ensure that the texture of food/fluids is in accordance to the residents' assessed needs.

A folder to record all accidents and incidents had been implemented following the inspection on the 9 July 2020 with a template for auditing any trends and/or patterns with a section to record an action plan. There had been no falls recorded within the home following the inspection on 9 July 2020 and a new post falls pathway had been implemented and displayed behind each resident's bedroom door and on the staff notice board. The manager further provided evidence of planned training in falls prevention/management scheduled for a number of dates in September 2020.

Review of one resident's care records specific to urinary catheter care evidenced that updated information was available from the continence nurse specialist which was reflected within the resident's care plan. A care management review had also taken place following the inspection on 9 July 2020 to ensure that the resident's assessed needs are kept under review. However, on review of the catheter care recording charts, the frequency of catheter care interventions was not as per recommendations made by the continence nurse specialist and there were a number of entries which had not been signed by staff. This was discussed with the management team and an area for improvement has been made.

A review of one resident's care records evidenced that an OT referral had been made following a change in the resident's mobility. The OT visited the home and made a number of recommendations and provided the necessary mobility aids. On review of the resident's care records all relevant care plans and risk assessments had been updated, however, these were not updated until the manager returned from leave five days later. A discussion was held with the manager regarding records being updated immediately following new instructions from other health care professionals and an area for improvement was made.

All staff wore the appropriate PPE and were observed using hand sanitising gel at various times throughout the inspection. The inspector's temperature was checked on arrival to the home and all staff were wearing face masks. The manager informed us that staff were using the resident's dining area for their meals when not occupied by residents. We discussed the importance of staff ensuring that a green zone is used for staff breaks and not a resident area due to the potential risk of spread of infection and that this had previously been discussed during the inspection on 9 July 2020. Following the inspection the manager provided written confirmation that the staff room location has been changed to an area on the ground floor and that a memo has been circulated to inform all staff.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, the dining room and storage areas. We observed that wardrobes had been secured to bedroom walls, the radiator within the communal bathroom had been adjusted to ensure that the temperature is maintained at a safe level and hot water pipes within a store had been covered. We discussed an identified bedroom where pipes remained exposed following the previous inspection on 9 July 2020 and the manager agreed to action this with the maintenance person.

The door to the laundry room was unlocked with washing detergent accessible to residents within an unlocked cupboard. This was discussed with the manager and the laundry room door was then locked by the laundry assistant. The manager advised that the laundry room door is normally kept locked and agreed to monitor this during daily walk arounds and to discuss the importance of securing this room with relevant staff. The manager further agreed to have a lock installed to the cupboard within the laundry room. This will be reviewed at a future inspection.

We further identified a malodour within one of the unoccupied bedrooms and staining to the floor covering within this bedroom and the adjoining bedroom. Following the inspection written confirmation was received from management that a leak from the washing machine had been identified which caused water damage under the floor coverings and that the maintenance person had resolved the leak and new floor coverings had been ordered.

The home was found to be neat and tidy throughout with fire exits and corridors observed to be clear of clutter and obstruction.

Areas of good practice

Evidence of good practice was found in relation to maintaining residents' dignity and privacy, and the inclusion of residents in decision making around the redecoration plans for the home. We observed friendly, supportive and caring interactions by staff towards residents and we were assured that there was a strong culture of compassionate care in the home.

Areas for improvement

Three new areas for improvement were identified during the inspection in relation to policies and procedures, urinary catheter care and care records.

	Regulations	Standards
Number of areas for improvement	0	3

6.3 Conclusion

Significant improvements had been made to address the actions within the notices and we were satisfied that the appropriate action had been taken to address any further issues identified during the inspection. Evidence was available to validate compliance with FTC000104 and FTC000105.

New areas for improvement were identified and are referenced within the body of this report.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Also included in the QIP is an area for improvement which has been carried forward from the last care inspection on 9 July 2020. Details of the QIP were discussed with Julie Murphy, manager and Mike Barton, area manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 residential care 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 27.1 **Stated:** First time **To be completed by:** 1 June 2020	The registered person shall ensure the building is decorated to a standard acceptable for the residents. Ref: 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 2 **Ref**: Standard 21 **Stated:** First time **To be completed by:** 3 October 2020	The registered person shall ensure that policies and procedures are centrally indexed, are subject to a systematic three yearly review and are available for staff and residents where applicable. Ref: 6.2
	Response by registered person detailing the actions taken: All Potens Policies are under review to ensure they comply with and are relevant to Northern Ireland regulations and guidance. A number of policies had been reviewed and updated in early 2020 (Notification of Significant Events / Recruitment & Selection) for example. Supervision, Safeguarding being the most recent (Sept 2020). Policies are reviewed in the 3-year timeframe. Unfortunately, on the last inspection, out of date policies had not been removed from file, when updated once distributed. There is a system in place to remove and add policies as they are updated
Area for improvement 3 **Ref**: Standard 6.2 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the frequency of urinary catheter care interventions are: • in accordance with the recommendations made by the continence nurse specialist • evidenced within recording charts • signed by relevant staff following each catheter care intervention. Ref: 6.2
	Response by registered person detailing the actions taken: This was amened on day of inspection to show the times are recorded in accordance with the recommendation by the health care professionals. The manager informed all staff in writing of the need to ensure checks and times are within a max of 2.5 hours. This is also evidenced on the record charts and signed by staff. It is checked as part of the managers audits
Area for improvement 4	The registered person shall ensure that when the needs of a resident

Ref: Standard 6.6 **Stated:** First time **To be completed by:** With immediate effect	have changed, their care records are amended to accurately reflect these changes and any recommendations made by health care professionals. Ref: 6.2
	Response by registered person detailing the actions taken: Staff have been informed by the manager that any changes and recommendations are dealt with immediately and care and support plans amended. This is reviewed as part of the monthly care plan review and documentation audits to ensure compliance. In addition the keyworkers will complete the Keyworker Summary which will also identify changes needed to support plans

Please ensure this document is completed in full and returned via Web Portal

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