Apple Mews
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Armagh
BT61 8AB

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Unannounced Follow up Care Inspection
of
Apple Mews

22 March 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 22 March 2016 from 06.30 to 09.45 hours.

This inspection was undertaken to follow up on the progress made regarding the findings of an unannounced care inspection, 13 January 2016, which was conducted in response to information received by RQIA. The inspection identified serious concerns in regards to:

- early morning rising
- wound/pressure care management
- review of patients assessment of needs

Information and findings from this inspection were shared with the adult safeguarding team of the Southern Health and Social Care Trust (SHSCT) in keeping with regional protocols.

The SHSCT'S safeguarding team are managing the SOVA issues identified and are liaising directly with the homes management. While RQIA are not part of the investigatory process, RQIA have been kept informed at all stages of the investigations by the Trust and will attend multi agency strategy meetings as deemed appropriate. The investigation process remains ongoing at time of writing this report.

The findings of the previous care inspection, 13 January 2016 related specifically to Blossom Cottage. A serious concerns meeting was held with management representatives of Parkcare Homes No2 Ltd and senior management within RQIA on 20 January 2016. Parkcare Homes No2 Ltd provided RQIA with an action plan and assurances to address the concerns raised during the care inspection on 13 January 2016 as a matter of urgency.

During this inspection, the inspector reviewed services and care provided in four out of the five bungalows within Apple Mews; Orchard Cottage; Blossom Cottage; April Cottage and Bramley Cottage.

On the day of this inspection, the concerns and areas of improvement identified from the previous care inspection 13 January 2016 in Blossom Cottage were in the majority addressed and the care in the home was found to be safe, effective and compassionate. The inspection found no significant areas of concern in relation to the areas inspected; however, some areas for improvement are still required and are set out in the Quality Improvement Plan (QIP).

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

A serious concerns meeting was held with management representatives from Parkcare Homes No2 Ltd, 20 January 2016 as previously referred to in section one of this report. At this meeting, it was agreed by RQIA to give Parkcare Homes No2 Ltd a period of time to address the concerns identified. No further actions/ enforcement were required other than those detailed in the previous QIP.

1.2 Actions/Enforcement Resulting from This Inspection

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

Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	*1	*3

*The total number of requirements and recommendations includes one requirement stated for the second time and one recommendation stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with Dawn Rhodie, Registered Manager, and Tim Fitzpatrick, Deputy Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Parkcare Homes No2 Ltd / Mrs Sarah Hughes	**Registered Manager:** Ms Dawn Rhodie
Person in Charge of the Home at the Time of Inspection: Dawn Rhodie Tim Fitzpatrick	**Date Manager Registered:** 28 February 2016
Categories of Care: NH-LD, NH-LD (E)	**Number of Registered Places:** 30
Number of Patients Accommodated on Day of Inspection: Orchard Cottage: 6 Blossom Cottage: 4 & 1 in hospital April Cottage: 6 Bramley Cottage: 6	**Weekly Tariff at Time of Inspection:** £1641 - £2806

3. Inspection Focus

The inspection was undertaken to follow up and assess progress with the concerns raised as during and since the previous inspection on 13 January 2016.

4. Methods/Process

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

Prior to inspection the following records were analysed:

- a review of the action plan submitted following the unannounced inspection 13 January 2016 and the serious concerns meeting 20 January 2016
- a review of written and verbal communication received since the last care inspection
- a review of notifiable events submitted since the last care inspection
- the previous care inspection report and the returned quality improvement plan (QIP) from the previous care inspection

During the inspection, the inspector observed all patients accommodated in the four bungalows inspected. Four registered nurses and seven care staff were consulted.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangement
- training records
- eight patient care records
- a sample review of repositioning charts
- evaluation and feedback

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 13 January 2016. The completed QIP was returned and approved by the care inspector.

Review of Requirements and Recommendations from the Last Care Inspection 13 January 2016

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 15 (2)(b) **Stated:** Third time	The registered person shall ensure that the patient's assessment of need is revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that since the last care inspection the assessment of need record had been reviewed for all patients accommodated in the five bungalows. A sample review of six care records evidenced that the assessment of need record had been reviewed and updated as advised and reflected the patients current needs. This requirement has been met.	

Requirement 2 **Ref:** Regulation 14 (4) Stated: First time	The registered person shall ensure that patients who have made an active choice to rise early (prior to 7 am) are assisted to do so. These decisions must be in the patient's best interest. Care plans should be detailed to include the rationale for this practice and be reviewed at regular intervals.	**Partially Met**
	Action taken as confirmed during the inspection: Since the last inspection, the registered manager advised the home had undertaken a review of all patients in regards to "early morning rising" and care plans had been developed to include a rationale for early morning interventions. In the majority, a review of care records for patients who had been identified to rise early (prior to 07.00) evidenced detailed explanations for this practice, the interventions and care required. Three patients were observed up washed and dressed at this inspection prior to 07.00. A review of care records for two of the three identified patients evidenced a rationale for this early morning rising. However, the care record for the third patient who was observed up washed and dressed at 06.30 did not provide evidence for "early morning rising". Discussions with the registered manager and staff on duty advised that this identified patient rose early on most days between 06.00 and 07.00. A review of the daily progress notes did confirm this information. The patient was observed as very alert and active and content to be up washed and dressed and was mobilising around the bungalow. Despite the actions and assurances as provided by the management team to address the concerns raised previously, the home have still not fully addressed this matter. This requirement has been partially met and will be stated for a second time.	

Requirement 3 **Ref:** Regulation 12 (1)(a)(b) **Stated:** First time	The registered person must ensure that any patients with pressure care /wound management needs, has a care plan for the treatment and care required and all records pertaining to pressure care/wound management are completed, up to date and reviewed as indicated. An urgent actions record was issued.	**Met**
	Action taken as confirmed during the inspection: Pressure care/wound management was reviewed for three patients identified as being at risk from pressure damage or had previous wound and /pressure damage. There were no patients receiving treatment for wounds/pressure damage at this inspection. A review of documentation for one identified patient with previous wound/ pressure damaged evidenced that a care plan and wound chart were completed. Ongoing wound charts were completed each time the wound/ pressure ulcer was redressed, evaluations recorded the progress of the wound and/or if the wound/pressure ulcer had healed. There was evidence that referrals had been made to the Trust tissue viability nurse and advice/ instructions had been adhered to. This requirement has been met.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 23 **Stated:** First time	It is recommended that repositioning charts should contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning and the actual positional change is recorded. Records should reflect the care delivered/not delivered.	**Partially Met**
	Action taken as confirmed during the inspection: A review of repositioning records for two patients evidenced some improvements and progress in recording the required information. However, some repositioning records were incomplete as the charts did not always reflect the actual positional change. A discussion with some care staff indicated a continued lack of knowledge in this area of practice, despite the provision of training for staff since the last inspection. These findings were discussed with the registered manager who agreed to monitor and provide supervision in this regard. This recommendation has been partially met and has been stated for a second time.	
Recommendation 2 **Ref**: Standard 13 Criteria 11 **Stated:** First time	It is recommended that additional training in safeguarding and protection of vulnerable adults is provided for staff appropriate to their role and there is evidence of how the learning has been embedded into practice.	**Met**
	Action taken as confirmed during the inspection: Formal training in safeguarding and protection of vulnerable adults was provided for all relevant staff and 32 attended training on 15 & 17 February 2016. The registered manager advised that all staff working in Blossom Cottage had received supervision following the concerns raised at the previous care inspection. The home had updated the Safeguarding Flow Chart and had also displayed information in all bungalows for staff to access and reference in relation to safeguarding and protection of vulnerable adults. Staff spoken with was knowledgeable of how to recognise types of abuse and how to report any concerns. This recommendation has been met.	

Recommendation 3 **Ref:** Standard 39 **Stated:** First time	It is recommended that training is provided for staff in relation to the prevention of pressure damage based on best practice guidelines.	**Met**
	Action taken as confirmed during the inspection: Formal training in regards to the prevention of pressure damage and wound care has been completed by 35 staff on 15 & 17 February 2016. In addition, training regarding the management of continence care with particular focus on skin care was completed by 55 staff on the 22 February 2016. This recommendation has been met.	

5.3 Additional Areas Examined

5.3.1. Records and Record Keeping

A review of some care records evidenced that registered nurses were not always evaluating care plans accurately and in some cases were not recording meaningful and detailed information. For example, written entries included, “no change” and “condition remains unchanged”. One care record reviewed evidenced recent changes in the patient’s condition in relation to one aspect of care, and the alternative treatment/interventions prescribed however, the care plan evaluation statement recorded “no changes at present”. Additional examples were provided during feedback and the registered manager agreed that these statements were not adequate. A recommendation has been made.

A review of records in one bungalow evidenced that some entries were not contemporaneous in regards to the time of recording. This matter was discussed with the registered manager and staff member at time of inspection who gave assurances this would be addressed. This practice will be monitored at subsequent care inspections.

5.3.2. Individualised Care and Support

A review of a care record for an identified patient evidenced that additional levels of supervision and safety checks were required to ensure the patient’s health and welfare. The care plan provided detailed information regarding the interventions required, however there was no record to evidence that the supervision and safety checks had been completed. This was discussed with the staff on duty who advised that a record had been completed at one stage however, no record was held currently. This was discussed with the registered manager and a recommendation has been made.

5.3.3. Governance

Since the last care inspection, enhanced structures and processes have been put in place to effectively respond to the concerns raised and monitor the quality of nursing and other services provided. The management team have completed three out of hour’s visits and a record was available to evidence the findings and action to be taken. No concerns were raised.

Areas for Improvement

It is recommended that registered nurses ensure that care plans are evaluated using meaningful statements and information and any changes in regards to the treatment and care are recorded accordingly.

It is recommended that a record is developed and maintained for any patient who requires additional levels of supervision and monitoring to ensure that the patients assessed need is met in accordance with their plan of care.

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 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	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 14 (4) Stated: Second time **To be completed by:** 29 April 2016	The registered person shall ensure that patients who have made an active choice to rise early (prior to 07.00) are assisted to do so. These decisions must be in the patient's best interest. Care plans should be detailed to include the rationale for this practice and be reviewed at regular intervals. **Ref Section:5.2**
	Response by Registered Person(s) Detailing the Actions Taken: The resident who rises each morning early has had her care plan updated to reflect this practice. It is noted that this is the residents choice to rise early and to be showered and dressed on rising. The care plans are reviewed regularily.
Recommendations	
Recommendation 1 **Ref**: Standard 23 **Stated:** Second time **To be completed by:** 9 May 2016	It is recommended that repositioning charts should contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning and the actual positional change is recorded. Records should reflect the care delivered/not delivered. **Ref Section: 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Ongoing training and supervision for staff in relation to skin care and documentation. Home Manager audits note a good improvement in the recording of residents positioning.
Recommendation 2 **Ref**: Standard 4 Criteria 7 **Stated:** First time **To be Completed by:** 9 May 2016	It is recommended that registered nurses ensure that care plans are evaluated using meaningful statements and information and any changes in regards to the treatment and care are recorded accordingly. **Ref Section:5.3.1**
	Response by Registered Person(s) Detailing the Actions Taken: Ongoing training and supervision in relation to documentation. Home Managers audits of care plans note a good improvement in the review of care plans.
Recommendation 3 **Ref**: Standard 4 Criteria 9 **Stated:** First time	It is recommended that a record is developed and maintained for any patient who requires additional levels of supervision and monitoring to ensure that the patients assessed need is met in accordance with their plan of care. **Ref Section: 5.3.2**

To be Completed by:	Response by Registered Person(s) Detailing the Actions Taken:
29 April 2016	Review of documented evidence of care plan interventions has taken place. Home Manager cross-checks planned interventions against documented evidence of actual support given.

Registered Manager Completing QIP	Dawn Rhodie	**Date Completed**	17.05.16
Registered Person Approving QIP	 Sarah Hughes	**Date Approved**	23.05.16
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

RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	23 May 2016