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Inspector: Donna Rogan
Inspection ID: IN022067

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Unannounced Care Inspection
of
Cherry Tree House

21 July 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced care inspection took place on 21 July 2015 from 10.00 to 15.30.

The focus of this inspection was to review the previous quality improvement plan (QIP) and to review the governance arrangements as there has been a recent change in the management of the home.

Overall on the day of the inspection, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is meeting the required standards. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to section 1.2 below.

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

For the purposes of this report, the term 'patients' will be used to described those living in Cherry Tree 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 3 February 2015.

1.2 Actions/Enforcement Resulting from this Inspection

An urgent action record to provide an overall management strategy to RQIA in relation to the management of nursing and residential patients was issued to Dr Harron, at the end of the inspection. The action detailed is required to be submitted within seven days to ensure the continuous safety and wellbeing of patients in the home.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	4	3

The details of the Quality Improvement Plan (QIP) within this report were discussed with Dr Dean Harron, registered person and Emeliza Insauriga, acting manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Dean Harron	**Registered Manager:** Emeliza Insauriga (Acting)
Person in Charge of the Home at the Time of Inspection: Josh Nortale (Nurse in charge)	**Date Manager Registered:** 1 July 2015
Categories of Care: NH-LD, RC-I, RC-MP(E), RC-PH(E), NH-I, NH-PH	**Number of Registered Places:** 56
Number of Patients Accommodated on Day of Inspection: 23 residential 30 nursing 1 in hospital	**Weekly Tariff at Time of Inspection:** £470 to £637

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to review the governance arrangements in place due to a recent change in the management of the home.

Correspondence was received on 1 July 2015 from Dr Harron, registered person, informing RQIA that the management arrangements in the home had changed. Dr Harron stated that Emelisa Sauringa was now acting manager of the home and that the independent nurse consultant was no longer in employment to provide support and guidance.

Following discussion with senior management, it was agreed that an inspection would be undertaken to review the following areas:

- review the previous QIP
- review governance and management arrangements
- review the standard of care

4. Methods/Process

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

Prior to inspection the following records were examined:

- 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 returned quality improvement plans (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report

During the inspection, observation of care delivery/care practices and a review of the general environment were undertaken. Approximately 25 patients, the acting manager, two registered nurses, six care staff and three ancillary staff were spoken with. There were no visiting professionals available during the inspection.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP
- the staff duty rota
- two patient care records
- accident/notifiable events records
- statement of purpose
- regulation 29 monitoring reports
- relatives and staff meetings

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 3 February 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last care Inspection 03 February 2015

Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref:** Regulation 24 (3) **Stated:** First time	The registered person shall ensure the record of complaints is more formalised using a systematic approach in keeping with the homes policy and procedure and DHSSPS guidance.	**Met**
	Action taken as confirmed during the inspection: A review of the complaints records evidenced a systematic approach in recording complaints; they were recorded in keeping with the home's policy and procedure and DHSSPS guidance.	

Requirement 2 **Ref:** Regulation 27 **Stated:** First time	The registered person shall ensure the following issues are addressed in relation to the environment: • ensure the identified communal areas in the home are dusted and maintained clean; • ensure patients' seating in the lounge areas are cleaned on a daily basis; • ensure bathrooms are not used for storage; and • ensure cushions are replaced on seating.	**Met**
	Action taken as confirmed during the inspection: A review of the environment evidenced all communal areas to be dusted and maintained clean. Patients' seating was observed to be clean. There was no inappropriate storage observed in the bathrooms. Cushions were observed on all seating.	

5.3 Inspection Findings

5.3.1 Staffing

There were two registered nurses, one senior carer and seven care staff on duty on the morning of the inspection. At 11.30 hours, whilst patients were observed to have had their breakfast, not all were up washed and dressed. The morning medication round for both nursing and residential patients was not completed until 12.10 hours. The lunch time medications were prescribed for 14.00 hours. Staff spoken with informed the inspectors that the routine in the home had changed recently and they were now allocated a certain number of patients to get up in the morning. This included a mix of residential and nursing patients in their allocation. With the exception of a senior carer, there was no designated care staff assigned to direct and supervise the care afforded to the residential residents. As a result, there was no differentiation between patients requiring nursing or residential care. All staff spoken with informed the inspectors that this system was unorganised; staff did not have a routine and they were unable to provide care in a timely way.

An urgent findings letter was issued to the registered person, Dr Harron, to ensure that a management plan/strategy was forwarded to RQIA within seven days in relation to the management of nursing patients and residential residents. RQIA can confirm that a management plan/strategy had been received and the plans received satisfactory. The plan's implementation will be monitored during subsequent inspections.

Confirmation has been received since the inspection, that staffing arrangements have changed to include designated staff for both nursing patients and residential residents.

5.3.2 Governance and management arrangements in the home

An independent nurse consultant had previously been working in the home to provided advice and support on management and day to day operational matters. However, at the time of inspection, this arrangement had ceased. Prior to inspection, RQIA had been informed by Dr Harron, registered person, about the change in management arrangements and that from 1 July 2015, Emelisa Sauringa, who has been working in the home as a registered nurse, had agreed to act as the manager until a permanent manager was appointed. Dr Harron, registered person, confirmed that he is available to support the acting manager on a daily basis.

The permanent staffing arrangements in the home have improved and four new registered nursing staff has been employed since the previous inspection. This should provide more stability and continuity of care in the home. The duty rosters are currently being managed by Angela Wilson, administration manager, who prepares the duty rosters and they are validated by the acting manager, on a weekly basis.

Complaints are recorded as they occur and follow a formal process. The complaints record observed was comprehensive in detail. However the inspectors were concerned that there were common themes reoccurring which involved the personal care of patients. Issues such as nail care and not answering the nurse call system in a timely way were recent issues raised. These issues were recorded as being resolved. However, it is recommended that the complaints record is audited by the registered person during the Regulation 29 monitoring visit to evidence that any patterns or themes are identified and appropriately addressed/actioned. Refer also to section 5.3.3.

Dr Harron visits the home very regularly over several days during the month and very detailed Regulation 29 monitoring reports are available. However, for the purposes of Regulation 29 monitoring visits, it is recommended that the report reflects on one visit to the home to monitor the quality of services. In keeping with Regulation 29, The Nursing Homes Regulations (Northern Ireland) 2005, this visit should be unannounced.

A review of the home's Statement of Purpose did not reflect, in sufficient detail, the services provided and the categories of care the home is registered for. This must be reviewed to include these details. A requirement is made in this regard.

5.3.3 Quality of care

As previously stated, the morning routine was observed to be disorganised and staff informed the inspectors that they felt their deployment of duties were not patient led and in accordance with patient need. Whilst patients were not all dressed by 11.30 hours, the inspectors observed most to have been assisted with personal care. For example, patients had received their breakfast, had their toileting needs tended to and were sitting in the lounge areas or in their bedrooms.

All patients spoken with were complementary of the care they were receiving, stating that staff were attentive, kind, considerate and caring. One patient and one relative spoken with raised the issue that the nurse call bell was not always promptly answered.

All patients, with the exception of one, were observed to be content in their surroundings. The one identified patient who was in need of personal care was observed to sound the nurse call bell. The call bell was not answered in a timely way and the inspectors observed three members of staff go by the patient's room and did not call to check on the patient. The issue was brought to the attention of staff who made arrangements to have the patient's needs tended to. A requirement is made that the nurse call system and records are appropriately maintained and to accurately reflect any action taken, if required.

One infection control issue was identified regarding the replacement of personal protection equipment, (PPE) such as gloves and aprons. The PPE units were observed to require restocking. The registered person stated this task was usually carried out by domestic staff. A recommendation is made that these items are replaced regularly and that regular checks are conducted to ensure sufficient supply at all times.

5.3.4 Care records

Following the observation of care practice during the inspection, two patients' care records were selected for review. The review of one care record focused on wound care management and the second on the elimination needs of a patient.

Evidence was not present that staff were undertaking wound care management in a consistent manner and in accordance with the wound management plan. There was a period of 15 days when there was no recorded evidence to support that the wound had been dressed despite the wound care management plan stating the wound should be dressed every three days. Recording in the patient's progress notes did report on the status of the wound.

The review of the second care record evidenced a care plan in respect of the patient's elimination needs had been prescribed. The care plan was written in a person centred and gave clear information as to how to assist the patient. Observation at the time of inspection did not confirm staff were supporting the patient in accordance with prescribed care.

A requirement has been made to ensure that the care and treatment provided to patients adheres to the patients' prescribed care plans and meets their individual needs.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Dr Harron, 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.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time **To be Completed by: 28 July 2015**	The registered person must ensure that the management strategy plan provided to RQIA is fully implemented so that nursing patients and residential residents are managed in accordance with the relevant DHSSPS Care Standards for Nursing Homes April 2015. **Ref: Section 5.3.1** **Response by Registered Person(s) Detailing the Actions Taken:** Following our letter to the Nursing Home Inspector Ms Donna Rogan on 22nd July 2015, I can confirm that we are currently in the process of relocating Residents with their consent ensuring they are managed in accordance with the relevant Care Standards
Requirement 2 **Ref:** Regulation 6 **Stated:** First time **To be Completed by: 18 August 2015**	The registered person must ensure that the Statement of Purpose is updated to reflect in sufficient detail the services and categories of care provided in the home. **Ref: Section 5.3.2** **Response by Registered Person(s) Detailing the Actions Taken:** Cherry Tree have updated Statement of Purpose including Categories of Care provided in the Home. Please see copy attached.
Requirement 3 **Ref:** Regulation 14 (2) (c) **Stated:** First time **To be Completed by: 18 August 2015**	The registered person must ensure that the nurse call system is evidently monitored and records maintained of the action taken, if required. **Ref: Section 5.3.3** **Response by Registered Person(s) Detailing the Actions Taken:** Staff notice displayed 1st September by Acting Home Manager explaining the importance of answering buzzers promptly. This will be monitored by Nurse In Charge. Ongoing supervisions for all staff in place.
Requirement 4 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time **To be Completed by: 18 August 2015**	The registered person must ensure that the care practice of staff and the care afforded to patients' is in accordance with their assessed needs and wishes and as stated in their care plans. **Ref: Section 5.3.4** **Response by Registered Person(s) Detailing the Actions Taken:** Care Plans will now be available with Residents care records located in there bedrooms to ensure all Care Staff have access to individual Resident care requirements.

Recommendations	
Recommendation 1 **Ref:** Standard 35.6 and 35.7 **Stated:** First time	The registered person should ensure that the Regulation 29 monitoring report is comprehensive and includes for example; auditing of the complaints record, accident and incident records and a review of staffing arrangements in the home. **Ref: Sections 5.3.2, 5.3.3 and 5.3.4**
To be Completed by: **18 August 2015**	**Response by Registered Person(s) Detailing the Actions Taken:** The Registered Provider will liaise with the Home Manager to ensure audits for the Complaints, Accidents and Incidents are up to date before completing the Regulation 29 each month. A review of staffing arrangement will be recorded detailing staffing levels and occupancy
Recommendation 2 **Ref:** Standard 35 **Stated:** First time	The registered person should ensure that the Regulation 29 monthly monitoring report reflects on one visit to the home to monitor the quality of services. **Ref: Section 5.3.2**
To be Completed by: **18 August 2015**	**Response by Registered Person(s) Detailing the Actions Taken:** The Registered Provider will follow this instruction.
Recommendation 3 **Ref:** Standard **Stated:** First time	The registered person should ensure that all protective personal equipment items are replaced regularly and that regular checks are conducted to ensure sufficient supply at all times. **Ref: Section 5.3.3**
To be Completed by: **18 August 2015**	**Response by Registered Person(s) Detailing the Actions Taken:** The Registered Provider has assigned the Domestic Supervisor to ensure all protective personal equipment items are replaced regularly and that regular checks are conducted to ensure sufficient supplies at all times.

Registered Manager Completing QIP	Mrs Emeliza Insauriga	**Date Completed**	02/09/2015
Registered Person Approving QIP	Dr DWG Harron	**Date Approved**	02/09/2015
RQIA Inspector Assessing Response	**Donna Rogan**	**Date Approved**	**03/09/2015**

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