Unannounced Enforcement Compliance Inspection Report
05 January 2017

The Court Care Home

Type of Service: Nursing Home
Address: 1a Queens Avenue, Ballymoney, BT53 6DF
Tel no: 028 2766 6866
Inspector: Sharon Loane & Lyn Buckley

1.0 Summary

An unannounced enforcement compliance inspection of The Court Care Home took place on 05 January 2017 from 10.00 to 15.30 hours.

The purpose of the inspection was to assess the level of compliance achieved by the home regarding the two failure to comply notices issued on 3 November 2016. The areas for improvement and compliance with regulation were in relation to governance arrangements (FTC/NH/1451/2016-17/01) and the quality of nursing care (FTC/NH/1451/2016-17/02). The date for compliance with the notices was 5 January 2017.

FTC Ref: FTC/NH/1451/2016-17/01

Evidence was available to validate full compliance with the above failure to comply notice.

FTC Ref: FTC/NH/1451/2016-17/02

Evidence at the time of inspection was not available to validate full compliance with the above failure to comply notice. However there was evidence of some improvement and progress made to address the required actions within the notice. Following the inspection, RQIA senior management held a meeting on 6 January 2017 and a decision was made to extend the compliance date up to the maximum legislative timeframe of 90 days. Compliance with the notice must therefore be achieved by 4 February 2017.

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

The findings of this inspection were discussed with Louisa Rea, regional manager, Louise McIlrath, registered manager and Claire Wilkinson; recently appointed manager, as part of the inspection process.

Enforcement action is ongoing as a result of 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 27 October 2016.

Following the inspection, the registered persons were required to attend a meeting at RQIA, with the intention of issuing two failure to comply notices in regards to governance arrangements and the quality of nursing care. This meeting was held on the 2 November 2016. The registered person; Dr Maureen Claire Royston was unable to attend the meeting and nominated the Resident Experience Regional Manager, Ruth Burrows, to attend on her behalf. The regional manager, Louisa Rea also attended the meeting.

Following discussion with the above persons RQIA were not fully assured that the actions discussed had been sufficiently embedded into practice: and given the potentially serious impact on patient care a decision was made that two failure to comply notices under The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 10 (1), in relation to governance arrangements and Regulation 12 (1) (a) and (b), in relation to the quality of nursing care would be issued.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons (No 11) Limited/Dr Maureen Claire Royston	**Registered manager:** Mrs Louise McIlwrath
Person in charge of the home at the time of inspection: Mrs Louise McIlwrath	**Date manager registered:** 03 April 2013
Categories of care: NH-DE, NH-D, NH-PH A maximum of three persons in category NH-PH. A maximum of 14 patients in category NH-DE to be accommodated in the dementia unit	**Number of registered places:** 45

3.0 Methods/processes

Prior to inspection we analysed the following records:

- the requirements as indicated in the failure to comply notices
  FTC Ref: FTC/NH/1451/2016-2017/01
  FTC Ref: FTC/NH/1451/2016-2017/02
- the registration status of the home
- written and verbal communication received by RQIA since the last care inspection
- the previous care inspection report
- the returned QIP from the previous care inspection
- notifications received since 27 October 2016.

The following methods and processes used in this inspection include the following:

- discussion with the regional manager, registered manager and proposed registered manager
- discussion with staff
- discussion with patients
- a review of quality audits

- review of monthly monitoring reports for November and December 2016 in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- review of three patient care records
- review sample of patients' supplementary care records such as food and fluid intake charts and/or repositioning charts.

The inspectors observed the majority of patients who were either resting in bed and/or seated in one of the day lounges. Two registered nurses and a sample of five care staff on duty, the activities co-ordinator and two ancillary staff were consulted.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 27 October 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. The QIP was not validated during this inspection due to the enforcement compliance focus. The requirements and recommendation have been carried forward for validation at a future care inspection.

4.2 Inspection findings

4.2.1 FTC Ref: FTC/NH/1451/2016-2017/01

Notice of Failure to Comply with Regulation 10 (1) of The Nursing Homes Regulations (Northern Ireland) 2005

The registered provider and the registered manager shall, having regard to the size of the nursing home, the statement of purpose, and the number and needs of the patients, carry on or manage the nursing home (as the case may be) with sufficient care, competence and skill.

In relation to this notice the following three actions were required to comply with this regulation.

- The registered person must ensure, sufficiently robust auditing systems, are in place to quality assure the delivery of nursing and other services provided. This includes, but is not limited to: care records; wound care; nutrition and weight loss. Records regarding the completion of these quality assurance audits must be available for inspection by RQIA.
- The registered person must ensure that a detailed and comprehensive monthly monitoring report is maintained in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. Clear action plans, detailing all areas of improvement should be developed and monitored to ensure compliance.
- The registered person must ensure that all notifiable events are reported to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with management and a review of information evidenced that systems and processes had been implemented as required by the failure to comply notice. A number of audits had been undertaken since the last care inspection, these included; care records, wound care, patients' weight and nutritional management, and accident and incidents. A review of the audits evidenced that an action plan had been developed for areas of improvement and/or required actions. There was also evidence that the areas for improvement had been re-audited to check compliance and quality assurance.

A discrepancy was noted in an audit completed in regards to patients' weights. The information recorded did not accurately reflect the information documented in one patient's care record. Following discussion and review of additional information it was evident that this discrepancy was attributed to a recording error made within the auditing record. Given the discussion with management and the level of improvement noted in regards to this action, we were satisfied that this was a minor error of recording.

Monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, completed for November and December 2016 were reviewed. The reports were completed by the regional manager for the home on behalf of the responsible person. The reports reviewed were detailed and informative and included an action plan for areas of improvement across all areas examined. There was evidence that these actions had been reviewed by the regional manager during subsequent visits to ensure appropriate actions had been taken by the registered manager to ensure compliance.

A review sample of accident and incident reports recorded since the last care inspection evidenced that RQIA were notified appropriately in accordance with Regulation 30 of the Nursing Homes Regulations, Northern Ireland (2005).

The actions required to comply with regulations as stated within the failure to comply notice FTC/NH/1451/2016-2017/01 were evidenced to have been met in full.

4.2.2 FTC Ref: FTC/NH/1451/2016-2017/02

Notice of Failure to Comply with Regulation 12 (1) (a) (b) of The Nursing Homes Regulations (Northern Ireland) 2005

The registered person shall provide treatment, and other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and other services provided to each patient –

(a) meets his individual needs;
(b) reflects current best practice;

In relation to this notice the following nine actions were required to comply with this regulation.

- The registered person must ensure that patients' assessment of needs, including risk assessments are completed and updated regularly, to reflect the needs of the patient and inform the care planning process.
- The registered person must ensure that care plans are established to guide and inform the delivery of care.
- The registered person must ensure that care plans fully reflect any instructions from the multi professional team and that these are implemented accordingly.

- The registered person must ensure that patients' weights are monitored and evaluated, in accordance with their care plans and level of risk. Subsequent action taken in response to any identified deficits should be clearly recorded in the patient's individual care records.
- The registered person must ensure that supplementary care records such as food and fluid charts and repositioning charts are maintained accurately, and evidence the subsequent action taken in response to any identified deficits.
- The registered person must ensure that patient repositioning charts are accurately maintained and reflect the care plan requirements for wound and/or pressure care management.
- The registered person must ensure registered nurses evaluate the effectiveness of care delivered, in regards to the management of wounds, nutrition and weight loss. This information must accurately inform the patient's daily progress notes.
- The registered person must ensure that registered nurses liaise with members of the multi professional team on an ongoing basis to ensure patients health and welfare.
- The registered person must ensure that care records in relation to wounds, nutrition and weight loss are maintained in accordance with professional standards and guidelines.

A review of three care records evidenced that patient assessment of needs, including risk assessments had been completed, reviewed and/or updated in response to the changing needs of patients. Care plans reviewed accurately reflected the outcomes of risk assessments completed.

A review of three care records identified that the majority of care plans were established to guide and inform the delivery of care. However some shortfalls were identified as follows. A review of one care record pertaining to the management of "weight loss" identified that the care plan had not been developed when the actual weight loss was first identified. The identified delay was 14 days.

The care plan reviewed also indicated that referrals should be made to the General Practitioner and/or Dietician however; there was no evidence within the records examined that these instructions had been actioned. During discussion, management presented additional evidence held within the nursing diary and the DATIX incident / accident record. It was evident that, action had been taken by nursing staff in response to the patient's weight loss. A satisfactory explanation was also provided, by the deputy manager and registered manager as to why referrals had not been made, as indicated in the care plan. Although the management team provided inspectors with additional information to illustrate that actions had been taken, none of the information provided was recorded in the patient's care record. Furthermore, despite the provision of this additional information there was still a delay between the identification of the patient's weight loss and follow up actions. This shortfall was acknowledged and accepted by the management team.

A second care record reviewed in regards to the management of wounds and/or pressure damage evidenced that nursing staff continued to record the delivery of care and treatment for a wound that had actually healed. The care plan in place was no longer relevant to the patient's current needs and should have been discontinued and a new care plan implemented that was appropriate to the level of risk identified.

Whilst the review of the care records aforementioned evidenced some improvement and progress, the improvement was not consistent across all records reviewed.

As previously referenced a review of two care records pertaining to wound and/or pressure management evidenced that care plans were available and identified the treatment actions required in accordance with the Tissue Viability Nurse (TVN) and/or Podiatry assessments. A review of a sample of wound assessment charts and associated documentation evidenced that the dressing regimes had been adhered to and were recorded in line with best practice guidelines.

A review of information evidenced that patients' weights were being monitored and recorded accordingly. Records reviewed identified any weight loss and/or gain and in most instances the subsequent actions taken. However, as previously discussed, a review of records for one patient identified with weight loss evidenced that there was a significant delay in the development of a care plan to address the patients' weight loss.

A sample review of food and fluid intake charts evidenced some improvement; however the improvement was not consistent across all records reviewed. Records reviewed reflected meals and fluids refused. There was evidence that the 24 hour fluid intake received was totalled although some of the calculations were inaccurate. However, following review of patients' progress notes there was limited evidence to demonstrate what actions, if any, had been taken by nursing staff when fluid and/or food intake was inadequate. This is discussed further below as part of another action reviewed.

A review of repositioning records for an identified patient evidenced that the repositioning schedule was carried out as directed in the patient's care plan. All records reviewed were maintained to a satisfactory standard and reflected best practice guidelines.

Although there was significant improvements noted in regards to the management and recording of repositioning of patients; these improvements were not consistent in regards to records reviewed in relation to food and fluids.

The review of care records evidenced that registered nurses were not evaluating the effectiveness of care delivered consistently across all areas examined.

As previously discussed, there was still insufficient evidence to demonstrate that registered nurses were monitoring and evaluating care and treatment in relation to the management of food and fluids. Records reviewed indicated that registered nurses on night duty recorded the previous 24 hours fluid intake. However, there was no evidence available to demonstrate that registered nurses on day duty had monitored and /or taken any action to address fluid intake deficits. This process meant that timely actions were not being taken to address identified deficits. A registered nurse on duty advised inspectors that at 15.00 hours each day, care staff met to discuss patients' progress and any relevant information regarding their care and condition. Food and fluid intake formed part of these discussions. However, this information was not reflected in patients' care records.

Furthermore, registered nurses were not recording information in the daily progress notes to demonstrate if the actual fluid intake was appropriate or what actions had been taken when fluid intake was inadequate. A care plan reviewed, for one patient, identified that the General Practitioner (GP) was to be contacted if a fluid deficit was evidenced over a three day period. However, this patient's fluid intake records identified a fluid intake deficit over a consecutive 11 day period. There was no evidence that registered nurses had taken any actions to address these deficits despite the interventions recorded in the patient's care plan. This was concerning as it had the potential to impact negatively on the patients well-being.

A review of weight monitoring records evidenced that this patient had an approximate weight loss of 4kg within a short timeframe. The daily progress notes completed when the weight loss was identified did not reflect this information. Other examples were provided in detail to the management team during feedback.

A review of care records evidenced that registered nurses had liaised with members of the multi professional team on an ongoing basis to ensure patients health and welfare. These included referrals and communications with Tissue Viability Nurses (TVN); Dietician; Speech and language Therapist (SALT) and the General Practitioner.

A review of care records pertaining to the management of wounds evidenced that the majority of these were completed appropriately and in line with professional standards and guidelines. Improvement was required in the standard of recording in relation to nutrition and weight loss.

The findings of the inspection and evidence available confirmed that not all actions detailed within the failure to comply notice had been met. There was evidence available to confirm that some progress had been made toward achieving compliance and the above notice was extended with a compliance date of 4 February 2017.

4.2.3 Management arrangements

At the commencement of the inspection Louisa Rea, regional manager, advised that the registered manager, Louise McIlrath, had resigned her position and was currently working her notice period through to the end of February 2017. Claire Wilkinson had been appointed as home manager and was in the process of receiving an induction/handover. The expectation was that by end of week commencing 9 January 2017, the new management arrangements would be effective and Claire Wilkinson would be in day to day operational control of the home. RQIA can confirm that the appropriate documentation has been received in regards to this matter**.**

Conclusion

The actions required to comply with regulations as stated within failure to comply notice FTC/NH/1451/2016-2017/01 were evidenced to have been met in full.

Evidence at the time of inspection was not available to validate full compliance within failure to comply notice FTC/NH/1451/2016-2017/02. However there was evidence of some improvement and progress made to address the required actions within the notice. Following the inspection, RQIA senior management held a meeting on 6 January 2017 and a decision was made to extend the compliance date of the notice up to the maximum legislative timeframe of 90 days. Compliance with the notice must therefore be achieved by 4 February 2017.

The Regulation and Quality Improvement Authority

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