Unannounced Care Inspection Report
03 May 2017

Ashgrove

Type of service: Nursing Home
Address: 55 Belfast Road, Newry, BT34 1QA
Tel no: 028 3026 9110
Inspector: Donna Rogan

1.0 Summary

An unannounced inspection of Ashgrove Care Home took place on 3 May 2017 from 09.15 to 17.10 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led. On the day of inspection patients, relatives and staff spoken with generally commented positively in regard to the care in the home. A review of records, discussion with the deputy manager and staff and observations of care delivery evidenced that the areas for improvement identified during the previous inspection had been complied with. Refer to section 4.2.

Is care safe?

There were areas of good practice identified throughout the inspection in relation to; staff induction, training and development; adult safeguarding arrangements; and risk management.

Areas for improvement were identified in relation to the provision and availability of selection and recruitment files for inspection. A requirement was made.

Is care effective?

There were examples of good practice found throughout the inspection in relation to the care records, review of care delivery and effective communication systems.

Areas for improvement were identified in relation to the locking of patients' doors and the management of mealtime choices. Two recommendations were stated.

Is care compassionate?

There were examples of good practice found in relation to the culture and ethos of the home, treating patients with dignity and respect. A number of comments from the consultation process and the returned questionnaires are included in the main body of the report.

There was one area of improvement identified in the delivery of compassionate care this is in regards to management considering the comments made by patient, staff and relatives and addressing them where necessary.

Is the service well led?

There was evidence of good practice identified in relation to governance and management arrangements; management of complaints and incidents; quality improvement and maintaining good working relationships.

An area for improvement was identified regarding the inclusion of the registered manager's hours on the duty rotas. A recommendation was made.

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	1	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Lisa Preece, deputy manager on the day of inspection and via telephone with Jolly Joseph, registered manager, the following day 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 finance inspection undertaken on 25 January 2017. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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 Healthcare Maureen Claire Royston	**Registered manager:** Jolly Joseph
Person in charge of the home at the time of inspection: Lisa Preece, deputy manager	**Date manager registered:** 17/08/2016
Categories of care: NH-DE	**Number of registered places:** 52 All 52 residents accommodated shall be assessed as DE

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 returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

A poster was displayed in the home, inviting feedback from patients and their representatives. During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken.

Questionnaires were distributed to ten patients, eight relatives and ten staff. We also met with eighteen patients; five care staff; two registered nurses; one domestic staff and three patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- staff training records for 2016/2017
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 25 January 2017

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 27 June 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 12 (4) **Stated:** First time	The registered persons must ensure that the management of meal times are reviewed and that meals are served in a timely way to meet the needs of the patients. Following the review if additional staff are required to meet the needs of the patients this should be accommodated.	**Met**

	Action taken as confirmed during the inspection: Observation of how meals were served in both units evidenced that patient's needs were attended to in a safe, effective and compassionate manner. The deputy manager confirmed that the the management of mealtimes had been reviewed. Registered nursing staff had responsibility for overseeing the provision of all meals to patients throughout the day. A recommendation was made in relation to patient choices during meal times. Please refer to section 4.4 for further detail.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 43.11 **Stated:** First time	The registered persons should ensure that the planned works to the outer grounds area is completed as planned.	**Met**
	Action taken as confirmed during the inspection: The outer ground works had been completed as planned.	
Recommendation 2 **Ref**: Standard 21 **Stated:** First time	The registered persons should ensure that wound care records are supported by the use of photography in keeping with the home's policies and procedures and the NICE guidelines.	**Met**
	Action taken as confirmed during the inspection: A review of care records of patients identified as having wounds evidenced that the records were supported by the use of photography.	

4.3 Is care safe?

The manager confirmed that the planned daily staffing levels for the home were generally adhered to and that these levels were determined by the dependency levels of patients using the Care Home Effective Support Service (CHESS) assessment tool, developed by Four Seasons Healthcare. A review of the staffing rota for week commencing 1 May 2017 to 14 May 2017 evidenced that the planned staffing levels were generally adhered to. Discussion with patients and their representatives evidenced that there were no concerns regarding staffing levels. However, three staff, four patients and one relative expressed concern in relation to the staffing levels in the returned questionnaires. Details of the comments can be viewed in section 4.5.

Staff recruitment information was not made available for inspection. The deputy manager stated that the administrator and registered manager are the only two members of staff with access to this information. A requirement was made to ensure that all records required under legislation are made available upon request during an inspection.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Inductions were also completed for agency staff members.

There were systems in place to monitor staff performance and to ensure that staff received support and guidance. This included mentoring through one to one supervision; competency and capability assessments and annual appraisals. Group supervisions were also conducted with care staff in relation to learning opportunities. This is commendable practice. Following discussion with the registered manager it was established that individual supervision for care staff is planned for the near future.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Discussion with staff and a review of staff training records confirmed that training had been provided in the majority of areas and this was kept up to date. A review of staff training records evidenced that staff completed e-learning (electronic learning) modules on basic life support; medicines management; control of substances hazardous to health; fire safety; food safety; health and safety; infection prevention and control (IPC), safe moving and handling and adult prevention and protection from harm.

The records reviewed confirmed that the majority of staff had, so far this year, completed the home's mandatory training. Overall compliance with training was monitored by the registered manager and this information informed the responsible person's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the deputy manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

The deputy manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The staff spoken with understood what constituted abuse and how they should report any concerns they had. There are no been no incidents of staff misconduct recorded. There were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and were reviewed as required. There was evidence that risk assessments informed the care planning process. A review of the accident and incident records confirmed that falls risk assessments and care plans were generally completed following each incident and that care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm and clean throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items.

Fire exits and corridors were observed to be clear of clutter and obstruction. There was a fire risk assessment in each patient's care record; this related to the bedroom risk assessment and included the level of assistance each patient required in the event of the building needing to be evacuated in an emergency. IPC measures were generally adhered to.

Areas for improvement

One area for improvement was identified in relation to the provision of selection and recruitment records being made available for inspection.

Number of requirements	1	Number of recommendations	0

4.4 Is care effective?

A review of six patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process. Care records accurately reflected the assessed needs of patients; were kept under review and included input from patients and/or their representatives, if appropriate. There was also evidence of regular communication with representatives within the care records.

Areas of good practice related to the management of wound care and pressure ulcers. Protocols for managing wound care and pressure ulcers were included in the care record alongside the care plan. Care plans had also been developed in response to acute infections, for which patients' required antibiotic therapy. Some patients required a modified diet due to swallowing difficulties. Staff were aware of the SALT recommendations and this information was included in the care plan. Staff were also observed to implement care in keeping with the care planning process. There was also a system in place to monitor the weights of patients who were at risk of weight loss.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Supplementary care records were noted to accurately reflect prescribed care and were reviewed regularly.

Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff on duty confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. However, three of the staff questionnaires returned stated that information provided at the handover meeting was insufficient. See section 4.5 for details of comments made.

All those consulted with expressed their confidence in raising concerns with the home's staff/ management. The records reviewed confirmed that staff meetings were held on a regular basis and minutes were available. A meeting had been held with registered nurses on 16 February 2017 and a general staff meeting was held on 16 February 2017. The registered manager also obtained feedback from three patients on a weekly basis, to ascertain their views on the home. Each quarter had a different focus, such as the environment; housekeeping; the social life in the home; and the dining experience.

A vast majority of bedroom doors in both units of the home were observed to be locked. Staff stated that the reason for locking the doors was to prevent other patients walking into the bedrooms and taking items belonging to other patients. Following discussion with the deputy manager it was agreed that this issue should be managed in accordance with individual patients' needs. Preventative diversional measures other than blanket restrictive practice such as locking most bedroom doors should be considered and used in accordance with best practice. A recommendation was made in this regard.

A review of the lunch time meal evidenced improvement in the dining experience in the Clanrye Unit of the home. Staff were observed to serve meals and assist patients in accordance with their individual nutritional needs. Registered nursing staff were observed to guide and manage patients' nutrition.

In the Carlingford suite the lunchtime meal was also found to be organised and meals were served in a timely manner and in accordance with patients' individual nutritional needs. However, deficits were identified in relation to the serving of the lunch time meal. Staff did not routinely offer patients alternative meal choices and patients were not afforded the opportunity to accept or decline sauces such as gravy with their meals. Dining tables also lacked available condiments for patients to use. Choices were not actively offered to patients; for example, all patients who required their meals softened or pureed were provided with a pork dinner, they were not offered the second choice on the menu which was chicken. All patients who required a normal diet were provided with a chicken dinner and were not offered the alternative, pork as a choice. Choices such as gravy and the choices of condiments were not provided at the serving of the meal. All meals were readily plated prior to them arriving to the dining room. All meals served already had gravy poured on them. A recommendation is made that choices are provided and readily available for patients at the point of serving the meal.

Areas for improvement

Two areas for improvement were identified during in relation to the locking of patients' bedroom doors and the provision of choices at meal times.

Number of requirements	0	**Number of recommendations**	2

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients stated that they were afforded choice and privacy; dignity and respect; and that the staff spoke to them in a polite manner. Patients stated that they were involved in decision making about their own care. For example, a review of one patient care record evidenced that the patient's gender preference of carer had been included in their care plan. Another patient had their preference for having a weekly shower included in their care plan. However, one patient's relative stated that the patient's expressed preference for the provision of personal care only by female staff was not always adhered to. This was discussed during feedback and the deputy manager agreed to ensure that this request was implemented.

We observed the lunchtime meal in both dining rooms. We observed that the atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set with tablecloths and specialist cutlery; plate guards were available alongside specialised crockery in order to promote the independence of patients. The lunch served appeared appetising and patients spoken with stated that it was always very nice. As previously stated in section 4.4 a recommendation is made that alternative meal choices should be offered during the serving of meals.

Patients who could be consulted with confirmed that they were able to maintain contact with their families and friends. They confirmed that staff supported them to maintain friendships and socialise within the home. There was a dedicated staff member employed to provide activities in the home. Patients consulted with confirmed that there were always different activities they could participate in.

An electronic feedback system was situated in the reception area. This was available to patients, relatives and other visitors to give general feedback. The deputy manager confirmed that there was also another electronic tablet around the home that patients could use to provide feedback. All comments provided had been positive. A comprehensive annual quality audit from the previous year was also reviewed.

At the time of the inspection no one was receiving end of life care. Care plans detailed the 'do not attempt resuscitation' (DNAR) directives for patients, where appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met.

From discussion with the deputy manager, staff, relatives and a review of the compliments record, there was evidence that staff cared for the patients and the relatives in a compassionate manner. We read some recent feedback from patients' representatives. All comments were positive regarding the services provided.

During the inspection, we met with 18 patients, five care staff, two registered nurses, one domestic staff and three patients' representatives. Seven out of 10 staff questionnaires were returned; six of 10 patient questionnaires were returned and three out of eight relatives' questionnaires were returned in time for their comments to be included in the report. Some comments received during the inspection and in the returned questionnaires are detailed below:

Staff

"I think we work very well as a team."
"I really enjoy working here - it is very rewarding."
"I don't think there is enough individual staff supervision."
"The care is good; I would have no hesitation in having my relative placed here."
"We are well trained and we have a good induction."
"It would be better if we were trained with someone coming in to show us."
"The handover meeting only lasts five minutes; some staff are very bad at communication."
"We have had two staff meetings in the last year, we keep fighting for more but it is not happening."
"When I work I feel very overwhelmed and stressed, I feel I am doing the work of three people."
"Sometimes we can be short staffed."
"Don't see the manager most days; no regular meetings; no notes of meetings shared. The manager is always very busy."

Patients

"I am happy here."
"I enjoy the food."
"Staff are good to me."
"I couldn't complain."
"Staff are kind and helpful."
"I never see the manager; staff are very busy and overworked."
"Not enough staff have the time to listen to me."
"Staff are constantly busy - 'give me two minutes' is all I hear."
"Manager has never introduced herself to me."

Patients' representatives

"I think Ashgrove is great; everyone is so kind to my …."
"I feel I am kept very well informed."
"I have no worries when leaving my …. in the care of the staff."
"I feel at times staff are under pressure as some patients require a lot of help."
"If I have concerns or complaints I will go to the staff nurse on duty, I find they always listen."
"Some of the younger staff needs to be trained in dementia care."

A recommendation is made that the comments made by staff, patients and their representatives are considered and are addressed.

Areas for improvement

One area for improvement was identified in relation to staff, patient and relatives' comments made during the inspection and in the returned questionnaires. A recommendation is made.

Number of requirements	0	Number of recommendations	1

4.6 Is the service well led?

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff described the registered manager mainly in positive terms; comments included "she is great, very approachable." However, two members of staff and two patients stated in the returned questionnaires that, "the manager was always very busy", and that, "there was a lack of staff meetings". As previously stated, a recommendation is made to address issues raised.

Staff were able to identify the person in charge of the home, in the absence of the registered manager. A deficit was identified relating to the registered manager's working hours not being included in the duty rota. A recommendation was made that the registered manager's hours are included in the duty roster to ensure that staff are aware of when the registered manager is available.

Discussion with the deputy manager and staff evidenced that there was clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities.

Discussion with the deputy manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the deputy manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure.

Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. We examined the log of complaints and could see that issues raised had been taken seriously and had been investigated and responded to.

The deputy manager confirmed that there were systems and processes in place to ensure that urgent communications such as medication/equipment and Chief Nursing Officer (CNO) alerts were reviewed and where appropriate, made available to appropriate staff in a timely manner. There was also evidence that the systems in place had been consistently updated.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous inspection confirmed that these were appropriately managed.

Discussion with the deputy manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. The home also has an electronic governance system which includes Thematic Resident Care Audits ("TRaCAs"). Information in areas, such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This system is designed to support the "find and fix" approach. The deputy manager was able to evidence that a small number of 'linked actions' remained outstanding from the TRaCA audits as they were still in progress.

A review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. The monthly quality monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. Discussion with the deputy manager and a review of relevant records evidenced that all areas identified in the action plan were progressing or had been addressed.

Areas for improvement

One area for improvement was identified in relation to the provision of the registered manager's working hours on the duty roster

Number of requirements	0	**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 Lisa Preece, deputy manager on the day of inspection, and via telephone with Jolley Joseph, registered manager, the following day 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 web portal 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 19 (2) (b) **Stated:** First time **To be completed by:** 30 May 2017	The registered persons must ensure that all records required to be retained within the home are made available for inspection. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: All records will continue to be available for inspection, however if the Home Manager and Administrator are not on site (which is exceptional) then personnel files will not be available for viewing due to the sensitive information held in same. The company must insist that in the interests of protecting the confidentiality of its employess (much like the confidentiality of its residents), staff files will only ever be shared when an appropriate person is available to grant access. whilst arrangements will always be made to accommodate this requirement, wherever possible (an in keeping with the Company's policies); it is inevitable that there will be unavoidable instances when this is not possible. The company will continue to ensure compliance on this matter, and would request your co-operation going forward.
Recommendations	
Recommendation 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 19 June 2017	The registered persons should ensure preventative diversional measures other than the blanket restrictive practice such as locking most bedroom doors should be considered and used in accordance with best practice. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: The identified issue has been discussed with all staff and it will closely monitored by the Home manager. Any resident who wishes to have their bedroom locked will have this documented in their care plan.
Recommendation 2 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 30 May 2017	The registered persons should ensure that patient choice and independence is promoted during the serving of all meals. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Residents are offered choices from the menu daily and this is recorcded on the meal choice form. The cook / assistant cook is also present to serve meals in the dining rooms and choice if offered again at point of service
Recommendation 3 **Ref**: Standard 7	The registered persons should ensure that the comments made by staff, patients and their representatives are considered and are addressed accordingly.

Stated: First time **To be completed by:** 19June 2017	**Ref: Section 4.5** **Response by registered provider detailing the actions taken:** Comments raised have been discussed with staff at a staff meeting and action taken as needed. A relative meeting is to be scheduled were issues will be raised and addressed as needed.
Recommendation 4 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 30 May 2017	The registered persons should ensure that the registered manager's working hours are included on the duty roster to ensure that staff are aware of when the registered manager is available in the home. **Ref: Section 4.6** **Response by registered provider detailing the actions taken:** The Home managers working hours are recorded on the duty roster and retained within the duty roster file

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