Unannounced Care Inspection Report
15 May 2018

Ashbrook Care Home

Type of service: Nursing Home
Address: 50 Moor Road, Coalisland, Dungannon, BT71 4QB
Tel no: 028 87741010
Inspector: Gerry Colgan

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 59 persons.

3.0 Service details

Organisation/Registered Provider: Ashbrook Home Ltd **Responsible Individual:** Marcus James Mulgrew	**Registered manager:** Gillian Larmour
Person in charge at the time of inspection: Gillian Larmour	**Date manager registered:** 26 July 2016
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment. Residential Care (RC) I – Old age not falling within any other category.	**Number of registered places:** 59 consisting of NH-PH, NH-DE, NH-MP(E), NH-I A maximum of 19 patients in category NH-DE, a maximum of 1 patient in category NH-PH and category NH-MP(E) for 1 identified patient only.

4.0 Inspection summary

An unannounced inspection took place on 15 May 2018 from 08.45 to 16.30 hours.

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.

The inspection assessed progress with any areas for improvement identified 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.

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, risk management and the home's environment, particularly the dementia unit. There were also examples of good practice found in relation to communication between residents, staff and other key stakeholders, the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives, taking account of the views of patients, management of complaints and incidents and maintaining good working relationships.

Areas for improvement were identified under the standards in relation to care records and governance processes which focus on quality assurance and service delivery.

Patients described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. There was evidence that the management team listened to and valued patients and their representatives and taking account of the views of patients.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	*4

*The total number of areas for improvement includes one under the standards which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Gillian Larmour, registered manager, and Marcus James Mulgrew, registered person, 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.

4.2 Action/enforcement taken following the most recent inspection dated 20 November 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 20 November 2017.

There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

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

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with 20 patients, 12 staff, and two patients' visitors/representatives. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was provided which directed staff to an online survey and staff not on duty during the inspection.

The following records were examined during the inspection:

- duty rota for all staff from 7 May 2018 to 21 May 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- three staff recruitment and induction files
- five patients' care records
- five patients' care charts including food and fluid intake charts and repositioning charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 20 November 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 30 May 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 15 (2) (a) and (b) **Stated:** First time	The registered persons must ensure that risk assessments are reviewed in response to patients' changing needs. This refers specifically to pressure risk assessments, which must be reviewed when skin damage has been reported; and in relation to pain assessments.	**Met**

	Action taken as confirmed during the inspection: A review of documentation and conversation with the registered manager confirmed that risk assessments were reviewed in response to patients' changing needs, specifically, pressure risk assessments and pain assessments.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	The registered persons should review the system for recording the delivery of oral hygiene to patients, to ensure that it is delivered in keeping with the care plan. This refers particularly to patients who are nil by mouth and require specialist care intervention.	**Met**
	Action taken as confirmed during the inspection: A review of documentation confirmed that systems were in place to record the delivery of oral hygiene to patients in keeping with the relevant care plan. Care plans had been enhanced to include specific directions in relation to those patients who were nil-by-mouth.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered persons should ensure that care plans are developed and reviewed in response to acute infections.	**Not met**
	Action taken as confirmed during the inspection: Although a review of care records did confirm that care plans were in use to indicate when patients were at risk of developing an acute infection, there were no person centred care plans which reflected those patients receiving antibiotic therapy for current infections. This area for improvement has not been met and has been stated for a second time.	
Area for improvement 3 **Ref**: Standard 7 **Stated:** First time	The registered persons should ensure that patients' and relatives' meetings are carried out on a regular basis.	**Met**
	Action taken as confirmed during the inspection: A review of minutes and conversation with the registered manager confirmed that patient and relatives meetings were carried out on a regular basis.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of patients were met. A review of the staffing rota from 7 May to 21 May 2018 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of patients and to support nursing and care staff. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients' needs in a timely and caring manner. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of patients. Two relatives spoken with did not raise any concerns regarding staffing levels.

Review of three staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work. 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.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the Nursing and Midwifery Council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC). There were systems and processes in place to ensure that alerts issued by Chief Nursing Officer (CNO) were managed appropriately and shared with key staff.

We discussed the provision of mandatory training with staff and reviewed staff training records. Staff confirmed that they were enabled to attend training and that training provided them with the necessary skills and knowledge to care for patients. Training records were maintained in accordance with Standard 39 of the Care Standards for Nursing Homes, 2015. Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager and staff confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

Review of five patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

We reviewed accidents/incidents records from the previous care inspection in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the registered manager and review of records confirmed that on a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. Following this review an action plan was devised to address any identified deficits. This information was also reviewed as part of the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. From a review of records, observation of practices and discussion with the registered manager and staff there was evidence of proactive management of falls.

A review of the home's environment was undertaken and included observations of most of the bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. The 19 bed area for patients with dementia evidenced a high standard throughout. Patients/representatives/staff spoken with were complimentary in respect of the home's environment. Fire exits and corridors were observed to be clear of clutter and obstruction. All equipment was appropriately stored and labelled when last cleaned.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, risk management and the home's environment.

Areas for improvement
No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of five patient care records evidenced that care plans were in place.
We reviewed the management of nutrition, patients' weight, management of infections and wound care. However, not all care records contained details of the specific care requirements in each of the areas reviewed and the daily record did not evidence the delivery of care. For instance, one patient who required a sacral dressing had no corresponding care plan within their care record. Although the patient's daily progress notes evidenced that the patient was repositioned on alternate sides, nursing staff did not reference the state of the wound or condition of the skin. A review of five repositioning charts evidenced that the condition of the patient's skin at the time of repositioning was documented but this was not reflected in the daily progress notes maintained by nursing staff. Two areas for improvement under the standards were made.

Three patients' care records indicated that they were recently treated for infections. While discussion with nursing staff confirmed that a generic care plan was used for those patients who had an acute infection, there were no person centred care plans in place which reflected specific treatment that had been provided to those patients. In addition, these patients' daily progress notes did not indicate whether the treatment was successful or not. An area for improvement has been stated under the standards for a second time.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), speech and language therapists (SALT) and dieticians. Supplementary care charts such as food and fluid intake records evidenced that contemporaneous records were maintained. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), the speech and language therapist or the dietician.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

The registered manager advised that patient and/or relatives meetings were held on a regular basis. Minutes were available. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between residents, staff and other key stakeholders.

Areas for improvement

Two areas for improvement under the standards were identified in relation to care plans and supplementary records. An area for improvement under the standards was stated for a second time in regards to care plans focusing on acute infections.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 08.45 hours and were greeted by staff who were helpful and attentive. Patients were observed enjoying breakfast or a morning cup of tea/coffee in the dining room, in one of the lounges or in their bedroom, as was their personal preference. Some patients remained

in bed, in keeping with their personal preference or their assessed needs. Patients had access to fresh water and/or juice and staff were observed assisting patients with enjoying their chosen activity and to eat and drink as required.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff and review of the activity programme evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home Morning service from the local church is broadcast daily on a large screen in one of the lounges.

The environment had been adapted to promote positive outcomes for patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example, appropriate signage, photographs, the provision of clocks and prompts for the date.

We observed the serving of the lunchtime meal. Patients were assisted to the dining room or had trays brought to them as required. Staff were observed assisting patients with their meal appropriately while nursing staff supervised the provision of lunch to patients. Patients able to communicate indicated that they enjoyed their meal. A patient made the comment "You wouldn't get better in a five star hotel." Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes.

Cards and letters of compliment and thanks were displayed in the home and there were systems in place to obtain the views of patients and their representatives on the running of the home.

Consultation with 20 patients individually, and with others in smaller groups, confirmed that living in Ashbrook was viewed as a very positive experience. Three patients returned questionnaire responses and they all indicated they were very satisfied with the service.

Patients' comments made during the inspection included:

- "I couldn't be better looked after. I like everything about it. No complaints."
- "I call this place a grade A hotel. The girls couldn't be better. They have great patience."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Ten relative questionnaires were provided and four were returned within the timescale. All four indicated that they were very satisfied with the care provided.

Patients' representative's comments included the following:

- "I think the care is of a high satisfactory standard. My mum is looked after with great care."

Staff were asked to complete an on line survey, we had no staff responses within the timescale specified.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff/patients/representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager/manager.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The service did not collect any equality data on service users and the registered manager was encouraged to contact the Equality Commission for Northern Ireland for guidance on best practice in relation to collecting the data.

Review of the home's complaints records evidenced that systems were in place to ensure 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.

Discussion with the registered manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, infection, prevention and control (IPC) practices, care records and catering arrangements. Discussion with the registered manager highlighted that wounds are not audited within the home. An area for improvement under the standards was made.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005/ The Care Standards for Nursing Homes.

Discussion with staff confirmed that there were very good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management of complaints and maintaining good working relationships.

Areas for improvement

An area for improvement was identified under the standards in relation to developing robust governance measures relating to the provision of wound care within the home.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Gillian Larmour, registered manager and Marcus James Mulgrew, registered person as part of the inspection process. The timescales commence from the date of inspection.

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

Matters to be addressed as a result of this inspection are set in the context of the current registration of the 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

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

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 30 June 2018	The registered persons shall ensure that care plans are developed and reviewed in response to acute infections. Ref: Section 6.5
	Response by registered person detailing the actions taken: Staff nurses all reminded during a meeting that all residents with an infection should have a separate care plan in relation to that infection and that it is not enough to have a generalised care plan. Auditing to ensure that a resident with an infection has an appropriate care plan in place has been increased in frequency by Nurse Manager/ Deputy Nurse Manager.
Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 30 June 2018	The registered persons shall ensure the following in relation to patients receiving wound care: • that patient care plans accurately reflect the assessed needs of patients and the prescribed care and treatment which should be delivered • that patients' notes contemporaneously and comprehensively describe the improvement/deterioration of all wounds including any nursing interventions Ref: Section 6.5
	Response by registered person detailing the actions taken: Staff Nurses all reminded during a meeting that all residents with a wound should have an appropriate care plan in place, which reflects their prescribed care and treatment that should be delivered. Nurses also reminded to ensure that their daily progress notes describe effectively the progress of wounds and interventions applied as well as when care plan is reviewed and updated. Auditing in place by Nurse Manager/ Deputy Nurse Manager to ensure same.
Area for improvement 3 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 30 June 2018	The registered person shall ensure that daily progress notes for patients who require assistance with repositioning accurately reflect the condition of the patient's skin. Ref: Section 6.5
	Response by registered person detailing the actions taken: Staff Nurses all reminded during a meeting to ensure that daily progress notes are written to reflect the skin condition of a resident who requires assistance with repositioning as well as on repositioning charts by care staff.

Area for improvement 4 **Ref**: Standard 35 **Stated:** First time	Robust measures should be developed to provide the registered manager with an overview of the management of wounds occurring in the home. Ref: Section 6.7
To be completed by: 30 June 2018	**Response by registered person detailing the actions taken:** Wound care audits will be performed at intervals that are more regular. A new wound care checklist has been devised for Nurses to complete and forward to Nurse Manager. It includes information on how the wound occurred and a checklist to establish if all documentation and interventions are in place.

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

The Regulation and Quality Improvement Authority

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