Unannounced Care Inspection Report
23 June 2016

Ashbrooke Care Home

Type of Service: Nursing Home
Address: 2a Ashbourne Manor, Old Tempo Road, Enniskillen, BT74 4BB
Tel No: 02866325500
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Ashbrooke Care Home took place on 23 June 2016 from 06.30 to 11.15 hours.

Information was received by the RQIA duty desk on 20 June 2016, that patients were being woken up in the early hours of the morning by staff, without any choice or reason and against their preferred rising times. The purpose of this inspection was to seek assurances that the care and welfare of patients was in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 and DHSSPS Care Standards for Nursing Homes 2015.

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection was unable to substantiate the specific concerns raised in the complaint and found no significant areas of concern. However, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

For the purposes of this report, the term 'patients' will be used to described those living in Ashbrooke Care Home which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	*2

* The total number of requirements and recommendations above includes one recommendation which was not examined and has been carried forward for review at the next inspection.

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager 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 care inspection undertaken on 3 May 2016. Other than those actions detailed in the previous QIP there were no further actions required. 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 provider: Countrywide Care Homes (4) Limited Mrs Victoria Craddock	**Registered manager:** Heather Johnston
Person in charge of the home at the time of inspection: Kinga Joniec, registered nurse, from 06.30 to 08.30 Heather Johnston, registered manager from 09.30 to 11.15	**Date manager registered:** 19 October 2015
Categories of care: NH-I, RC-DE, NH-DE A maximum number of 32 patients in category NH-DE and a maximum of 8 patients in category NH-I. A maximum of 24 residents in category RC-DE.	**Number of registered places:** 64

3.0 Methods/processes

Information was received by RQIA on 20 June 2016 that patients were being woken up in the early hours of the morning by staff, without any choice or reason and against their preferred rising times. The focus of this inspection was to assess the day to day operations of the home since the last inspection and to ascertain if patients were being woken inappropriately against their wishes.

It is not the remit of RQIA to investigate complaints or safeguarding allegations made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. Following discussion with senior management at RQIA, it was agreed that an inspection would be undertaken to review the information provided.

Prior to the inspection we analysed the following information:

- notifiable events since the previous care inspection
- 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.

During the inspection the inspector spoke with seven patients individually and greeted others in small groups, four care staff and two registered nurses and the registered manager. There was no opportunity to speak with relatives as none were present at the time of the inspection.

The following information was examined during the inspection:

- a sample of staff duty rotas
- a review of five care records.

The inspector observed the majority of patients in the home some of whom were resting or sleeping in bed or seated in the day lounges. All staff on duty were spoken with.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 3 May 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 also partially validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 3 May 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 5.1 **Stated:** First time	The registered persons should ensure that the mealtime experience is reviewed, to ensure that patients are afforded choice and treated with respect and dignity.	**Carried forward until next inspection**
	Action taken as confirmed during the inspection: The registered manager informed the inspector that supervision had been undertaken with staff in relation to patients' mealtime experience. It is also planned that staff will participate in experiential learning in relation to meals and mealtimes. Due to the time of the inspection, meals were not observed by the inspector. This recommendation will be carried forward until the next inspection.	

Recommendation 2 **Ref**: Standard 39.4 **Stated:** First time	The registered persons should ensure that training is provided to staff, as appropriate, in the principles of choice, dignity and respect which underpin the care standards for nursing homes, 2015.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of records confirmed that training had been provided in the principles of choice, dignity and respect.	

4.3 Inspection Findings

4.3.1 Early morning rising

The inspection commenced at 06.30 hours. An inspection of all bedrooms of the dementia residential unit was undertaken; this was facilitated by the senior carer. At this time the senior carer in charge advised that there were 20 patients accommodated on this unit, seven of whom were up. All other patients were asleep/lying resting. The staff on duty advised that the patients who were up had either wakened themselves or had been assisted to get up, as they had been unsettled in the early morning. A review of care records confirmed that the identified patients had unsettled sleep patterns and this information was included in the patients care plans.

An inspection of all bedrooms in the nursing unit was undertaken and facilitated by the nurse in charge of the home. There were 29 patients accommodated in this unit, four of whom were up. Patients who were up were observed to be in their day attire. Discussion with staff informed the inspector that they had their morning wash and were up through their individual choice or care needs. One patient was observed to be agitated and was calling out. This patient was seated in the lounge area and was being attended to appropriately by staff. Another patient who was dressed and observed to be lying on their bed confirmed to the inspector that it was their own choice to get up early. A review of the care records confirmed that both patients had unsettled sleep patterns. Two other patients who were up had been assisted with washing and dressing due to personal care needs; one patient had been vomiting and the second patient required a full wash to meet their care needs. Staff consulted with confirmed that there was no expectation on the night staff to get a certain number of patients up before the day staff commenced and reiterated that the registered manager had clarified with all staff that patients were never to be woken out of their sleep. The inspection was unable to substantiate the specific concerns raised in the complaint and found no significant areas of concern.

4.3.2 Care practices

Observation during the inspection evidenced that patients who were up were not offered fluids in a timely manner. The staff were prompted by the inspector on two separate occasions, to offer a patient fluids, before they did so. A review of the fluid intake records evidenced that they had not been completed contemporaneously. There was no evidence that fluid intake had been recorded since approximately 20.00 hours on the previous evening. The care staff

spoken with advised that they normally completed these records at the end of the shift. This was discussed with the registered manager. A requirement has been made in this regard.

4.3.3 Care records

A review of supplementary care records evidenced that they were not being maintained in line with best practice. For example, all patients' bowel patterns were recorded on a 'Bowel Sheet' and this information was not consistently transferred into the individual patients' care records. Similarly, where patients were assisted to have a bath/shower, this information was recorded in a bath book and was not recorded in the patient care records. A review of the care records also identified that the time of the registered nurses' entries in the daily progress notes were not consistently recorded. This was discussed with the registered manager. A recommendation has been made in this regard.

4.3.4 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager 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 may enhance service, quality and delivery.

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for review 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 13 (1) (a) **Stated:** First time **To be completed by:** 21 August 2016	The registered persons must ensure that that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. Fluids must be provided to patients and records and fluid intake records must be completed contemporaneously. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: The above has been discussed with Nurses and care staff. Supervisions have been held The registered Manager will monitor this through periodic checks of documentation as well as ensuring provision of checks at shift by nursing staff where their signature on the fluid charts will be required..
Recommendations	
Recommendation 1 **Ref**: Standard 5.1 **Carried forward from last inspection**	The registered persons should ensure that the mealtime experience is reviewed, to ensure that patients are afforded choice and treated with respect and dignity. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Dining experience audit will be undertaken with actions and timescales applied so as improvement to service delivery can be evidenced. This will also be included in discussion for feedback at relative and resident meetings.
Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 21 August 2016	The registered persons should ensure that the systems for recording personal care delivery, which includes bathing and elimination records, are reviewed to ensure that the contemporaneous records of all nursing interventions are maintained within the patient care record. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: A sample of documentation has been provided for staff . Supervisions have also been held. Care plans will be further developed to incorporate full and up to date needs so as all staff are able to reference these against daily records.

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews