Unannounced Enforcement Compliance Inspection
11 January 2017

Ashbrooke Care Home

Type of Service: Nursing Home
Address: 2a Ashbourne Manor,
Old Tempo Manor
Enniskillen
BT74 4BB
Tel no: 028 6632 5500

Inspector: Sharon Loane & Aveen Donnelly

1.0 Summary

An unannounced enforcement compliance inspection of Ashbrooke Care Home took place on 11 January 2017 from 9.30 to 15.30 hours.

The purpose of this inspection was to assess the level of compliance achieved by the home regarding a failure to comply notice issued on 11 November 2016. The areas for improvement and compliance with regulation were in relation to the quality of nursing care (FTC/NH/1853/2016-17/01). The date for compliance with the notice was 11 January 2017.

FTC Ref: FTC/NH/1853/2016-17/01

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 12 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 11 February 2017.

Throughout the report the term “patients” is used to describe those living in the home which also provides residential care.

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	2	0

The findings of this inspection were discussed with John Rafferty, Responsible Individual, and Ciara Cochrane, Home Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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 3 November 2016.

Following the inspection, the registered persons were required to attend two separate meetings at RQIA. Firstly, a meeting was held with the intention of issuing a failure to comply notice in relation to the quality of nursing care. Additional findings in regards to governance/management arrangements and other areas of quality care were discussed at a serious concerns meeting. Both meetings were held on 9 November 2016 at RQIA.

Following discussion with the registered person at the intention meeting held, 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 a failure to comply notice under The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 12 (1) (a) and (b), in relation to the quality of nursing care would be issued.

As previously discussed, a serious concerns meeting was also held on the same date to discuss additional inspection findings in respect of quality care and governance and management arrangements in the home. Following discussion and assurances provided and given that Runwood Care Homes Ltd had only recently taken over the operational control of the home, in August 2016, RQIA agreed to give Ashbrooke Care Home a period of time in which to implement the actions and make the necessary improvements required in the areas discussed.

A further care inspection will be undertaken in the near future to validate compliance and drive improvements.

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: Runwood Homes Ltd Mr John Rafferty, Responsible Individual	**Registered manager:** Not yet registered
Person in charge of the home at the time of inspection: Ciara Cochrane, Home Manager	**Date manager registered:** Ciara Cochrane - application not yet submitted
Categories of care: A maximum number of 32 patients in category NH-DE and a maximum of 8 patients' category NH-I, accommodated in a separate unit. A maximum of 24 residents in category RC-DE	**Number of registered places:** 64

3.0 Methods/processes

Prior to inspection we analysed the following records:

- the requirements as indicated in the failure to comply notice;
  FTC Ref: FTC/NH/1853/2016-17/01
- the registration status of the home
- written and verbal communication received by RQIA since the last care inspection
- the previous care inspection report
- notifications received since November 2016

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

- a discussion with the responsible individual and home manager
- discussion with staff
- discussion with patients
- a review sample of staff duty rotas
- a review of the patient register
- review sample of staff training records
- review sample of accident and incident records
- review of four patient care records
- a review of quality audits
- review of monthly monitoring reports for December 2016 & January 2017 in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

During the inspection, care delivery and care practices were observed and a review of the general environment of the home was undertaken.

A number of staff were consulted during the inspection process including two registered nurses, care staff and ancillary staff on duty. In addition, the representatives of two patients' and the Ambassador for Ashbrooke Care Home were also consulted.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 3 November 2016

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

4.2 Inspection findings

4.2.1 FTC Ref: FTC/NH/1853/2016-17/01

Notice of Failure to Comply with Regulation 12 (1) (a) and (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 seven actions were required to comply with this regulation.

- The registered person must ensure that care plans are maintained to reflect patients' assessment of need and risk assessments. The care records must be regularly reviewed, with the outcomes for patients needs evaluated and recorded in the daily progress notes.
- The registered person must ensure that patients' weights are monitored, in accordance with their care plan and level of risk. Subsequent action taken in response to any identified deficits should be clearly recorded in the patient's care records.
- The registered person must ensure that appropriate actions are taken when a patient requires wound care or has been identified at high risk of pressure damage.
- The registered person must ensure that patients are repositioned in accordance with care plans and that repositioning records are accurately maintained.
- The registered person must ensure that accidents and incidents are managed in accordance with best practice guidelines, and appropriate actions are taken to minimise risks to patient's health and welfare.
- The registered person must ensure that staff are provided with training relevant to their role and responsibilities in relation to; the management of wounds, prevention of pressure damage, nutrition and accident and incidents with specific focus on the management of head injuries.
- The registered person must ensure sufficiently robust audit and governance systems are in place to quality assure the delivery of nursing care. On this occasion, this refers to the areas of concerns identified above.

A review of care records evidenced that risk assessments and care plans were either not in place, not sufficiently reviewed in response to the changing needs of patients or contained conflicting information. The review of one patient's care record did not evidence that advice had been sought from or a referral made to relevant health professionals and the patient's risk assessments and care plan did not reflect the patient's current care needs as observed at time of inspection.

A review of information evidenced that a systematic and robust strategy was in place for monitoring patients' weights. The records reviewed identified any weight loss and/or gain. Within the care records examined there was evidence that appropriate actions had been taken to include referrals and communications with the Dietician; Speech and Language Therapist (SALT) and the General Practitioner. Risk assessments and care plans had been reviewed and updated on a regular basis to reflect the current identified need and treatment and care interventions required.

At the time of inspection, the acting manager advised that there were no patients currently receiving any treatment for wounds and/or pressure management. A review sample of care records for patients identified at the last inspection with wounds and/or pressure damage was undertaken. The review 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. There was evidence that the treatment and care delivered was effective as the wounds had healed completely.

The review of the supplementary care records regarding the prevention of pressure damage did not evidence that repositioning charts were being consistently maintained. A review of repositioning records for two patients, identified that there were no records available for up to and including three days. The repositioning charts did not record the condition of the patients' skin at each positional change. A discussion with staff on duty highlighted that staff lacked knowledge and understanding in regards to this area of practice and advised that they had not received any training since the last inspection when similar shortfalls had been identified.

A review of accident and incident records evidenced improvement and progress in this area of practice. Since the last inspection, staff had been provided with additional information and training and there was evidence that this learning had been sufficiently embedded into practice. Records were maintained in accordance with best practice guidelines. In the event of an accident/incident where a head injury was suspected, there was evidence that appropriate actions had been taken by staff; medical attention had been sought as deemed appropriate and patients were monitored for any adverse side effects.

A review of training records and discussion with staff and the acting manager evidenced that training for staff regarding; the management of wounds, prevention of pressure damage, and nutrition had not yet been undertaken, by staff. The home manager advised that it had been difficult to organise formal training for an earlier date and that training was scheduled for the day following the inspection. Although the home manager advised supervision sessions had been undertaken in the areas aforementioned there were no records available to reflect this information with the exception of accident and incident management where improvements had been noted. Furthermore, the findings of this inspection continued to identify shortfalls in the other areas identified and demonstrated that staff required additional training and knowledge in the areas aforementioned.

Discussion with management and a review of information evidenced that auditing systems had been developed and implemented as outlined in the failure to comply notice. However, a sample review of audit records evidenced that these were not sufficiently robust; some audit findings were contrary to the findings of this inspection. For example; audits completed in relation to care records; repositioning records; were incomplete and did not identify the areas for improvement found during this inspection. Whilst some areas for improvement had been identified through the audit processes, there was no evidence in the audit records that the areas for improvement had been re-audited to check compliance. The completion of the audit cycle as a means to ensure quality improvement was discussed with management.

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 11 February 2017.

4.3.2 Staffing arrangements

A sample review of staff duty rotas identified that these were inaccurate and had not been updated to reflect the changes and the staff working in the home. For example; a staff member working on duty at the time of inspection was not recorded on the duty rota. There were other examples of similar inaccuracies. There was no evidence that duty records had been reviewed by the home manager or designated representative to verify the actual hours worked by staff. This matter was discussed with the home manager who had limited oversight of the staffing arrangements. A requirement has been made.

4.3.3 Records management

In addition to the issues outlined in the failure to comply notice regarding care records; the following shortfalls were also identified.

A review of a care record for one identified patient evidenced that records had not been updated to reflect the patients return to the home following an admission to hospital. At the time of the patient's re-admission to the home, no written entries had been made within the daily progress notes to reflect that the patient had returned to the home and if there were any changes to their care and treatment. A review of a register maintained for all patients admitted, discharged and transferred to hospital was not up to date and therefore there was no actual record to evidence the patient was in the home. This was concerning as it had the potential to impact negatively on the patients treatment, care and safety. A requirement has been made.

A second record provided to inspectors at the time of inspection raised some concerns. The authenticity of the record could not be validated for the following reasons: the information recorded in the record was not consistent with other records examined which were all maintained in chronological order and signed by two staff members. The record provided was not completed as outlined above and a review of the staff duty rotas for the date the record was completed identified a further discrepancy. This matter was discussed with the management team who acknowledged these findings and advised that an investigation would be undertaken in regards to this matter. A request was made that the outcome of the investigation was shared with RQIA and any subsequent actions taken.

Areas for improvement

Requirements have been made in relation to records management and staffing arrangements.

Conclusion

Evidence at the time of inspection was not available to validate full compliance within the failure to comply notice FTC/NH/1853/2016-17/01. 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 12 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 11 February 2017.

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed 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 nursing.team@rqia.org.uk 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) Schedule 4 (7) **Stated:** First time **To be completed by:** 11 January 2017	The registered provider must ensure that the duty roster of persons working in the home is kept up to date and verified as to whether the roster was actually worked. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: The duty rota is now well maintained and kept up to date daily with all changes made if needed. It is checked daily to ensure all staff are present. No changes are made to rota except management
Requirement 2 **Ref:** Regulation 19 (1) (a) Schedule 3 (3) **Stated:** First time **To be completed by:** 11 January 2017	The registered provider must ensure that patient care records are kept up to date and are compliant with the records to be maintained in respect of each patient as outlined in Schedule 3 (3) of the Nursing Homes Regulations (Northern Ireland) 2005. **Ref: Section 4.3.3**
	Response by registered provider detailing the actions taken: There is now a named nurse system in place for each patient. All careplans are then updated monthly. A new careplan audit is in place to ensure this is met daily

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

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