Unannounced Care Inspection Report
15 May 2017

Ashbrooke Care Centre

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

1.0 Summary

An unannounced inspection of Ashbrooke Care Centre took place on 15 May 2017 from 10.30 to 16.15 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.

Is care safe?

There was evidence of safe delivery of care. Staff were required to attend mandatory training and observation of care delivery evidenced that knowledge and skill gained, through training, was embedded into practice.

Staffing arrangements were satisfactory and plans were in place to increase staffing levels following a recent staffing review. The home was decorated to a satisfactory standard. A discussion was held with the manager in respect of some matters pertaining to infection prevention and control and the environment.

A recommendation has been made in relation to monitoring staffs registration with their professional bodies.

Is care effective?

There was evidence of positive outcomes for patients. All staff understood their role, function and responsibilities. Staff also confirmed that if they had any concerns they could raise these with the nurse in charge or the manager. All staff consulted clearly demonstrated their ability to communicate effectively with patients, with their colleagues and with other healthcare professionals.

Is care compassionate?

The interpersonal contact between staff and patients was observed to be compassionate and caring. Patients were afforded choice, privacy, dignity and respect. Patients, representatives and members of staff spoken with confirmed that patients were listened to, valued and communicated with in an appropriate manner. 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. A varied programme of activities was available.

Is the service well led?

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. A review of records evidenced that systems were in place to monitor and report on the quality of nursing care and other services provided.
As discussed in the preceding sections, it was evident that the manager had developed, implemented and managed systems of working within the home which were patient focused, impacted positively on the patient experience and involved and encouraged staff and relatives to participate in the daily life of the home. The manager was available to patients and their relatives and operated an ‘open door’ policy for contacting her.

A requirement made at a previous inspection in regards to notifications continued not to be met and has been stated for a second time.

The term 'patients' is used to describe those living in Ashbrooke Care Centre which provides both nursing and 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	1*	1

*The total number of requirements includes a requirement which has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ciara Cochrane, 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 medicines management inspection undertaken on 6 March 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.

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

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd Mr John Rafferty	**Registered manager:** Not yet registered
Person in charge of the home at the time of inspection: Ciara Cochrane	**Date manager registered:** Ciara Cochrane – application not yet submitted

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

Specific methods/processes used in this inspection include the following:

Prior to inspection we analysed the following records:

- 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

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 patients, relatives and staff. We also met with patients individually and the majority of others in smaller groups, four care staff, two registered nurses, one member of catering staff and an activities leader and two patient's representatives.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- staff training records
- staff induction records
- competency and capability assessments
- records of staff, patient and relatives meetings
- six patient care records
- accident and incident records
- complaints record
- audits in relation to care records
- records relating to adult safeguarding
- 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 6 March 2017

There were no issues required to be followed up during this inspection and any action taken by the registered provider, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from care inspections dated 3 November 2016 and 11 January 2017

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 19 (2) Schedule 4 (7) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A sample review of duty rotas evidenced the hours worked by staff. The manager advised that they reviewed these frequently and signed the duty record at the end of each working week.	
Requirement 2 **Ref:** Regulation 19 (1) (a) Schedule 3 (3) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of patient care records and supplementary care records for example; food and fluid intake charts; repositioning charts evidenced that records were maintained in accordance with legislative requirements.	

4.3 Is care safe?

The 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 the patients were met. A review sample of staffing rotas for weeks commencing 7 and 14 May 2017 evidenced that the planned staffing levels were adhered to in the majority of occasions. The manager advised that a recent review of staffing arrangements had resulted in the number of care staff on night duty being increased and plans were in place to increase the number of care staff for the morning shift on day duty.

Discussion with patients, representatives and staff evidenced that there were no significant concerns regarding staffing levels. Although, some staff spoken with advised that at times it was difficult to respond to patients needs in a timely manner. As previously discussed, the proposed staffing arrangements should result in more positive outcomes for patients and staff.

Observation of the delivery of care evidenced that although the home was busy, patients' needs were met by the levels and skill mix of staff on duty.

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. Staff were mentored by an experienced member of staff during their induction. Induction records for three staff members, to include one agency staff, were reviewed and found to be completed in full and dated and signed appropriately.

A discussion with the manager and a review of information evidenced that probationary reviews were carried out twice within a six monthly period to ensure they were achieving and maintaining their competency in regards to their roles and responsibilities. This is good practice.

Competency and capability assessments for two registered nurses identified as given the responsibility of being in charge of the home were reviewed. The assessments had been completed in February 2017 and were signed by the manager to confirm that the assessment process had been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

Discussion with staff and a review of the staff training records confirmed that the manager had a system in place to monitor staff compliance with mandatory training requirements. A review of staff training records confirmed that training was delivered via e-learning (electronic learning) supported with face to face training for practical components. Training outcomes for 2016/17, thus far, indicated that the manager ensured mandatory training was completed. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

Discussion with the manager and a review of information, confirmed that all registered nurses identified on the duty rota were on the live NMC register. However, the system in place for monitoring this information was not sufficiently robust. For example; the matrix in place did not include the details of a number of registered nurses. Similar findings were evidenced in relation to checks completed for care staffs registration with Northern Ireland Social Care Council (NISCC). A recommendation has been made in this regard.

The manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the manager confirmed that the arrangements in place were currently being reviewed to ensure that they were in accordance with the new regional operational safeguarding policy and procedures. The manager advised that the policy for the home in relation to same was to be updated to reflect same. This information will be reviewed at the next care inspection to ensure it has been successfully implemented.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last inspection evidenced that some of these were not appropriately managed. Please refer to section 4.6 for further detail.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, and lounge/s, dining room/s and storage areas. The home was found to be warm, well decorated, fresh smelling and reasonably clean throughout. Infection prevention and control measures were in the majority adhered to and equipment was appropriately stored. However, a number of practices observed in a bathroom in the residential unit were not consistent with infection prevention and control guidance. For example; continence products were stored out of their packaging; a hair brush was sitting on top of a waste bin and a number of communal toiletries were also observed. An identified bathroom in the residential unit was in need of repainting and re-decoration. The manager confirmed that works were scheduled to complete these improvements and also agreed to address the other observations made. These matters will be reviewed at a subsequent care inspection to ensure the necessary improvements have been made.

Fire exits and corridors were observed to be clear of clutter and obstruction. A number of items were observed being stored under a stairwell. The manager advised that arrangements had been made to organise the disposal of same.

Areas for improvement

A robust system should be developed to monitor staffs registration with their professional bodies. A recommendation has been made.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

Review of six patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Following an admission to hospital, risk assessments were reviewed and updated. The manager advised that a care record audit was completed for all patients on return from hospital. A review of one care record confirmed the accuracy of this information. Where shortfalls had been identified there was evidence of follow-up actions. This is good practice.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning/food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements.

A review of repositioning records evidenced that these reflected positional changes were consistent with the care plan. Records also reflected the condition of the patient's skin and interventions implemented when risks were identified.

A review of food and fluid management evidenced that robust systems and processes had been implemented to monitor this area of practice. A sample review of food and fluid intake charts for an identified patient evidenced that these were maintained to a satisfactory standard. There was good evidence that food and fluids were offered at regular intervals. Supplements were also being recorded. Charts evidenced that the total 24 hour intake was calculated and subsequently recorded in the patient's daily progress notes. There was evidence that appropriate actions had been taken when intake was poor for example; were a patient had a poor fluid intake they were commenced on 'hourly' fluids the following day. This is good practice.

A review of weight monitoring records evidenced these were maintained to a satisfactory standard. There was evidence that patients' weights were being monitored and recorded accordingly. Appropriate actions had been taken and included referrals to the dietician and General Practitioner (GP). There was evidence in the care records that recommendations made by the medical and healthcare professionals had been adhered to accordingly; for example food and fluid intake charts had been commenced and nutritional supplements were administered in accordance with the prescribed guidance.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

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.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. Nursing and senior care staff attended a meeting at 11:00 hours every day. This meeting provided an opportunity to discuss any concerns re patients and make collective decisions re their plan of care. The manager advised that they also attended the meeting and this kept her informed of any potential issues and provided assurances that appropriate actions were taken. A discussion with the manager confirmed that they were knowledgeable regarding the patients and issues within the home. Staff and relatives spoken with advised that the manager had a visible presence and demonstrated a very hand on management approach. This is commended.

Discussion with the manager confirmed that staff meetings were held on a frequent basis and records were maintained.

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 their line manager and/or the manager.

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

Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

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.

Activities were being provided at the time of the inspection and patients were observed participating at various levels. An activity programme displayed, evidenced that a range of activities were been provided which included both group and individual sessions. Examples of these included; the 'cookie jar activity' – this is an activity that staff initiate by pulling a patients name from the jar and then spending 10-15 minutes with that patient on a one to one basis doing an activity that the patient enjoys; for example; make-up, reading or a walk. Staff record all activities delivered and the effect it had on the patient.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Consultation with patients individually, and with others in smaller groups, confirmed that they received safe effective and compassionate care and that living in the home was a positive experience.

Comments provided to the inspector included:
“Care is terrific, couldn’t ask for better.”
“Food is all good, no complaints.”

Comments provided by relatives spoken with included:
“Very positive, impressed with the standard of care provided.”
“Kept well informed and the manager is very visible.”
“Staff are very good, have been invited to review and discuss my mother’s care plan.”

In addition, 10 relative/representatives; 10 staff and eight patient questionnaires were provided by RQIA to the manager for distribution. At the time of issuing this report none had been returned within the timeframe specified.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

A discussion with the manager, Ciara Cochrane, confirmed that an application was currently being submitted to RQIA for the position of registered manager. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the manager and review of records and observations evidenced that the home was operating within its registered categories of care. A variation application was submitted to RQIA 2017, to amend the current registration of the home. This application was still pending and will be reviewed accordingly.

Discussion with the 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. The compliments received were also reviewed and acknowledged the improvements made in the home by new management.

Patient’s representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. However, a review of accident and incidents records evidenced that some had not been reported appropriately. A discussion with the manager indicated that there had been some ambiguity in regards to information provided to them in this regard. Furthermore, this shortfall had not been identified during the monthly quality monitoring visits. A requirement had been made at a previous care inspection continued not to be met and therefore has been stated for a second time.

Discussion with the manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

The manager advised that there were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. This information was not reviewed at this inspection.

Discussion with the manager and review of records evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, and staff and Trust representatives.

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

Areas for improvement

No new areas for improvement were identified during the inspection in the well led domain.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ciara Cochrane, 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/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 the 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 30 (1) **Stated:** Second time **To be completed by:** Immediately from the date of the inspection.	The registered persons must ensure that notifications are submitted to RQIA in accordance with legislative requirements. **Ref: Section 4.2 , 4.3 & 4.6**
	Response by registered provider detailing the actions taken: RQIA will be notified of the transfers of any resident to other professionals or hospitals for medical investigations. This requirement will be shared with all Runwood Homes in Northern Ireland.
Recommendations	
Recommendation 1 **Ref:** Standard 35 Criteria 6 **Stated:** First time **To be completed by:** 30 June 2017	The registered persons should ensure that a robust system is implemented to monitor staffs registration with the national midwifery council (NMC) and Northern Ireland Social Care Council (NISCC). **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: NMC and NISCC trackers are in place within the home. The bank member of staff discussed during the inspection is now on the staff registration tracker maintained in the home. Going forward all bank staff will be on the staff registration trackers.

Please ensure this document is completed in full and returned to the web portal

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