Urgent Unannounced Care Inspection Report
16 August 2017

Ashbrooke Care Home

Type of Service: Nursing Home
Address: 2a Ashbourne Manor, Old Tempo Road, Enniskillen, BT74 4BB
Tel No: 028 6632 5500
Inspectors: Sharon Loane and Aveen Donnelly

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 provider 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 nursing home registered to provide nursing and residential care for up to 64 persons.

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual(s):** Mr Gavin O'Hare- Connolly (acting)	**Registered Manager:** See below
Person in charge at the time of inspection: Ciara Teague	**Date manager registered:** Ms Ciara Teague – Acting Manager, no application received
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. Residential Care (RC) DE – Dementia.	**Number of registered places:** Maximum number of registered beds: 64 Comprising: 32 – NH-DE 8 – NH-I 24 – RC-DE

3.0 Previous Regulatory/Enforcement History

Runwood Homes Ltd took over the running of Ashbrooke Care Home on 1 August 2016.

The first care inspection took place on 3 November 2016 as a result of concerns raised by the Western Health and Social Care Trust (Western Trust) in relation to the delivery of care and the day to day operational control of the home. Following this inspection, a failure to comply notice under regulation 12 (1) (a) and (b) (Quality of Nursing Care) of The Nursing Homes Regulations (Northern Ireland) 2005 was issued to the home on 10 November 2016 with a date of compliance of 11 January 2017. An unannounced enforcement compliance inspection conducted on 11 January 2017 evidenced that full compliance with the failure to comply notice had not been achieved. Matters outstanding included risk assessments and care plans were not in place or had not been reviewed in light of the changing needs of the patients, repositioning charts were not consistently maintained, the relevant staff training had not occurred and an appropriate audit system had not been fully developed. This information was shared with the manager and responsible individual at the end of the compliance inspection. A decision was made by RQIA to extend the compliance date to the maximum legislative timeframe of three months, 11 February 2017. A further unannounced enforcement compliance inspection, conducted on 13 February 2017, evidenced that the outstanding matters had been addressed and the home had achieved full compliance with the failure to comply notice.

A scheduled medicines management inspection on 6 March 2017 resulted in one area for improvement under regulations being identified in relation to the receipt of medicine information during the admission process.

An unannounced care inspection on 15 May 2017 resulted in an area for improvement under the regulations being made for the second time; this requires the registered person to report death, illness and other events to RQIA. One area for improvement under the care standards was also identified relating to the monitoring of staff's registration with their professional bodies.

A finance inspection on 17 July 2017 identified two areas for improvement under regulations. These related to the availability of a safe place being accessible to patients to deposit or withdraw their money or valuables and the need for specific records to be available at all times.

4.0 Inspection summary

On 15 August 2017, RQIA received information from the Western Health and Social Care Trust in relation to an incident that had occurred on 14 August 2017 in Ashbrooke Care Home. On 16 August 2017, further information relating to a separate incident that occurred the previous day was received from the trust's Adult Safeguarding team. RQIA had not been informed by the home of either incident which is a breach of Regulation 30 which requires RQIA to be notified. When taken with the concerns raised by the manager with the trust about the management and staffing arrangements in the home RQIA made the decision to undertake an immediate unannounced inspection of Ashbrooke Care Home.

The inspector, with the senior inspector, considered; the information received from the Western Trust, the regulatory history of the home, the recent resignation of the manager of the home and the conflicting information received about the current management arrangements. A decision was made to conduct an urgent unannounced inspection of the home on 16 August 2017. The inspection was conducted by inspectors who had previously inspected the service. The inspection commenced at 14.05 and concluded at 20.05.

While RQIA is not responsible for the investigation of complaints or managing safeguarding concerns, where it is notified of a potential breach of regulations or minimum standards, it will review the information and take appropriate action as required which may include an inspection of the home.

During this inspection, the following areas were examined:

- health and welfare of patients including care delivery and care records
- management and governance arrangements including accidents and incidents
- staffing arrangements
- fitness of premises (fire safety and security)
- environment

RQIA considered that the concerns identified during this inspection posed serious risk to the life, health or well-being of the patients at Ashbrooke Care Home. During the inspection, RQIA contacted the Western Health and Social Care Trust, Adult Safeguarding Team, and the acting responsible individual of Runwood Homes Ltd, to highlight the serious concerns identified. RQIA was assured that, on completion of the inspection, interim contingency measures would be put in place to ensure the safety of patients overnight. The acting responsible individual of Runwood Homes Ltd advised RQIA, that he and an experienced manager would be in the home the following day.

On 17 August 2017, senior management considered the outcome of this inspection and a recommendation was made to present the findings to a Decision Making Panel of the RQIA Board.

The term ‘patients’ is used to describe those living in Ashbrooke Care Home which provides both nursing and residential care.

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
- the registration status of the home including the name of the current manager and the categories of care of patients living in the home
- written and verbal communication received since the previous care inspection

During this inspection, care delivery and care practices were observed and a review of the general environment was undertaken. RQIA inspectors spoke with three patients individually and with others in small groups. The majority of patients were observed sitting in the lounges or resting in their bedrooms during the inspection. Nine staff, two patients and five patients' visitors/representatives and one visiting professional were also spoken with during the inspection. Comments are included throughout the main body of the report.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following information was examined during the inspection:

- a review sample of staff duty rotas
- care records
- supplementary care records for example; repositioning and personal care records
- accident/incident records
- personal emergency evacuation plans
- monthly quality monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005

The findings of the inspection were discussed with the person in charge at the conclusion of the inspection.

6.0 The inspection

Health and welfare

- Wound care at Ashbrooke Care Home was not appropriately managed. This was evidenced by; wound dressings not being changed as prescribed, no referral to a Tissue Viability Nurse, conflicting information in care plans, repositioning records evidenced gaps of up to 11 hours (rather than two hourly). It was noted that the repositioning records were completed exactly on the hour, for example, 08.40; 10.40; 12.40 and thereafter.
- Falls management preventive measures were either not in place or not working effectively to ensure patient safety. In June 2017, assurances had been given by management representatives of Runwood Homes Ltd to the Western Health and Social Care Trust and the adult safeguarding team that appropriate action had been taken to address patient safety issues in relation to falls management, identified as a result of two safeguarding incidents. Despite these assurances and those provided to the Western Health and Social Care Trust, by the manager on 15 August 2017, inspectors found safety measures were either not in place or not working effectively.
- RQIA also noted a failure by management at Ashbrooke Care Home to identify that equipment was faulty.
- Serious concerns were identified in relation to personal care with the majority of patients appearing unkempt. There was evidence within records that hygiene needs were not met, for example, one record indicated that a patient's most recent shower took place over five weeks previously. One relative stated that the standard of personal care provided to her mother and other patients had deteriorated significantly and she was of the opinion that this was due to the high usage of agency and shortage of staff. Comments included, "dirty nails, clothing stained and hair sticky."

- A notice was on display, stating, “For the month of August all food must be fortified. Residents are losing weight alarmingly.” Two records reviewed evidenced weight loss of up to 6.5kg in one week. There was no evidence that this had been addressed, or any action taken to ensure the accuracy of the information. Comments regarding weight loss were also recorded in the monthly quality monitoring report completed on 10 August 2017.
- Relatives spoken with advised that staff did not have time to feed patients. One relative advised that she helped staff and one patient advised food was often cold.
- A recent safe guarding incident that had occurred in the home demonstrated that the staff on duty at that time did not display the necessary skills, knowledge and competency to care for people living with a diagnosis of dementia.

The findings outlined above are evidence that basic nursing and personal care needs were not being met, posing risks to patients’ life, health and wellbeing. These are breaches of Regulation 12 (1) (a) and (b) and Regulation 13 (1) (a) (b) of the Nursing Homes Regulations (Northern Ireland) 2005.

Management and Governance arrangements:

RQIA were concerned about the governance and oversight arrangements in the home. Prior to the inspection, RQIA had been informed of a change in management arrangements for the home. Runwood Homes Ltd had advised of the appointment of a new acting responsible individual on 24 July 2017. Additional information was then received on the 31 July and 1 August advising of the resignation of the manager of the home and the appointment of an acting manager. RQIA had also received information that the acting manager had been appointed without the appropriate employment checks being undertaken. The acting responsible individual confirmed that this had not been the case. The absence of a skilled and experienced manager to direct and supervise the delivery of care was a significant factor in RQIA’s findings in Ashbrooke Care Home.

During the inspection the following information was provided:

- The manager at Ashbrooke Care Home identified herself as “the point of contact, and not the acting manager.”
- The manager demonstrated that she was unaware of the organisational structures within Runwood Homes Ltd.
- There was no written evidence of the manager raising concerns with senior management at Runwood Homes Ltd.
- The manager requested that a witness should be present when discussing her concerns with the inspectors.
- The manager stated she “did not want to be there, or fulfil the role.” She advised that she had raised concerns with RQIA in June 2017 and advised she had given her details to be shared with relevant others. RQIA had received information in July 2017 from a person stating that they were an ex-employee who wished to remain anonymous. These were in relation to safeguarding concerns, management and governance and care delivery in the home.
- The manager demonstrated a lack of understanding of her role and responsibilities for ensuring patient welfare, including knowledge of the adult safeguarding procedures.
- Statutory notifications (Regulation 30) were not submitted to RQIA in respect of recent patient safety incidents, for example, falls and safeguarding incidents.

- The monthly quality monitoring report by the registered provider (Regulation 29) for July 2017 was not completed. The most recent report, completed on the 10 August 2017, identified concerns regarding; staffing, meals and high incidents of medication errors, staff attitude and knowledge re dementia care, care records and weight loss. There was no evidence of the actions taken to address the identified concerns. The acting responsible individual, when questioned during the teleconference the next day, advised he was aware of this report. No action had been taken to address the failures. Some information recorded in the report was not consistent with RQIA's inspection findings, for example, information relating to pressure mats and alarms, which were found by the inspectors to be broken.

These are indicative of poor governance and management arrangements and these failures were impacting negatively on the quality of care and services provided in the home. These failings are breaches of Regulation 10 (1) and Regulation 30 (1) (c) (d) of the Nursing Homes Regulations (Northern Ireland) 2005.

Staffing arrangements

- A review of duty rotas identified that the number of registered nurses on duty was less than the number required to be working in the home. During the inspection, the manager advised that she had worked the gaps in the rota, however, the records reviewed did not reflect this information. The manager recorded this information at the time of the inspection.
- The continuity of care was being impacted negatively by an over reliance on agency nurses with the number in the home greater than the number of permanent nurses. Agency staff advised that they had received no induction.
- The duty rota was poorly recorded and there was evidence that it was not completed accurately.
- Management and staff advised the inspectors that Runwood Homes Ltd had reduced staffing levels two weeks previously to below the baseline required to meet the assessed needs of the patients. At the time of the inspection, steps were being taken by the manager to reinstate the previously agreed staffing arrangements.
- Staff reported that morale was very low; some staff on duty advised they were looking for alternative employment to protect their professional registration status.
- Relatives and patients also raised concerns regarding staffing and provided examples of the impact on patient care. For example, one patient spoken with advised that they had to wait 20 minutes for staff to respond and they were fearful that, because they had diarrhoea, they would soil themselves. A relative advised that she had observed staff working under so much pressure that they "were crying" and in her opinion this was impacting on care delivery.
- During the inspection, staff at Ashbrooke Care Home were observed working under pressure, trying to attend to patients' needs. There was a lack of supervision by staff of patients in the lounges to ensure patient safety.

The lack of robust management and oversight of the staffing arrangements and the evidence of insufficient staff to meet the care needs of patients had impacted significantly on the delivery of safe, effective, compassionate care. The home was not well-led.

These findings are breaches of Regulation 20 - (1) (a) (b) and (2) of the Nursing Homes Regulations (Northern Ireland) 2005.

Fitness of premises

- The building was not secure, with a fire door open at the side of the home.
- A fire escape route was obstructed with laundry equipment.
- In some bedroom doors, self-closer devices were not working with some wedges in use.
- The door leading from the dementia unit to the nursing unit was not closing effectively.
- The personal emergency evacuation plans (PEEPS) were last updated on 25 July 2017 and were inaccurate.

These findings are indicative that fire safety and security were not being managed appropriately and had the potential to cause serious risks to the life, health and wellbeing of patients.

The findings outlined above are breaches of Regulation 27(1), (2) (b) (c) (d), (4) (b), (d) (iii) of the Nursing Homes Regulations (Northern Ireland) 2005.

Environment

- The overall cleanliness of the environment and equipment was far below the standard expected.
- There were malodours throughout the residential unit; the inspectors noted a strong smell of urine and faeces. This had been identified in the monthly monitoring reports, conducted by Runwood Homes Ltd, in June 2017. A copy of this report was made available to RQIA during inspection. There was no evidence that any action had been taken to address this.
- A bathroom was out of use for three weeks or more.
- Inspectors were informed that the maintenance man had left the home several weeks prior to the inspection and there was no evidence of any contingency arrangements in place.
- The nurse call system was defective in a number of areas and this had not been identified or addressed by management.

This lack of review and maintenance of the environment was indicative of poor governance oversight and day to day management arrangements and was impacting on the dignity and safety of all patients.

These findings are breaches of Regulation 18 (1), (2) (j) of the Nursing Homes Regulations (Northern Ireland) 2005.

7.0 Inspection outcome

The inspectors took the necessary actions immediately to ensure the safety of patients. This included directing that, where there was a need, patients were moved to bedrooms with working alarm systems in place.

Areas of concern and breaches in regulations were discussed with the person in charge in the home and the acting responsible individual of Runwood Homes Ltd, by telephone, during the inspection.

Post Inspection

The Western Health and Social Care Trust arranged a teleconference at short notice on the 17 August, to discuss recent safeguarding incidents and concerns identified at this inspection that included RQIA and representatives of Runwood Homes Ltd. The acting responsible individual advised that, although he had seen the monthly quality monitoring report completed for August 2017, no action had yet been taken to address the concerns identified.

The Western Health and Social Care Trust expressed concern that, despite the assurances provided by the acting responsible individual the previous day, there was no management team present in the home when they visited the home the morning after the inspection.

Runwood Homes Ltd advised that, in the interim, a manager from another Runwood home had been identified to manage Ashbrooke. Additional staff had also been brought in to ensure the safety of patients. Where necessary, patients had been moved to rooms with functioning falls prevention equipment. The Western Health and Social Care Trust confirmed that it would conduct care management review for each patient at the home.

On 17 August 2017, the inspectors met with RQIA senior management to consider what actions should be taken in relation to the findings of the inspection. The following were considered.

Failure to Comply Notice

- There had been a previous failure to comply notice issued in November 2016. Whilst improvement had been made this had not been sustained.
- The issuing of a further Failure to Comply Notice was considered not to be sufficient to drive the necessary improvement at this time.

Place conditions on registration

- For example, to close the home to admissions and provide an opportunity for the home to improve.
- The failings evidenced related to a lack of governance and management. In the absence of a registered manager with good governance systems in place and not enough staff rostered to provide safe care this was deemed not to be sufficient to safeguard patients from further deterioration.

Cancel the registration of the manager

- With no registered manager in place, we considered the failings to be the responsibility of the registered provider. This was considered not to be an appropriate action at this time.

Cancel the registration of the registered provider in relation to this home

- This would have the effect of closing the service and residents would be moved from a place of neglect to a place of safety. On the basis that inspectors found evidence of neglectful care that was impacting on the life, health and welfare of patients, this is deemed to be appropriate, risk based and proportionate.
- Given the rapid deterioration in the welfare of the patients since the last care inspection, as well as the conflicting information about patients and management arrangements, the option of making an application for an urgent order to cancel registration was deemed the most appropriate method of safeguarding the patients against further harm.

A recommendation was made to present the findings to a Decision Making Panel of the Board in line with RQIA's enforcement policy to consider cancellation of the registration of Runwood Homes Ltd in respect of Ashbrooke Care Home.

Legal Advice

RQIA sought legal advice in relation to this enforcement action and the steps that were required to be taken in line with our enforcement policy and procedure and the relevant regulations.

Deliberation of the Decision Making Panel

A Decision Making Panel consisting of two RQIA Board members and the Chief Executive met to consider the proposal for urgent cancellation of registration.

The inspectors presented their findings to the panel. The Director of Regulation and Nursing informed the panel of the enforcement options that had been considered during an Enforcement Decision Making meeting. Approval was sought from the Decision Making Panel to seek an urgent order for the cancellation of the registration of Runwood Homes Ltd in respect of Ashbrooke Care Home.

The staff in attendance and observers left the meeting to allow the panel to consider the evidence and reach a decision.

- The panel was satisfied that there were a significant number of the regulations and/or parts of the 2003 Order breached.
- The panel was satisfied that sufficient evidence had been provided to demonstrate that there were risks to service users' life, health or wellbeing if the order was not made.
- The panel was assured that emergency arrangements were in place from Thursday 17 August 2017 that would ensure the safety of the patients within the home until the order could be approved by the Lay Magistrate.

The Decision Making Panel approved the application to a Lay Magistrate to seek an urgent order for the cancellation of the registration of Runwood Homes Ltd in respect of Ashbrooke Care Home.

A successful application was made to the Lay Magistrate on 18 August 2017 and Runwood Homes Ltd was served with this notice later in the day of 18 August 2017.

All relevant stakeholders were informed on this date.

The enforcement policies and procedures are available on the RQIA website.

www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

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