The Regulation and Quality Improvement Authority

Inspection Report

Name of Service:Ashbrook Care Home

Provider:Ashbrook Home Ltd

Date of Inspection:9 January 2025

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Ashbrook Home Ltd
Responsible Individual:	Mr Marcus James Mulgrew
Registered Manager:	Ms Kathleen Buccat

Service Profile –
This home is a registered nursing home which provides nursing care for up to 59 patients. The home is separated into two units to provide general nursing care for patients under and over 65 years of age. There are separate lounge and dining areas within each unit.

There is a separate registered residential care home which occupies the same building and the registered manager for this home manages both services.

2.0 Inspection summary

An unannounced inspection took place on 9 January 2025 from 9.45am to 5.20pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 9 January 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led.All areas for improvement from the previous inspection were found to have been met, including, two medicines management areas from a previous medicines management inspection. However, improvements were required with staff supervisions and patients' nutritional assessments. Full details, including the areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home.This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "The staff are very good", and, "Food is nice".

Patients told us that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options and where and how they wished to spend their time.A patient told us, "It's very homely here".

Staff were happy with the staffing arrangements and there was a good working relationship between staff and the management team.

Relatives spoke positively on the care their loved ones were receiving. One told us their relative always looked clean and good attention was given to their skin and nails.

A visiting professional told us that they found the home responsive to patients' needs and adhered well to any recommendations for patient care that they left.

We did not receive any questionnaire responses from patients or their visitors or any responses from the staff online survey.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.However, all staff had not had a six monthly supervision completed. This was discussed with the manager and identified as an area for improvement.

Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

Patients said that there was enough staff on duty to help them. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

A relative told us, “The staff are excellent; absolutely no complaints at all”.

Observation of the delivery of care evidenced that patients’ needs were met by the number and skills of the staff on duty.

3.3.2Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient’s needs, their daily routine, wishes and preferences.

Staff were observed to be prompt in recognising patients’ needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients’ needs.

Staff respected patients’ privacy by their actions such as knocking on doors before entering, discussing patients’ care in a confidential manner and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care. A restrictive practice register was monitored and reviewed monthly.

Patients may require special attention to their skin care. For example, some patients may need assistance to change their position in bed or get pressure relief when sitting for long periods of time. These patients were assisted by staff to change their position regularly and records maintained.

Where a patient was at risk of falling, measures to reduce this risk were put in place. In addition, falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented. A review of accident records following a fall in the home confirmed that the correct actions were taken and the correct persons notified following the fall.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. However, some of these had been incorrectly scored. This was discussed with the manager and identified as an area for improvement.

Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Patients were safely positioned for their meals and the mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs. Staff were aware of the actions to take to ensure patients remain hydrated.

Patients confirmed that activities took place in the home. An activities planner was available for review. Activities included games, arts and crafts, quiz, women's group, music, manicures, walks and reading. Daily records of activity provision were maintained and included one to one or group activities.

Patients spoken with told us they enjoyed living in the home and that staff were friendly. One patient told us, "They are very good here, the staff are very nice". Another commented, "I am very happy here; it is a good place and the staff are all good". A relative told us, "The home is five star; they (the staff) genuinely care for patients here. You can feel the ethos as soon as you walk in".

3.3.3Management of Care Records

Patients' needs were assessed by a nurse at the time of their admission to the home.Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Supplementary care records were maintained to evidence personal care delivery, checks on patients, food/fluid intake, bowel management and records were kept of when patients were assisted with a walk during the day.

Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

3.3.4Quality and Management of Patients' Environment

The home was clean and tidy and patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Fire safety measures were in place to protect patients, visitors and staff in the home. Actions required from the most recent fire risk assessment had been completed in a timely manner.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5Quality of Management Systems

There has been no change in the management of the home since the last inspection.Ms Kathleen Buccat has been the Registered Manager in this home since 1 December 2022. Staff commented positively about the manager and described heras supportive, approachable and always available to provide guidance. The manager was supported by a general manager in the home.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place.

There was a system in place to manage any complaints received. A compliments log was maintained and any compliments received were shared with staff.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further. Patients and their relatives spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Seamus Mulgrew, Director and Ms Dympna Farnan, General Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)

Area for improvement 1 **Ref:** Standard 40 **Stated:** First time **To be completed by:** 31 March 2025	The registered person shall ensure that there is a system in place to make sure that staff receive, at minimum, a recorded supervision every six months. Ref: 3.3.1 **Response by registered person detailing the actions taken:** There is a system in place to ensure that staff receive a recorded supervision every six months.
Area for improvement 2 **Ref:** Standard 12 **Stated:** First time **To be completed by:** With immediate effect (9 January 2025)	The registered person shall ensure that the nutritional assessment tool in use is scored correctly to make sure appropriate actions are taken when a deficit is detected. Ref: 3.3.2 **Response by registered person detailing the actions taken:** Malnutritional Universal Screening Tool (MUST) for all residents will be scored accuratelty with appropriate actions being taken as required. All resident files have been reviewed with current MUST scores checked and amended if required.

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

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews