

**THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)****FAILURE TO COMPLY NOTICE**

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| <b>Name of Registered Establishment</b>  | <b>Name of Registered Person:</b><br>Hutchinson Care Homes Limited<br><br>Ms Naomi Carey<br>Responsible Individual |
| <b>Address of Registered Establishment:</b> 6 Steeple Road, Antrim, BT41 1AF   |  |
| <b>Issue Date:</b> 23 October 2024   | <b>FTC Ref:</b> FTC000226  |
| <b>Regulation not complied with:</b>   |  |
| <p><b><i>The Nursing Homes Regulations (Northern Ireland) 2005</i></b></p> <p><b><i>Registered person: general requirements</i></b></p> <p><b><i>Regulation 10. — (1)</i></b><br/> <i>The registered provider and the registered manager shall, having regard to the size of the nursing home, the statement of purpose, and the number and needs of the patients, carry on or manage the nursing home (as the case may be) with sufficient care, competence and skill.</i></p>  |  |
| <b>Specific failings to comply with regulations:</b>   |  |
| <p>During the inspection on 8 October 2024 significant concerns were raised in relation to the governance and oversight in the home; and the lack of progress with the areas for improvement identified during previous care inspections conducted on 15 June 2023, 12 October 2023 and 6 March 2024.</p> <p>Two areas for improvement, stated under the regulations in relation to the consistent recording of post fall observations and access to hazards have been stated on three occasions since 15 June 2023 and, to date, have not been complied with. A separate FTC Notice has been issued in this regard (FTC000227).</p> <p>Four areas for improvement stated under the standards regarding menu choice and the displaying of the menu, activity provision, infection control measures and staff knowledge of the call bell system were first stated on 12 October 2023 and, to date, have not been complied with.</p> <p>Whilst there was a regular programme of auditing in place it was not effective in driving the improvements required to achieve compliance with the areas for improvement.</p> <p>Nurse in charge competencies had not been completed for all staff who were given the responsibility of being in charge of the home in the absence of the manager. There were only three registered nurses who had a competency assessment completed; none</p> |  |

of the nurses left in charge of the building at night had a competency assessment completed.

It was identified that the call bell system was not working in four bedrooms. RQIA were unable to establish for how long the call bell system for the identified bedrooms had been inactive and the staff on duty were not aware of how to identify faults with the system and had therefore not reported this to the manager. There was no evidence of a system in place to regularly check to ensure that the system is operational/effective. This was concerning as staff knowledge of the call bell system was identified as an area for improvement during a previous inspection on 12 October 2023. The lack of an effective well maintained system to alert staff when patients need assistance places patients at potential risk of harm.

### **Action required to comply with regulations**

#### **The Responsible Person must ensure that:**

- a robust and comprehensive system of governance audits must be implemented effectively to identify any deficits in the delivery of nursing care or other services in the home; this should include, but is not limited to, audits for falls, environmental hazards, Infection Prevention and Control(IPC), call bell monitoring and the dining experience.
- where deficits are identified through the audit process a time bound action plan must be developed to ensure the necessary improvements are addressed
- the monthly monitoring reports in accordance with Regulation 29 are reviewed to ensure these are robust and include review of progress with meeting Areas for improvement identified in the Quality Improvement Plans
- nurse in charge competencies are completed for all staff who take charge in the home in the absence of the manager and a plan for review is established
- staff are to be trained in the use of the call bell system and how to detect and report faults; this training is embedded into practice
- a robust system is in place to ensure that call bells are regularly checked and in good working order

**The Registered Person may make written representations to the Chief Executive of RQIA regarding the issue of a failure to comply notice, within one month of the date of serving this notice.**

**Date by which compliance must be achieved: 10 December 2024**

*Elaine Connolly*

**Signed.....**  
**Director of Adult care services**

***This notice is served under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) (2005)***

***It should be noted that failure to comply with some regulations is considered to be an offence and RQIA has the power under regulations to prosecute for specified offences.***

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| <b>Issue Date:</b> 23 October 2024  | <b>FTC Ref:</b> FTC000227   |
| <p><b>Regulation not complied with:</b></p> <p><b><i>The Nursing Homes Regulations (Northern Ireland) 2005</i></b><br/> <b><i>Further requirements as to health and welfare</i></b><br/> <b><i>Regulation 14.-(4)</i></b></p> <p><i>The registered person shall make arrangements, by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse.</i></p>  |   |
| <p><b>Specific failings to comply with regulations:</b></p> <p>During the inspection on 8 October 2024 a review of a sample of patient records were reviewed in relation to post falls observations.</p> <p>An area for improvement in this regard was first stated on 15 June 2023 and again on 12 October 2023 and 6 March 2024. This area for improvement has not been met. A review of a sample of patient records in relation to the management of post falls observations evidenced that these continued to be inconsistently recorded, some gaps were evident with no clear rationale as to why and the recording was not in keeping with the home's own post falls protocol. At the intention meeting on 18 October 2024, RQIA were presented with the post falls management guidance and documentation provided to the home's staff. This was inaccurate and not in accordance with best practice in relation to falls management or good record keeping principles. The failure to consistently record neurological/post falls observations may result in a failure to identify deterioration in the patient and to seek medical assistance in a timely manner.</p> <p>During the inspection a number of hazards were identified which placed the patients at risk of harm.</p> <p>Patients requiring a specific modified diet to reduce the risk of choking, as prescribed by speech and language therapists had access to various food items throughout the home. A selection of food and yoghurts were stored in a cupboard in the dining room of Eden</p> |   |

Hill; staff belongings and drinks were also accessible in a communal area. In Ladyhill, the hairdressing room was unlocked and various items were accessible such as shampoos, conditioners and hairspray along with hairdressing equipment; a storeroom in Hollyhill was unlocked and hot water pipes were accessible which created a risk to patients from the hot surfaces; a small number of fire doors were observed to be propped/wedged open which compromised the effectiveness of the fire door in the event of a fire; and staff were observed wearing watches, jewellery and nail polish, which is not in keeping with regional infection prevention and control procedures.

An area for improvement in relation to the the management of hazards to patients was first stated on 15 June 2023 and again on 12 October 2023 and 6 March 2024. RQIA are concerned that the management and staff have failed, over time, to demonstrate the operation of a safe system of recognising or managing potential risks of harm.

### **Action required to comply with regulations**

The Responsible Individual must ensure that:

- the falls policy and post falls protocol is reviewed to ensure it is accurate and clearly guides staff on the actions to take following a fall
- registered nursing staff are provided with training relevant to their role and responsibilities in relation to the management of falls and the post falls protocol
- staff can demonstrate their knowledge of the falls policy and post falls protocol commensurate with their roles and responsibilities.
- falls are managed in accordance with the homes own falls policy in relation to the consistent recording of neurological/post falls observations
- there is a robust sytem in place to minimise risks to patients which includes the safe management of food and fluids, hot surfaces, access to chemicals used for cleaning/hairdressing and access to equipment
- the system to identify/recognise and manage various types of hazards to patients is clearly understood by staff commensurate with ther role and responsibilities
- there is a robust system in place to monitor and address staff practice in relation to inection prevention and control practices
- there is a robust sytem in place to ensure the practice of wedging or propping open of fire doors ceases.

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