Rapid investigation into the regulatory response to issues at Dunmurry Manor care home by the Regulation and Quality Improvement Authority (RQIA)
Terms of reference

The purpose of this report is to provide the Department of Health with an assurance as to the appropriateness of the Regulation and Quality Improvement Authority’s (RQIA) role in regulating Dunmurry Manor Care Home and of RQIA’s response when issues arose.

Specifically:

1. To review the actions taken by RQIA in respect of pre-registration; registration; and inspection activity to ensure these align with policies and procedures;
2. To review and assess the actions taken by RQIA when non-compliance with standards and regulations was found by inspectors and determine if these actions were in line with policies and procedures and appropriate given the level and scale of any non-compliance;
3. To make any recommendations for improvement in respect of the policies and procedures referenced above;
4. To consider the powers granted to RQIA by The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003 and consider any additional powers or flexibility under the legislation which would have enabled RQIA to have more effectively discharged their regulatory role in respect of Dunmurry Manor Care Home.

Context

A site visit of Dunmurry Manor was included in the review. During this visit the reviewer met with the registered manager of the home and the responsible person from the provider and during a walk-round met with a number of staff and residents.

At the time of this review, RQIA assessed that the home was operating in compliance with the regulations and has benefitted from a period of stability in management. The provider, manager and staff have worked to improve the service and the reviewer would highlight that it is of the utmost importance that the impact or publicity that may arise from this or any associated review and other investigations is considered in relation to the potential impact on the wellbeing of the current residents and their families and there is recognition that the way the service is operating now is different to how it was operating when non-compliant.

Scope and method

The Care Inspectorate appointed a Team Manager to undertake this review according to the terms of reference outlined above. As part of the review the following documentation was examined:

• A timeline of events provided by RQIA that covered the period from 3 October 2014 to 18 September 2017.
• Pre-registration inspection report dated 10 July 2014 and the Pre-registration premises document (New premises for new home) that covered the period May/ June / July 2014
• The template used for recording discussions with the candidate for registered manager / registered person post, the procedure for registration of registered manager and the procedure for
registration of responsible person.
• A timeline provided by RQIA of the managers of the care home from 16 July 2014 to 14 December 2016.
• Inspection reports for the inspections carried out between 15 October 2014 to 28 July 2017. This included inspections of care (including follow-up to concerns), medicines, premises, finance and enforcement compliance.
• Enforcement documentation. Namely, the enforcement policy (April 2013), letters to the provider, minutes of serious concern meetings, minutes of enforcement decision meetings, failure to comply notices, minutes of intention to issue a notice of proposal meetings, notice of proposal.
• Concerns logged on RQIA’s Iconnect system from 8 December 2014 to 30 December 2016
• An overview of the number and types of notifications received from Dunmurry Manor from 1 April 2014 to 8 March 2017.
• Guidance on complaints handling in regulated establishments and agencies (circular from DHSSPS dated 1 April 2009).
• Care Standards for Nursing Homes April 2015. DHSSPS.
• Policy and Procedure for the Inspection of Establishments and Agencies within the Regulated Sector 4 December 2008.

The review also encompassed discussions with the Chief Executive of RQIA, the Programme Lead for Nursing Homes, 2 senior inspectors and the allocated inspector for Dunmurry Manor for the time period covered by this review.

Findings

1. The regulatory actions taken by RQIA in respect of pre-registration, registration; and inspection activity aligned with their policies in procedures that were in place at the time covered by this review.

Pre-registration and registration
The reviewer found that between May and June 2014 RQIA had a checklist in place to record that all the required documentation for registering the premises of Dunmurry Manor was received and considered and where follow up actions were indicated these were pursued and put in place by the provider.

A pre-registration inspection was carried out by the allocated inspector on 10 July 2014 to determine compliance with the Registration and Nursing Home regulations. During this inspection discussions were held with the individuals applying to be registered as the manager and the responsible person to ensure they had the relevant knowledge and understanding of their responsibilities of the roles and of the DHSSPS Nursing Home standards.
From this inspection three recommendations were put in place, around development of the Statement of Purpose, the Patient’s Guide (to include financial arrangements) and completion of dementia audits. Given the assurances provided to RQIA the registration was appropriately recommended.

**Inspection**

During the time covered by this review there were 18 inspections carried out. This included 4 medicines inspections, 1 finance inspection, 1 premises inspection, 10 care inspection and 2 enforcement compliance inspections all of which were unannounced. The level of scrutiny and frequency of inspections was determined by RQIA’s consideration of risk and intelligence and was in accordance with the inspection policy in place at the time. This states that the RQIA are required to inspect a nursing home a minimum of twice in every 12 month period. However, an assessment of risks to the welfare of the service users will define the number of inspections (if more than the minimum frequency), the issues that will be considered during these inspections, whether they should be announced or unannounced inspections and the specialist inspectors that will be involved.

This review found that decision making around level of scrutiny, type of inspection and frequency was informed by professional discussion between the lead inspector and programme lead. Again, this was in line with the procedure in place at the time.

**Registration of manager and responsible person**

From the point of pre-registration to July 2017, when the enforcement action was removed, there had been 10 different managers of the care home and a number of changes to the responsible person. RQIA followed their process for registration of these posts, which included submission of information from the applicant, consideration of this by RQIA, disclosure checks and references and a face to face or telephone discussion. During these discussions RQIA staff routinely used a template for questions that helped to determine that the proposed management had the relevant knowledge and understanding of their responsibilities of the roles and of DHSSPS standards.

From the Care Inspectorate’s experience of inspecting care homes for older people and the evidence we gather; there is a clear correlation between the quality of management and leadership and the quality of care. Competent, effective and stable management and leadership is usually associated with good quality care and results in good experiences and outcomes for people who use services. Conversely, inconsistent or weak management and leadership is often associated with poor quality of care.

2. **Actions taken by RQIA when non-compliance with standards and regulations was found by inspectors were appropriate and in line with the policies and procedures in place at the time covered by this review.**

Enforcement action was taken against the provider of Dunmurry Manor care home in October 2016 when three ‘failure to comply notices’ were served. It is the reviewer’s view that all scrutiny activity taken prior to these notices being served was in line with the ways in which a regulator of care services should support improvement in a new service that was facing difficulty in recruiting and
retaining a registered manager. This review found that RQIA had promoted good practice, encouraged improvements and took action to protect people using the service when poor practice was identified.

There was consistency of lead inspector for the service. The lead inspector was experienced in regulation of nursing homes and had a very good knowledge of dementia care. It was clear that RQIA had allocated inspection staff to ensure the right skills, knowledge and experience was in place to properly regulate this service.

During inspections a number of requirements and recommendations were made when the service was found to require improvement to operate in line with regulations and care standards. Inspectors were robust in following these up in order to determine that the provider had taken the necessary action to improve. Inspectors had also followed the process for escalation of concerns when improvements in the standard of care were not made or sustained.

In February 2015, in line with RQIA enforcement procedures, a serious concerns meeting was held with senior inspectors and senior management from Runwood Homes (the provider of Dunmurry Manor). At this meeting assurances were given by the provider that actions to improve to the service would be implemented within timescales set out by the regulator. The provider was advised at this meeting that they would be given time to improve, however, if improvements were not made this could result in enforcement action being taken.

This review found that following this meeting and until November 2015 the care home had benefitted from a period of stability in the management team. The inspection findings show that improvements were being made to the standard of care during this period.

The evidence examined showed that concerns and safeguarding issues received by RQIA from various sources (members of the public, other providers, relatives of residents and staff) were dealt with in accordance with guidance (circular from DHSSPS dated 1 April 2009). RQIA staff either referred complainants and concerns they received to the service provider or to adult protection at the relevant trust or they used the intelligence to inform the inspection process or undertook a focused inspection.

The care inspection carried out in October 2016 found that improvements to the service had not been implemented or sustained and senior management from Runwood homes were required to attend a meeting with RQIA when they were advised of the regulators intention to issue ‘Failure to Comply Notices’. The reviewer found that inspectors and the programme lead had followed the RQIA’s policies for escalation and enforcement and had issued three ‘Failure to Comply Notices’. The process included informing relevant stakeholders, publishing information on the web-site, advising the provider of their right to make representation and setting timescales for compliance to be achieved.

In line with their policies and procedures RQIA then carried out further scrutiny (enforcement compliance inspection on 4 January 2017) that identified that compliance had not been achieved. Evidence examined shows that a Directorate decision was made by RQIA to extend the timescale to the legal maximum of 90 days for the provider to comply. Subsequently, a further enforcement compliance inspection was carried out on 27 January 2017 which found progress being made by the service to meet two of the notices and compliance was confirmed in the third notice.
The programme lead, senior inspectors and inspectors of the RQIA nursing home team met on 31 January 2017 and held an enforcement decision meeting when the regulatory history of the service, current enforcement and regulatory options were considered and the decision was made to hold a Notice of Proposal meeting. In line with RQIA escalation process this meeting took place; chaired by the Director of Regulation and a ‘Notice of Proposal’ was issued which ultimately led to conditions being placed on the registration of the service. The documentation examined by this review in respect of enforcement decision-making and activity demonstrates that RQIA ensured that the responsibilities for the implementation and application of the enforcement policy and procedures were being dealt with at the appropriate level and in accordance with policies, procedures and timescales in place at that time.

3. Recommendations for improvement in respect of RQIA policies and procedures based on the approaches taken by the Care Inspectorate.

Reflecting on our experience as the scrutiny body for social care in Scotland and based on the evidence examined during this review, the reviewer would make a number of recommendations for improvement for RQIA’s consideration. (The reviewer noted that work was already in progress in a number of the areas covered in these recommendations however, were not in place for the time period covered by the review. The reviewer also noted that there are aspects of RQIA’s practice that can inform improvements in the work of the Care Inspectorate).

RQIA has begun to further develop their policies, procedures and practices in respect of strengthening an improvement-based approach to regulation. The review found that from July 2014 to the current time, inspections were increasingly focussing on experiences and outcomes for residents and partnership working.

Over the past two years, the Care Inspectorate has evolved its approach to work more collaboratively with providers; with a focus less on compliance and more on improvement activity, where scrutiny activity is very much seen as the diagnostic tool to identify opportunities for improvement. One significant change for the Scottish regulator is that we have made fewer requirements of services and where we have made these there is a strong focus on improving experiences and outcomes for residents, as opposed to more technical requirements. RQIA could consider embedding this approach in their policies and procedures and reviewing the guidance for staff on when they make requirements.

The process in place to carry out checks on proposed managers/ responsible person for care services was found to be very good, in the most part. However, the reviewer found in some instances that it could take a period of time before applications were received and processed and in the case of Dunmurry Manor there were a number of times that the manager had been in post and then left before their registration had been processed. RQIA should give consideration to ways in which they could reduce the amount of time taken to carry out the relevant checks to identify that the individuals who are taking on these roles are suitably equipped to do so. Consideration could also be given to ways in which RQIA, providers of services and other agencies can work together to ensure individuals taking on these roles are supported to gain the knowledge and understanding required.

Dunmurry Manor had a high number of inspections carried out since it was first registered. High levels of scrutiny can burden services and may not necessarily support them to improve when they are
failing. There is a balance to strike to ensure that regulators are responsive and robust in their role of protecting people using services, whilst being proportionate and supporting improvement. The review noted that whilst the frequency of inspections was high most of the inspections were carried out over part of one day and none of the inspections took place at evenings, weekends or overnights. RQIA are in the process of implementing the RADAR tool to support more responsive regulation and have identified that the Inspection procedures require to be reviewed and updated. Consideration should be given to these procedures including guidance for staff on using intelligence to assess risk and support decisions about the timings of inspection to ensure the experience of residents is fully captured, including in the evening, first thing in the morning, overnight and at weekends.

Consideration could also be given to the benefits and consequences of the current types of inspection that are carried out by RQIA. All inspectors at the Care Inspectorate are required to look at aspects of the premises (setting), management of resident’s finances and medication management as part of each inspection. We do not have separate inspectors/ inspections to look at these areas and each subsequent inspection follows up all requirements or recommendations made at the previous inspection. In the case of Dunmurry Manor this review found that each specialist area (care, medicines, finance, premises) made assessments in their own area and only followed up on their own requirements. RQIA should consider reviewing how their specialist resources are best utilised to ensure services are clear on what is required to improve and have the support to do so.

A key area for supporting improvement at a provider and area level that is carried out by the Care Inspectorate is the role of the relationship manager. This entails an appropriately qualified person (usually a Team Manager, who line manages inspectors) who establishes links with local areas and providers of services and meets periodically to look at their performance, to share information and good practice guidance and to facilitate links with other agencies. This greatly assists the Care Inspectorate to enhance capacity for collaborative working, supporting improvements and gather intelligence about the strengths and areas for improvement of that provider. At a programme lead level RQIA link in with providers and representatives from the Trusts, however they could consider enhancing this work by the development of the ‘Relationship Manager’ role.

In relation to considering the intelligence from concerns and complaints, the model used by the Care inspectorate differs to that of RQIA. The Scottish regulator has a statutory responsibility for receiving complaints about care services and carries out focused complaint investigations where this is appropriate. The outcome of these complaints is then considered as part of our overall regulatory activity and any requirements or recommendations for improvements are followed up during inspections. Given that most complaints and concerns are handled by the service or the Trust, RQIA then depends on the information provided to them to inform their intelligence about the service. In the case of Dunmurry Manor, the reviewer found that a log of concerns received by RQIA was maintained and some of these concerns led to focused inspections. However, it was not clear that the outcome of investigations carried out by the provider or Trust was always made available to RQIA. Consideration should be given to ways in which communication around the outcome of complaint investigations could be improved.

Where services are not making improvements the Care Inspectorate would normally take a graduated approach to enforcement. This involves adopting the least restrictive action that is likely to address the identified issues and bring about the necessary improvement/outcomes.
The first step in this approach will be discussion with the provider to secure a resolution. This would not rule out the option to move directly to legal sanctions, where circumstances deem this necessary in the interests of people who use the service. If improvement is not demonstrated and people are at risk, we have extensive enforcement powers to require improvement, including through the courts. These are exercised rarely, because we always seek to support improvement first. However, in specific circumstances where there is a risk to the life, health, or wellbeing of people we may at any time issue an ‘Improvement Notice’ which can result in cancellation of registration, where the service does not comply with required improvements within the specified time period. We can also go straight to Emergency Cancellation of a service where there is immediate and serious risk to health, safety and wellbeing of residents (Public Services Reform (Scotland) Act 2010).

This review was made aware that RQIA had a system in place for identifying services at a pre-enforcement stage. This was mainly around the allocated inspector discussing with the programme lead at their monthly supervision and through bimonthly reports services where there were concerns. The Care inspectorate identifies poorly performing services by RAD (Risk Assessment Document) and by our grading of services performance across four quality themes. Both these measures are dynamic and are reviewed when significant intelligence is received and/or following inspection. When a service has low grades (indicating an unsatisfactory or weak performance) and/or a High RAD a regulatory plan and chronology is commenced. This helps the inspector and their manager to record discussions and decisions around our regulatory response. As referred to previously, RQIA are implementing RADAR and could consider the ways in which regulatory plans and chronologies could be used.

In terms of recommendations around the policies and procedures for enforcement this review found a key area related to the measures that could be taken to ensure that residents, relatives and staff are kept informed and receive assurance throughout the enforcement process. As part of a communication strategy it is normal practice at the Care Inspectorate for allocated inspectors and managers to attend meetings in services where enforcement action is taken to assure people that we are monitoring the service and to ensure the provider answers questions that residents and their relatives may have about the actions they will take to improve. RQIA should consider including the potential benefits of introducing this practice in their enforcement procedure.

4. Consideration of any additional powers or flexibility under the legislation which would have enabled RQIA to have more effectively discharged their regulatory role in respect of Dunmurry Manor Care Home.

In respect of the legislation, this review found that in general these were comprehensive, specific and when applied with the Care Standards focused on ensuring services were delivered in a way that upheld the human rights of people using services.

Consideration could be given to the extent to which dementia care and the outcomes for people with dementia (which was specific to Dunmurry Manor) is covered.

At the time of carrying out this review the registration for Dunmurry Manor was being changed to have separate registrations for the part of the home providing nursing care and the part providing residential care. (Previously both areas of the home, despite providing different categories of care as defined by the legislation, were under one registration). This may help provide clarity about what the service can provide when residents are placed there and help providers and regulators to apply the specific regulations.

In conclusion, and notwithstanding the recommendations made herein; this review found that RQIA regulated Dunmurry Manor care home in accordance with the policies and procedures in place at the time. Significant consideration has been given by RQIA into ways in which they can improve their systems and process and work is in progress in a number of the areas covered in the recommendations made in this report. Thanks are extended to RQIA staff for the time and cooperation given to this review.