APPENDIX 1

HOME OPERATION SUPPORT GROUP (HOSG) REPORT FOR BRINDAAVAN NURSING HOME, ABERBARGOED, CAERPHILLY

1. Background to the Report

1.1 Welsh Government (WG) introduced statutory guidance 'Escalating concerns with, and closures of, care homes providing services for adults' in May 2009. The guidance requires local authority and health board partners to use a process to manage escalating concerns within care homes and advised the use of inter agency panels or meetings to review progress of development and corrective action plans that could be used to manage the required improvements.

1.2 The escalating concerns guidance also requires arrangements to be put in place for the direct operational management of a care home closure; the Home Operation Support Group (HOSG). The guidance states that following any home closure the members will meet to evaluate the closure process and identify lessons learned with a report provided to Care and Social Services Inspectorate Wales (CSSIW). The guidance requires reports on home closures to be circulated to senior managers within local statutory agencies, the chairperson and members of the local authority scrutiny panel and also the chairperson and members of the Health Board.

1.3 Although the concerns identified in relation to Brindaavan Nursing Home culminated in the termination of contracts between the Local Authority, Aneurin Bevan University Health Board and the care provider, this was not a home closure, and therefore it was agreed at an early stage to use this process as a guide to best practice.

2. The Care Home & Rationale for Contract Termination

2.1 Brindaavan Nursing Home is registered with CSSIW to provide nursing care for people with dementia. The home is registered for 32 older people with dementia. At the time of the contract termination there were 23 residents, of which, 5 were in hospital. Of the residents being cared for in Brindaavan Care Home 14 residents were funded via CHC and 4 were funded via FNC.

2.2 Brindaavan Nursing Home was subject to the Provider Performance Monitoring Process (PPMP) on two previous occasions. However following further significant concerns that were raised in relation to the home, it became subject once again to the PPMP. The concerns raised related to -

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CSSIW were contacted by the Coroner's Office due to the death of a resident from Brindaavan Nursing Home. Subsequently, CSSIW facilitated an unannounced inspection at the home on 22/9/15 and 25/11/15. The outcome of the inspection resulted in a number of concerns being raised and 5 urgent non-compliance notices being served to the home. The non-compliance notices were issued in respect of -

- Leadership and management of the home
- Medication management
- Lack of robust staff recruitment processes
- Supervision of staff
- Staff training

Following the issuing of the non-compliance notices by CSSIW, commissioners of the service were informed that Brindaavan Nursing home had been identified by CSSIW as a 'Service of Concern'. As a result of the notification from CCSIW, ABUHB and CCBC instigated increased monitoring at the home – this identified the following areas of concern, all of which were subject to discussion, review and the management of risk as outlined within the Provider Performance Monitoring Protocol.

- Management, direction and leadership of the home
- Competence and performance of the qualified nurses – one nurse attended an NMC hearing on 30/11/15 in Cardiff
- Non-compliance notices issued by CSSIW
- Poor quality of documentation relating to residents
- Lack of DNACPR's
- Staffing level at the home and skill mix of staff
- Lack of appropriate response to falls, incidents and accidents
- Medication management
- Staff training
- Staff supervision
- Pressure management and skin integrity issues
- DOL's application not being made
- Use of restraint within the home
- Residents not being treated with dignity and respect in the home
- Lack of appropriate and timely referrals to health professionals/failure to recognise deteriorating health conditions
- Gaps in recruitment processes within the home
- Lack of administration support for the home

- Environment experiencing extremes of temperature due to the glass dome
- Communication systems
- Nutrition, the documenting of fluid intake and the dietary support mechanisms which were in place.
- Lack of an internal QA system to identify issues/concerns

2.3 CCBC and ABUHB contract monitoring and governance team worked collaboratively with the Provider to address the concerns identified in the Provider performance Action Plan. However, despite the intensive and direct intervention and support provided to the nursing home and the management, agencies were concerned there had been very little evidence that the Responsible Individual or Registered Manager had taken sufficient action to address the issues identified. In addition, there was a lack of confidence in the Registered Manager to make the necessary improvements required.

2.4 From the 12/1/15 to 11/11/15, there were 5 significant Adult Protection Referrals generated in relation to residents at Brindaavan Nursing Home. These related to –

- The ingestion of a medication pot that resulted in the death of the resident – this was subject to a coroner's inquest
- Maladministration of warfarin - this has been the subject of a coroner's inquest
- Concerns raised in relation to the management of a resident following a fall which resulted in the residents admission to hospital – this resident passed away in hospital
- Admission to hospital of a resident following collapse – multiple pressure areas identified by the hospital on admission
- Concerns were raised in relation to the monitoring of a resident following a fall – this resulted in a hospital admission – the resident passed away in hospital.

2.5 On conclusion of the initial provider performance meeting which was held on the 6/11/15, the risk associated with the home was at a severe/critical level, therefore it was agreed the requirement for daily monitoring of the nursing home. Actions given to the manager at that meeting were not all auctioned by the manager and by the second provider meeting on 20/11/15, further new concerns were identified.

These related to –

- Continuing failure to implement recommendations made by visiting professionals

- Further issues with medication
- Significant issues raised by the dietician that relate to failure to act on advice and treatment plans given, pureed food that was not an appropriate consistency, resident preferences not being given
- No fluids available in rooms for people being cared for in bed
- Poor quality of the food and significant concerns identified in relation to the kitchen arrangements and a lack of direction and ownership of providing good nutrition to the residents
- CSSIW expressed disappointment at the lack of progress made in relation to the evidence for the non-compliance notices that were issued
- It came to light that the nursing agency used by the home was not registered with CSSIW – manager had not undertaken the necessary checks in line with NMS
- Some bathing facilities at the home had not been available for a number of days
- New acting manager took a decision to implement a change in the observations undertaken at night, moving them to 3 hourly rather than taking a person centred approach to individual need, especially for residents who were unwell.
- An early morning visit undertaken by ABUHB identified that night staff identified a number of residents were provided with personal care and dressed at 5am, it appeared this practice was implemented to assist the day staff.
- Gwent Police advised one of the adult protection referrals was subject to a criminal investigation.

2.6 As a result of the significant concerns identified, a number of safeguarding measures were implemented –

- A review of the health and social care needs of all residents was undertaken
- Specialist healthcare support from the following professionals was arranged this included the following professionals, Dietician, Occupational Therapy, Tissue Viability Nurse, Community Psychiatric Nurses and a Pharmacist
- To monitor the quality of care and resident safety, ABUHB and CCBC coordinated a visiting schedule to ensure there was a daily presence at the home.
- A daily reporting system was developed by ABUHB and CCBC which required the home to inform the commissioners of any adverse events such as hospital admissions, staffing levels, falls, pressure damage, medication concerns

- Prior to any resident transfer, their fitness to travel was assessed by the GP aligned to the individual resident
- Occupational therapy assessments and review were undertaken in order to ensure safe and effective resident transfers and appropriate manual handling practice.
- Nurse assessors and care staff from Brindaavan Nursing home accompanied residents on transfer to their new homes.

2.7 A number of meetings between ABUHB and CCBC were held which discussed the serious and ongoing nature of the concerns a joint decision was made to terminate respective contracts with the Provider. A meeting was held on Monday November 30th 2015 between ABUHB, CCBC and the Responsible Individual/Owner of Brindaavan Nursing Home to advise of the decision to terminate the contracts.

3. Methodology

3.1 Weekly HOSG meetings were established on 19th November 2015. Membership of the group included CSSIW, Team Manager, Review Team CCBC, Contract Manager Complex Care ABUHB. The HOSG was jointly chaired by Alison Neville, Senior Nurse, Safeguarding and CHC and Viv Daye, Service Manager, Commissioning.

A weekly multi-disciplinary sub-group of the HOSG was also established comprising of contract monitoring officers, nurse assessors, lead governance nurses, dieticians, social workers and a representative from the older person's mental health team.

3.2 It is anticipated that a review meeting/lessons learned workshop for the HOSG process relating to Brindaavan Nursing Home will be held in the near future.

4 Legal Process

4.1 CCBC and ABUHB respectively sought legal advice in relation to the providers' breach of their contracts.

4.2 Following the meeting held on the 30th November 2015, to advise the Responsible Individual/Owner of the decision to terminate the respective contracts letters were sent by CCBC and ABUHB regarding the termination clause details.

5 Resident Relocation

5.1 CCBC and ABUHB took responsibility for all the residents of Brindaavan Nursing Home. There were no residents that were funding

their own care at the home, however 1 resident had been placed by Torfaen County Borough Council this resident was in hospital at that time.

5.2 Sharing information with families where concerns arise in care homes is a complex problem. One of the concerns expressed by families was the termination of contracts and the need for residents to move from the home came as a surprise. Many families were unaware of any concerns and even when families had been involved in / informed of protection of vulnerable adults concerns they were not inclined to move their relatives under the Choice Procedure. This resulted in delicate discussions being held with families in addition to the invitation to attend the relatives meeting. During the relative notification process difficulties arose with regards to initial inability to contact 2 residents' families. However this was resolved and the remaining family member was in contact with the Senior Nurse for CHC and Safeguarding on the 23.12.15 whereby a meeting was held with the relative to provide them with an opportunity to discuss their relatives move. Staff meetings were also arranged and attended by representatives of ABUHB and CCBC.

6. Home Operation Support Group (HOSG)

6.1 The membership of the HOSG is outlined in 3.1, the agencies involved in this process were mindful even though this process was not a home closure, it was agreed at an early stage to use the HOSG process from Escalating Concerns as a guide to best practice. The HOSG met weekly and was effective in sharing information and managing the overall process.

6.2 A HOSG Sub-Group was established to manage the process of assessing residents, offering advocates, working with families, coordinating visits to the home, coordinating the moves of residents, facilitating visits to potential new homes, supporting frontline staff and as a general forum for communication. The group comprised of social workers, community psychiatric nurses, nurse assessors, lead governance nurses and contract monitoring staff. There were many excellent examples of joint working on individual cases as evidenced through the work of the sub-group. Its members valued the sub-group as a forum for keeping up to date as circumstances changed throughout the process, for peer support and for coordinating activities on individual cases.

6.3 Effective joint working ensured success in relation to the relocation of residents given the breadth of complex interventions required prior to transfer to their new homes, audits of case records and most importantly the outcomes achieved by residents through the transition to new care homes as outlined below –

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The transfer's commenced from both Brindaavan Nursing Home and Ysbyty Ystrad Fawr on the 1 December 2015, and was completed on 16 December 2015. During this time, 18 residents were supported to move to a new home.

Resident	New Home	Date
1	Greenhill Manor, Merthyr	1/12/15
2	Ashville Care Home, Brithdir	3/12/15
3	Glan Yr Afon Care Home, Fleur De Lys	3/12/15
4	Bargoed Care Home, Bargoed	3/12/15
5	Ashville Care Home, Brithdir	4/12/15
6	Bank House, Blaenau Gwent	4/12/15
7	Bargoed Care Home, Bargoed	4/12/15
8	Bargoed Care Home, Bargoed	7/12/15
9	Glanbury Care Home, Blaenau Gwent	7/12.15
10	Plasgellar Care Home, Blaenau Gwent	8/12/15
11	Bank House, Blaenau Gwent	9/12/15
12	Glanbury Care Home, Blaenau Gwent	10/12/15
13	Bank House Home Blaenau Gwent	11/12/15
14	Valley Manor Care Home, Rhymney	11/12/15
15	Bank House, Blaenau Gwent	14/12/15
16	Meadowlands, Aberdare	15/12/15
17	Glanbury Care Home, Blaenau Gwent	16/12/15
18	Meadowlands, Aberdare	16/12/15

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6.5 Alongside information on individual service users a co-ordinated approach enabled the ability for daily visits by professionals to the home. This facilitated the requirement for up to date information concerning staffing levels and the ability to utilise the sharing of information. This was also cascaded and discussed at the sub-group and enabled a rounded picture of care at the home and the ability to share concerns. This was crucial in risk management on individual cases but also with regard to the home as a whole.

There were many positive elements to the HOSG process overall, including:

- Robust links between HOSG and HOSG sub-group with some members of the sub-group also being members of the HOSG
- It was helpful to have HOSG and subgroup meetings on the same day
- Professional roles were clearly defined
- Protection of vulnerable adults concerns were well managed and the links with frontline staff worked well
- Bed availability and moves from Brindaavan Nursing Home were coordinated
- Available beds in other homes could be secured in advance
- Management of visits to the home was coordinated via an electronic schedule to prevent too many professionals appearing at the home at the same time.
- Advocacy and IMCA services were coordinated
- Support for frontline staff was available at many levels (peer support, senior manager, team managers and the HOSG sub-group)
- Provided a focus for frequent contract monitoring visits and also regulatory visits.

6.5 Regulator - CSSIW were represented at the HOSG and were part of the management of the process. The lack of progress on responding to outstanding compliance notices remained a key issue until the last resident left Brindaavan Nursing Home. At the same time, CSSIW's responsibilities with regard to the registration of the manager and in enforcing minimum care standards were managed through their own line management and legal processes.

6.6 Bed Capacity - Available bed capacity remained an issue throughout the process of moving residents from Brindaavan Nursing home to their alternative homes. On completion of the process the moves had consumed all the available dementia nursing beds in the County Borough and it was necessary for 11 of the 18 residents to move to neighbouring boroughs as outlined in 6.3.

6.7 It also needs to be noted the impact of the residents moving to alternative care homes had an impact on the ability of the hospital to discharge patients into care homes for people with dementia.

6.8 Current situation - following the residents' move to a new home, the HOSG requested a weekly update on each resident in order to review the outcome and progress of each resident's move. As of 8/1/16, there has been positive feedback from families and visiting professionals.

Examples of this include –

- Residents being able and supported to access lounge areas rather than being cared for in bed
- Residents have gained weight
- Residents who were previously uncommunicative are now inclined to communicate and interact with staff and other residents
- Reduction in behaviours that challenge staff
- Reports of residents having settled well into their new home

Sadly, 2 residents that moved home have passed away due do acute health issues – there is no indication the deaths were associated with the transfers to their new home, as both residents had settled in very well to their new environments.

7 Recommendations

The termination of the contracts with Brindaavan Nursing Home and the ensuing process identified a number of lessons to be learned. It would be beneficial for a multi-agency workshop to be arranged in order to –

- Review the resident moves
- Review communication with relatives and families when concerns are identified in care homes
- Consider joint contracts for nursing care
- Review the level of intervention and subsequent resources required to manage the process

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Friday January 8th 2016