

Unannounced Care Inspection Report 9 November 2017



Oakmont Lodge Residential Unit

Type of Service: Residential Care Home
Address: 267 – 271 Old Belfast Road, Bangor, BT19 1LU
Tel No: 028 9185 4579
Inspector: Ruth Greer

www.rgia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for



2.0 Profile of service

Oakmont is a residential home registered to provide care for 27 residents whose needs have been assessed within the categories of care cited in the certificate of registration.

3.0 Service details

Organisation/Registered Provider: Maria Mallaband (9) Limited Responsible Individual(s): Mrs Victoria Craddock	Registered Manager: Mrs Lisa Harrison
Person in charge at the time of inspection: Annette Martin (senior care assistant)	Date manager registered: 26 June 2016
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia MP - Mental disorder excluding learning disability or dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years LD - Learning Disability LD (E) – Learning disability – over 65 years PH - Physical disability other than sensory impairment PH (E) - Physical disability other than sensory impairment – over 65 years	Number of registered places: 27

4.0 Inspection summary

An unannounced care inspection took place on 7 November 2017 from 9 50 to 14 20.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

The inspection assessed progress with any areas for improvement identified since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staff training, regular managerial audits and a person centred approach to the delivery of care.

Residents and their representatives reported that they were happy with the home and felt fully involved with and included in all aspects of the care delivery.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and resident experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Annette Martin, Senior Care assistant in charge as part of the inspection process and can be found in the main body of the report. Juliet Green, Manager Oakmont private nursing home was also present for the feedback session.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the most recent inspection on 23 May 2017.

5.0 How we inspect

Prior to inspection the following records were analysed: the previous inspection report, notifiable events, and written and verbal communication received since the previous care inspection.

During the inspection the inspector met with fifteen residents, five staff and two residents' visitors/representatives.

Questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA. No questionnaires were returned within the requested timescale.

The following records were examined during the inspection:

- Staff duty rota
- Induction programme for new staff
- Staff supervision and annual appraisal schedules
- Staff training schedule/records
- Five residents' care files
- The home's Statement of Purpose and Residents' Guide
- Minutes of recent staff meetings
- Complaints and compliments records
- Audits of risk assessments, care plans, care reviews; accidents and incidents (including falls, outbreaks), complaints, environment, catering
- Infection control register/associated records
- Accident/incident/notifiable events register
- Monthly monitoring report
- Fire safety risk assessment
- Fire drill records

- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- Individual written agreement
- Programme of activities
- Policies and procedures manual

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 23 May 2017

The most recent inspection of the home was an unannounced care inspection.

6.2 Review of areas for improvement from the last care inspection dated 23 May 2017

There were no areas for improvements made as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The senior care assistant confirmed the staffing levels for the home and that these were subject to regular review to ensure the assessed needs of the residents were met. No concerns were raised regarding staffing levels during discussion with residents, residents' representatives and staff.

A review of the duty roster confirmed that it accurately reflected the staff working within the home.

Review of completed induction records and discussion with the senior care assistant and staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities.

Discussion with staff confirmed that mandatory training, supervision and appraisal of staff was regularly provided. A schedule for mandatory training, annual staff appraisals and staff supervision was maintained and was reviewed during the inspection.

The senior care assistant confirmed that competency and capability assessments were undertaken for any person who is given the responsibility of being in charge of the home for any

period in the absence of the manager; records of competency and capability assessments were retained. Samples of completed staff competency and capability assessments were reviewed and found to satisfactory at the previous inspection. These were not reviewed on this occasion.

Arrangements were in place to monitor the registration status of staff with their professional body.

The adult safeguarding policy and procedure in place was consistent with the current regional guidance and included, definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed.

Discussion with staff confirmed that they were aware of the regional guidance (Adult Safeguarding Prevention and Protection in Partnership, July 2015) and a copy was available for staff within the home. Staff were knowledgeable and had a good understanding of adult safeguarding principles. They were also aware of their obligations in relation to raising concerns about poor practice and whistleblowing. A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff.

Discussion with the senior care assistant, review of accident and incidents notifications, care records and complaints records confirmed that all suspected, alleged or actual incidents of abuse were fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records were retained.

The senior care assistant confirmed there were risk management procedures in place relating to the safety of individual residents. Discussion with the senior care assistant identified that the home did not accommodate any individuals whose assessed needs could not be met. Review of care records identified that individual care needs assessments and risk assessments were obtained prior to admission.

A review of policy and procedure on restrictive practice/behaviours which challenge confirmed that this was in keeping with DHSSPS Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) and the Human Rights Act (1998). It also reflected current best practice guidance including Deprivation of Liberties Safeguards (DoLS).

The senior care assistant confirmed that no restrictive practices were undertaken within the home and on the day of the inspection none were observed.

Review of the infection prevention and control (IPC) policy and procedure confirmed that this was in line with regional guidelines. Staff training records confirmed that all staff had received training in IPC in line with their roles and responsibilities. Discussion with staff established that they were knowledgeable and had understanding of IPC policies and procedures. Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered. Observation of staff practice identified that staff adhered to IPC procedures.

Good standards of hand hygiene were observed to be promoted within the home among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

The senior care assistant reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with home policy and procedures, reported to the Public Health Agency, the trust and RQIA with appropriate records retained.

A general inspection of the home was undertaken and the residents' bedrooms were found to be personalised with photographs, memorabilia and personal items. The environment is maintained to a high standard and each bedroom has en suite hygiene facilities. The home fresh smelt, clean, was tastefully decorated and appropriately heated.

Inspection of the internal and external environment identified that the home and grounds were kept tidy, safe, suitable for and accessible to residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff. Discussion with the senior care assistant confirmed that risk assessments and action plans were in place to reduce risk where possible.

The home had an up to date fire risk assessment in place dated 8 November 2017 and all recommendations were noted to be appropriately addressed.

Review of staff training records confirmed that staff completed fire safety training twice annually. Records were retained of staff who participated and any learning outcomes. Fire safety records identified that fire-fighting equipment, fire alarm systems, emergency lighting and means of escape were checked weekly. The record showed that any actions highlighted by the checks had been signed off as completed. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place.

Comments received from residents, staff and two family members included:

- "You hear so much about old people living on their own I'm glad to be here where I'm safe." (resident).
- "Residents are encouraged to live the way they want and used to do. For example they love going out for coffee. I just take one or two at a time across to the shopping centre. This means they have more one to one time with me." (Activity coordinator)
- "She has a great life in here and is really well cared for." (Relative)
- "I've just been here for a short time and I had a very full induction when I started." (staff)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff induction, training, supervision and appraisal, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome

Discussion with the senior care assistant established that staff in the home responded appropriately to and met the assessed needs of the residents.

A review of five care records confirmed that these were maintained in line with the legislation and standards. They included an up to date assessment of needs, life history, risk assessments, care plans and daily/regular statement of health and well-being of the resident. Care needs assessment and risk assessments were reviewed and updated on a regular basis or as changes occurred. The home maintains a “residents at risk record” which contains the assessment of risk for each resident and is easily accessed by staff.

The care records also reflected the multi-professional input into the residents’ health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were signed by the resident where possible. Discussion with staff confirmed that a person centred approach underpinned practice. Residents choose the content and timing of their daily schedule and staff accommodate this as far as possible.

An individual agreement setting out the terms of residency was in place and appropriately signed. Records were stored safely and securely in line with data protection.

The senior care assistant confirmed that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. Audits of risk assessments, care plans, care review, accidents and incidents (including falls, outbreaks), complaints, environment, catering were available for inspection and evidenced that any actions identified for improvement were incorporated into practice. Further evidence of audit was contained within the monthly monitoring visits reports.

The senior care assistant confirmed that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included pre-admission information, multi-professional team reviews, residents’ meetings, staff meetings and staff shift handovers. Staff confirmed that management operated an open door policy in regard to communication within the home.

Residents and their representatives spoken with and observation of practice evidenced that staff were able to communicate effectively with residents, their representatives and other key stakeholders.

A review of care records, along with accident and incident reports, confirmed that referral to other healthcare professionals was timely and responsive to the needs of the residents. The registered manager confirmed that arrangements were in place, in line with the legislation, to support and advocate for residents.

Comments received from residents, staff and two family members included:

- “It was a really big move to come here and was strange at first but I’ve settled now, the staff are good to me and my family aren’t worried about me anymore.” (resident)
- “This is a brilliant place I’ve been visiting since February and I’ve never seen anything but good care.” (relative)
- “I have watched other staff with the residents and their attitude and tone of voice is always respectful.” (staff)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records, audits and reviews, communication between residents, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The senior care assistant confirmed that staff in the home promoted a culture and ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

A range of policies and procedures were in place which supported the delivery of compassionate care. Discussion with staff, residents and/or their representatives confirmed that residents’ spiritual and cultural needs, including preferences for end of life care, were met within the home. There was an end of life care plan in place in all of the care files examined. Discussion with residents, their representatives and staff confirmed that action was taken to manage any pain and discomfort in a timely and appropriate manner.

Residents were provided with information, in a format that they could understand, which enabled them to make informed decisions regarding their life, care and treatment.

The senior care assistant, residents and/or their representatives confirmed that consent was sought in relation to care and treatment. Discussion with residents, their representatives and staff along with observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff confirmed their awareness of promoting residents’ rights, independence and dignity and were able to demonstrate how residents’ confidentiality was protected.

Discussion with staff, residents, representatives and observation of practice confirmed that residents’ needs were recognised and responded to in a prompt and courteous manner by staff.

There were systems in place to ensure that the views and opinions of residents, and or their representatives, were sought and taken into account in all matters affecting them.

Residents are consulted with, at least annually, about the quality of care and environment. The findings from the consultation were collated into a summary report which was made available for residents and other interested parties to read. An action plan was developed and implemented to address any issues identified.

Discussion with staff, residents, and/or their representatives, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. The home employs a part time activity coordinator who confirmed that a designated budget for activities is ring fenced for residents’ use. Arrangements were in place for residents to maintain links with their friends, families and wider community.

Comments received from residents, staff and two relatives included:

- “I feel awful bringing my (relative) to a home but the staff are so very kind not just to my (relative) but to me too. They have time to listen to me.” (relative)
- “She (resident) has a better social life than I have, everything is organised for her.” (relative)
- “The staff are beautiful people every one of them.” (resident)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing residents and taking account of the views of residents.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

The senior care assistant outlined the management arrangements and governance systems in place within the home. These were found to be in line with good practice. The needs of residents were met in accordance with the home’s statement of purpose and the categories of care for which the home was registered with RQIA.

A range of policies and procedures was in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff. Policies and procedures were systematically reviewed every three years or more frequently as changes occurred.

There was a complaints policy and procedure in place which was in accordance with the legislation and Department of Health (DOH) guidance on complaints handling. Residents and/or their representatives were made aware of how to make a complaint by way of the Residents Guide.

Review of the complaints records confirmed that arrangements were in place to effectively manage complaints from residents, their representatives or any other interested party. Records of complaints included details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction. Arrangements were in place to share information about complaints and compliments with staff. An audit of complaints was used to identify trends and to enhance service provision.

There was an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of accidents/incidents/notifiable events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. A regular audit of accidents and incidents was undertaken and was reviewed as part of the inspection process. Learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

There was a system to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

Discussion with the senior care assistant confirmed that information in regard to current best practice guidelines was made available to staff. Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents. The senior care assistant in charge advised that she was currently undertaking a KSF level qualification.

A monthly monitoring visit was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, trust representatives and RQIA to read. The most recent monitoring visit took place on 10 October 2017.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability. This was outlined in the home's Statement of Purpose and Residents Guide.

The senior care assistant confirmed that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration and employers' liability insurance certificate were displayed.

Review of governance arrangements within the home and the evidence provided within the returned QIP confirmed that the registered provider/s respond to regulatory matters in a timely manner.

Review of records and discussion with staff confirmed that any adult safeguarding issues would be managed appropriately and that reflective learning would take place. The senior care confirmed that there were effective working relationships with internal and external stakeholders.

The home had a whistleblowing policy and procedure in place and discussion with staff established that they were knowledgeable regarding this. Staff confirmed that they could also access line management to raise concerns they will offer support to staff.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.



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