



The **Regulation** and
Quality Improvement
Authority

Unannounced Care Inspection Report 10 March 2020



Orchard Lodge Care Home

Type of Service: Residential Care Home
Address: Desert Lane Close, Armagh, BT61 8BF
Tel no: 028 3752 6462
Inspector: Gerry Colgan

www.rqia.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.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for



2.0 Profile of service

This is a registered residential care home which provides care for up to 19 residents with dementia.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd Responsible Individual: Gavin O'Hare Connolly	Registered Manager and date registered: Leanne McGaffin 20 August 2019
Person in charge at the time of inspection: Leanne McGaffin	Number of registered places: 19
Categories of care: Residential Care (RC) DE – Dementia	Total number of residents in the residential care home on the day of this inspection: 19

4.0 Inspection summary

An unannounced inspection took place on 10 March 2020 from 09.00 to 15.00.

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 during and 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.

The following areas were examined during the inspection:

- the environment
- dining experience
- incident management
- care records
- consultation with residents and staff

Residents described living in the home in positive terms. Residents unable to voice their opinions were seen to be relaxed and comfortable in their surroundings and in their interactions with others.

Areas for improvements identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

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 Leanne McGaffin, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 2 September 2019.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the findings from the previous care inspection, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with residents, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. No questionnaires were returned in the identified timescale.

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 previous inspection

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 13. (7) Stated: First time	The registered person shall ensure appropriate infection prevention and control procedures are in place to reduce or minimise the risk of infection in the home. Reference is made to ensuring appropriate checks on equipment and the environment including, for example, regular bathroom and ensembles checks as well as all other areas of the home.	Met
	Action taken as confirmed during the inspection: A review of records, the environment and discussion with the manager confirmed that appropriate infection prevention and control procedures are in place to reduce or minimise the risk of infection in the home.	

6.2 Inspection findings

6.2.1 The environment

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounge, dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Fire exits and corridors were observed to be clear of clutter and obstruction. We observed that all store rooms requiring restricted access were locked with either a key or keypad. Residents and staff spoken with were complimentary in respect of the home's environment.

6.2.2 Dining experience

Residents had been weighed on admission and monthly thereafter. Residents and staff confirmed that they had 24 hour access to food and drink. Residents commented positively on the food provided in the home. We reviewed the lunchtime meal experience in the home. Residents dined in the main dining room or at their preferred dining area such as their bedroom or the lounge. Food was plated in the dining room in accordance with resident's menu selection. The food was only served when residents were ready to eat their meals or to be assisted with their meals. A range of drinks was served with the meal. The food served appeared nutritious and appetising. Specialist diets were also catered for.

Staff were knowledgeable in relation to residents dietary requirements. Residents wore clothing protectors where required and staff wore aprons when serving or assisting with meals. Staff were observed chatting with residents when assisting with meals and residents were assisted in an unhurried manner. The mealtime was well supervised. Food intake records were maintained well.

6.2.3 Incident management

A review of accidents/incidents records completed since the previous care inspection confirmed that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. Accidents recorded had been appropriately managed with action taken to minimise recurrence. Audits of accidents/incidents were undertaken by the manager to address any trends or patterns identified.

6.2.4 Care records

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), speech and language therapist (SALT) and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), SALT or the dietician.

There was evidence that the care planning process included input from residents and/or their representatives, if appropriate. There was evidence of regular communication between staff and resident representatives within the care records.

Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each resident's condition and any changes noted.

6.2.5 Consultation with residents and staff

During the inspection we consulted with 10 residents and five staff. Residents appeared to be relaxed and comfortable in their surrounding and in their interactions with others. The residents spoken with were very positive about their experience of living in the home, stating that staff were very friendly and helpful. None of the residents spoken with voiced any concerns.

Staff were asked to complete an on line survey; we had no responses within the timescale specified. During the inspection staff commented positively on the care delivered and the working relationships.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the home's environment, record keeping, audits and reviews, and communication between residents, staff and other key stakeholders. There were further examples of good practice found in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing residents and their representatives, taking account of the views of residents. There were robust governance arrangements in place for the 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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