



Unannounced Care Inspection Report 14 January 2020



The Sperrins Residential Home

Type of Service: Residential Care Home

**Address: c/o Melmount Manor Care Centre, 1 Orchard Road,
Strabane, BT82 9QR**

Tel No: 028 7138 3990

Inspector: Laura O'Hanlon

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 12 residents.

3.0 Service details

| | |
|--|--|
| Organisation/Registered Provider: Larchwood Care Homes (NI) Ltd Responsible Individual: Christopher Walsh | Registered Manager and date registered: Annie Frobisher 14 May 2018 |
| Person in charge at the time of inspection: Annie Frobisher | Number of registered places: 12 |
| Categories of care: Residential Care (RC) DE – Dementia | Total number of residents in the residential care home on the day of this inspection: 12 |

4.0 Inspection summary

An unannounced inspection took place on 14 January 2020 from 09.40 hours to 15.40 hours to assess all areas for improvement in the home since the last care inspection.

There were examples of good practice found throughout the inspection in relation to staff communication, teamwork, care records and the management of accidents and incidents. There were no areas for improvement identified during this inspection.

Residents described living in the home in positive terms. Comments received from residents and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' 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 Annie Frobisher, registered manager and Chris Walsh, Responsible Individual, 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 inspection dated 29 July 2019

No further actions were required to be taken following the most recent inspection on 29 July 2019.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including 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.

During the inspection a sample of records was examined which included:

- staff duty rotas from 6 January 2020 to 19 January 2020
- three residents' records of care
- accident/incident records
- reports of visits by the registered provider
- RQIA registration certificate

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

6.0 The inspection

6.1 Inspection findings

On arrival to the home there was a warm and calm atmosphere with staff observed assisting and talking with residents in a friendly and respectful manner. Residents were well dressed in clean attire, vision glasses and walking aids were well maintained and a number of residents who had their finger nails painted advised this had been completed by the staff. Staff were able to describe the individual needs of residents and how these would be met in the home.

Residents advised that they were well cared for by staff who attended to their needs in a caring and kind manner and that they felt safe in the home. Some resident's comments included:

- "I feel very safe in here. The staff are very good to me. I am content and well cared for; it's a good home."
- "I am very happy here. We are well looked after; the food is very good, we get whatever we want."
- "I get my papers every day."
- "I love it in here. The food is good."

We observed the residents involved in activities in the home. Initially the residents were engaged in a session of reminiscence about "sayings" and "proverbs". Later in the morning the residents were singing with the activities coordinator while preparing for lunch.

We observed the serving of the main meal. Assistance and support was provided to residents where this was required. We could see that choices were offered and there was a variety of drinks available. The residents said that they enjoyed the food in the home. Drinks and snacks were observed as being served during the day.

The manager explained that staffing levels for the home were safe and appropriate to meet the number and dependency levels of residents accommodated and that staff numbers would be adjusted when needed. Review of the duty rota accurately reflected the staff working in the home and we were able to identify the person in charge in the absence of the manager.

We could see that there was enough staff in the home to quickly respond to the needs of the residents and provide the correct level of support. Staff were able to describe the individual care needs of residents and how these needs were met in the home.

The staff confirmed that there was good communication and team work in the home. The staff reported that they all work together for the benefit of the residents. There were systems in place to ensure effective communication across the staff team.

The staff advised that they attend handovers daily and that any concerns or information in relation to the care and treatment of residents is shared during handovers with duties delegated to staff for the provision of care for each resident. Some staff comments were:

- "There are sufficient staff on duty who are very supportive to each other. We work well as a team."
- "There is good teamwork here. We have reliable and consistent staff. There are ample staff on duty and we all trust each other."

Staff spoke positively about their roles and duties, training and managerial support. Staff also advised that they believed a good standard of care was provided for residents and if there were any concerns they would have no hesitation in reporting these to management. Observations of staff during the inspection found that they were reassuring to residents and acted in a caring and compassionate manner.

On review of the environment we found that all areas within the home were odour free and clean. Resident's bedrooms were found to be personalised with items of memorabilia and special interests displayed. We discussed with the manager during feedback about plans for redecoration within the home as some of the ceilings were discoloured. The manager agreed to follow this up.

We reviewed three residents care records. The records were written in a professional manner and used language which was respectful of residents. There was evidence within care records of assessments, care plans and associated risk assessments being completed and reviewed on a regular basis. Care plans were reflective of the needs of the residents and updated to reflect recommendations from the multi-disciplinary team and current guidance.

Care records were person centred and provided specific details to ensure staff were informed of resident's needs, likes and dislikes. Review of the progress notes confirmed that there was a recorded effect of care and treatment provided in the home.

An inspection of accidents and incident reports confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual. Copies of the report were available for residents, their representatives, staff and trust representatives and provided detailed and robust information in relation to the conduct of the home including an overview of care records, complaints, the environment, accidents and incidents and adult safeguarding. Where areas for improvement were identified, there was an action plan in place with defined timeframes.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff communication, teamwork, care records and the management of accidents and incidents.

Areas for improvement

There were no areas for improvement 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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