Unannounced Care Inspection Report
24 and 25 November 2020

Rosemount Care Centre

Type of Service: Residential Care Home (RCH)
Address: 2 Moy Road, Portadown, BT62 1QL
Tel No: 028 3833 1311
Inspectors: Bronagh Duggan and Paul Nixon

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 residential care home registered to provide residential care for up to 32 residents living with dementia.

3.0 Service details

Organisation/Registered Provider: Zest Care Home Limited **Responsible Individual(s):** Philip Scott	**Registered Manager and date registered:** Patricia Purvis registered 8.11.19
Person in charge at the time of inspection: Patricia Purvis	**Number of registered places:** 32
Categories of care: Residential Care (RC) DE – Dementia.	**Number of residents accommodated in the residential home on the day of this inspection:** 30

4.0 Inspection summary

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

The inspection sought to assess progress with issues raised in the previous quality improvement plan.

The following areas were examined during the inspection:

- Staffing
- Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE)
- Environment
- Care delivery
- Care records
- Governance and management
- Medicines management

Residents spoken with confirmed they were satisfied with the care provided in the home.

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	2	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Patricia Purvis, manager, as part of the inspection process. A senior manager was also present for feedback at the conclusion of the inspection. The timescales for completion commence from the date of inspection.

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

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with five residents individually and others in groups, four staff, and the manager. Questionnaires were also left in the home to obtain feedback from residents and residents' representatives. Thirteen residents' and residents' relatives/representatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the manager with "Tell Us" cards which were then placed in a prominent position to allow residents and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision. Thirteen completed questionnaires were returned within the identified timescale. Responses received indicated that respondents were either satisfied or very satisfied with the care provided in the home.

The following records were examined during the inspection:

- Duty rotas
- Three care records
- Staff registration information for Northern Ireland Health and Social Care Council (NISCC)
- A selection of quality assurance audits
- Regulation 29 monthly quality monitoring reports
- Complaints and compliments records
- Incident and accident records
- Certificate of registration
- Medicines management

Areas for improvement identified at the last care and medicines management inspections were reviewed and assessment of compliance recorded as met, partially met, or not met.

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(s)

The most recent inspection of the home was an unannounced care inspection undertaken on 3 February 2020.

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 27.1 **Stated:** First time **To be completed by:** 31 March 2020	The registered person shall ensure that: • The assisted toilet floor is repaired. • Vinyl edging in identified ensuite is repaired. • Damaged walls in identified ensuite and assisted toilet are repaired.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and inspection of the environment showed the the assisted toilet floor, the vinyl edging in the identified ensuite and the damaged walls in the identified ensuite and toilet area had been repaired.	
Area for improvement 2 **Ref**: Standard 28.3 **Stated:** First time **To be completed by:** Immediately	The registered person shall ensure tri-wheeled walkers and door closers are adequately cleaned.	**Met**
	Action taken as confirmed during the inspection: Inspection of a sample of tri wheeled walkers and door closures showed these were adequately cleaned. A system was also in place to ensure regular cleaning; records in the home confirmed this.	

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that staff receive further training and competency assessment on the management of warfarin.	**Met**
	Action taken as confirmed during the inspection: All senior staff had received further training on warfarin management and had competency reassessed in this area. Audits performed on warfarin showed that the medicine had been administered to residents in accordance with the prescribed instructions.	
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time	The registered person shall review and revise the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: All senior staff had received further training and had competency reassessed in the management of distressed reactions. For two residents who were prescribed medication for the management of distressed reactions, care plans were in place and records were maintained of the reason and outcome of administration.	

6.2 Inspection findings

6.2.1 Staffing

We arrived at the home at 09.45; the manager was in charge of the home. We discussed with the manager staffing levels for the home. Staff duty rotas for the period of 16 November 2020 until 29 November 2020 were reviewed. The duty rota accurately reflected the staff on duty on the day of inspection and highlighted the person in charge within each unit.

During discussions with staff they confirmed there was stable staffing arrangements in place, this was reflected on the duty rota. The manager outlined the staffing arrangements in the home, the manager advised there was also a bank list of staff available as needed. Staff spoken with were generally positive about staffing levels in the home, one staff shared that they thought staffing levels could be increased for certain times. This issue was discussed with the manager who advised staffing levels were kept under continual review, and staffing numbers were allocated according to the assessed needs and dependency levels of residents.

Observations made during the inspection showed resident's needs were being met appropriately.

Staff spoke positively about their experiences of working in the home. Staff confirmed they were aware of the reporting arrangements in the home and who to speak with if they had any concerns. Staff were aware of the homes safeguarding procedures and the whistleblowing policy and procedure. Staff spoken with confirmed there was good team working and they were aware of the individual needs of residents.

Comments received from staff included:

- "Staffing is good; during the outbreak we got cover. The manager is very good, very supportive. It's like home here, we support the residents with activities, they like arts and crafts in particular."
- "I do enjoy my work, I think it is a well-run home, am happy enough."
- "In here is a nice place to work, you have good support. Staff are working a long time, they know the residents well."

6.2.2 Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE)

Information was displayed at the entrance to the home regarding the current guidance on Covid 19; signage was also displayed throughout the home regarding handwashing technique and PPE.

The manager advised everyone's temperature was checked and relevant information recorded prior to admission to the home. The manager confirmed all residents and staff had temperatures taken and recorded twice daily. PPE supplies and hand sanitization were available throughout the home. Discussion with staff confirmed there was a good supply of PPE available. Staff were observed using PPE appropriately in accordance with current guidance.

During discussion with staff they were aware of what to do and how to reduce or minimise the risk of infection. Staff confirmed there were enhanced cleaning schedules in place which included regular cleaning of touch points throughout the home to minimise the risk of infection spread. Domestic staff were observed cleaning touch points at different intervals throughout the day.

We observed staff carrying out hand hygiene appropriately, and changing PPE as required.

6.2.3 Environment

During a walk around the home it was found to be warm, clean and tidy. No malodours were identified. Areas inspected included two communal living areas, dining areas, bathrooms, toilet areas and a sample of residents' bedrooms. We found residents bedrooms were nicely decorated and were personalised with individual interests and mementos.

We noted some general areas of the home were in need of improvement to the paintwork. This issue was discussed with the manager who confirmed that whilst some improvements had been made to date, other work had to be postponed due to Covid 19 restrictions and outbreak

management procedures. The manager advised plans were in place to address the environmental improvements and the work would be completed when deemed safe to do so.

Exits were kept clear and free from obstruction, doors were observed as being managed appropriately.

6.2.4 Care delivery

We observed staff practice in the home; interactions between residents and staff were warm and friendly. Staff showed good knowledge of residents individual needs and were observed supporting them with their routine.

Residents were well presented with obvious time and attention given to their personal care. Staff explained how residents were supported individually and that they were aware of their personal preferences. Staff were observed encouraging residents to participate in a quiz during the inspection while others relaxed watching TV.

Throughout the day some residents were observed relaxing in the communal living areas while others relaxed in their bedrooms. Residents appeared comfortable; staff were available throughout the day to meet their needs. For those residents that were able they confirmed they were happy with their life in the home. Other residents that had more limited communication ability were well presented and appeared comfortable in their surroundings.

Comments from residents included:

- “Im getting on the best, cant complaint.”
- “We are happy enough.”

The manager outlined the visiting arrangements for the home which were being managed in keeping with regional guidance during the inspection. The manager advised visiting arrangements were being monitored and risk assessed on an ongoing basis and would be adjusted according to the status of the home. The manager also advised telephone and video calls were available to residents on an ongoing basis.

6.2.5 Care records

A sample of three care records was reviewed; review of records showed that they included admission information, an assessment of needs, risk assessments, care plans and regular evaluation records.

Information from other health professionals including for example Speech and Language Therapy (SALT) were included in the care records. Records reflected the individual preferences of residents and also reflected the use of any restrictive practices.

We found there were some inconsistencies with regards to recording follow up information within the resident’s care records. Clarification on the outcomes for the residents was found in another location not contained within their individual care records. This issue was discussed with the manager as was the need to ensure records reflect a clear follow through for changes in resident’s needs. An area for improvement was identified.

6.2.6 Governance and management arrangements

The manager retains oversight of the home, and confirmed she felt well supported in recent months by the senior manager who confirmed they visit the home frequently. Staff spoken with confirmed they were kept informed of changes as they happened and information was readily available regarding Covid 19 guidance.

We reviewed a sample of audits including resident's weights, accidents and incidents, dining room experience, restraint register. Review of the audits showed when any issues were identified they were actioned as necessary.

There was a system in place regarding the reporting of notifiable events. Notifiable events including accidents and incidents were monitored on a monthly basis. Review of the records showed that these were effectively documented and reported to other relevant organisations as necessary. We discussed with the manager the recording processes in the home. The manager advised all staff were clear on the process in place.

A review of staff professional registration information showed there was a system in place to monitor staff registration with the Northern Ireland Social Care Council (NISCC) the information was reviewed on a regular basis.

There was a system in place regarding the management of complaints. The level of complaints was monitored on a monthly basis records showed any complaints received had been addressed accordingly. The home had received a number of compliments and thank you cards in recent months which included words of thanks and appreciation from relatives and representatives.

A visit by the registered provider's representative was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005. We reviewed the reports for August, September and October 2020. The reports included an overview of the working practices in the home. An action plan had been developed within the reports to address any issues identified, these reflected timescales and the person responsible for completing the action.

Staff confirmed there were good working relationships with external stakeholders. The homes certificate of registration was up to date and displayed appropriately

6.2.7 Medicines Management

Personal medication records and associated care plans

Residents in care homes should be registered with a general medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' needs will change and, therefore, their medicines should be regularly monitored and reviewed. This is usually done by the GP, the pharmacist or during a hospital admission.

Residents in the home were registered with local GPs and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. These are records used to list all the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that

medicines are administered as prescribed and because they may be used by other healthcare professionals e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were generally accurate and up to date. In line with best practice, a second member of staff had generally checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate. A couple of anomalies in the personal medication records were drawn to the attention of the manager, who gave an assurance that they would be rectified without delay.

Copies of residents' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All residents should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets, self-administration etc.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required.

Some residents may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the resident should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the resident. We reviewed the management of thickening agents for three residents. For each resident, a speech and language assessment report and care plan were in place. However, for one resident, records of prescribing and administration were not maintained. It is important to have a clear record of which medicines have been prescribed for and administered to residents to ensure that they are receiving the correct prescribed treatment. An area for improvement was identified.

Medicine storage and record keeping

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the residents' medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were generally available for administration when residents required them. A couple of instances were observed were medicines had run out-of-stock for short periods. The manager stated that the home was experiencing some difficulties in obtaining prescriptions in an efficient manner from one GP medical practice and there was evidence of the follow-up action taken by staff in such instances. The manager was advised that, if the problem persists, she has the option of consulting the Health and Social Care Board for advice/assistance.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each resident could be easily located. In each unit, a medicine refrigerator and controlled drugs cabinet were available for use as needed.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

Administration of medicines

It is important to have a clear record of which medicines have been administered to residents to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. However, for two residents who were prescribed eye-treatment medicines, there were significant gaps in the MARs. An area for improvement was identified.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in a controlled drug record book. We found that controlled drugs were safely managed in the home and that records were accurately maintained.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed during this inspection showed that medicines had mostly been given as prescribed. One incident was noted where a resident had been administered the wrong dose of a medicine on the day previous to the inspection. The manager gave an assurance that this incident would be reported to the relevant authorities and persons and that the advice of the GP would be sought.

Management of medicines on admission/re-admission to the home

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

We reviewed the management of medicines for two residents who had been recently admitted to this home. For one resident a hospital discharge letter had been received and a copy had been forwarded to the resident's GP. For the other resident, written confirmation of the medicines prescribed had been obtained from the GP practice. The residents' personal medication records had been accurately written and signed by two members of staff. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

Medicine related incidents

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

Medicines management training

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. Records of staff training in relation to medicines management were available for inspection. A written record was completed for induction and competency assessments.

Areas of good practice

There were examples of good practice in relation to staff team work, interactions between staff and residents, availability of PPE, governance arrangements and maintaining relations with external stakeholders.

Areas for improvement
An area for improvement was identified in relation to record keeping. In addition areas for improvement were identified in relation to the management of thickeners and eye-treatment medicines.

	Regulations	Standards
Total number of areas for improvement	2	1

6.3 Conclusion

The inspection found the four previous areas for improvement had been met. Three new areas for improvement were identified two related to medicines management and one related to the completion of care records.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Patricia Purvis, manager, as part of the inspection process. A senior manager was also present for feedback at the conclusion of the inspection. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate, from the date of the inspection onwards	The registered person shall ensure that, for each resident who is prescribed a thickening agent, records of prescribing and administration level are maintained. Ref: 6.2.7
	Response by registered person detailing the actions taken: Senior Care assistants will update records of those residents prescribed a thickeneing agent and will also receive up-date training on recording prescriptions and administration of medications.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate, from the date of the inspection onwards	The registered person shall ensure that eye-treatment medicines are administered in accordance with the prescribed instructions and that appropriate records of administration are maintained. Ref: 6.2.7
	Response by registered person detailing the actions taken: Spot audits will commence on administration of eye drops, and up-dated training on medication provided.
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 8.2 **Stated:** First time **To be completed by:** Immediate, from the date of the inspection onwards	The registered person shall ensure records reflect all personal care and support provided, changes in the residents needs and unusual or changed circumstances that affect the resident and any action taken by staff. Ref: 6.2.5
	Response by registered person detailing the actions taken: An immediate communication was issued to all Senior Care staff to ensure any info regarding resident care recorded in the unit diary was transposed to care files. Record keeping training will be provided for all Senior care assistants paying particular attention to details in care plans.

Please ensure this document is completed in full and returned via Web Portal

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