Unannounced Care Inspection Report
4 February 2020

Rylands

Type of Service: Residential Care Home
Address: 11 Doagh Road, Kells, Ballymena, BT42 3LZ
Tel no: 028 2589 2411
Inspector: Marie-Claire Quinn

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 14 residents.

3.0 Service details

Organisation/Registered Provider: Rylands **Responsible Individuals:** Trevor Duncan Karen Duncan	**Registered Manager and date registered:** Valerie Rutherford 6 June 2018
Person in charge at the time of inspection: Valerie Rutherford	**Number of registered places:** 14
Categories of care: Residential Care (RC) I - Old age not falling within any other category MP (E) - Mental disorder excluding learning disability or dementia – over 65 years PH (E) - Physical disability other than sensory impairment – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 14

4.0 Inspection summary

An unannounced inspection took place on 4 February 2020 from 11.40 hours to 16.05 hours.

This inspection was undertaken by the care inspector.

The inspection assessed progress with all areas for improvement identified in the home 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.

Evidence of good practice was found in relation to the cleanliness of the home's environment and the delivery of person centred and compassionate care. Residents were positive about their experiences living in the home. Residents unable to clearly voice their opinions looked relaxed and comfortable, and responded well when interacting with staff.

No areas for improvement were identified during this inspection.

Comments received from residents, people who visit them and staff during 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 Valerie Rutherford, 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 inspection dated 17 May 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 17 May 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

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 inspection and any other written or verbal information received, for example serious adverse incidents.

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. We received seven responses, which are referred to in the body of the report.

A poster was provided for staff detailing how they could complete an electronic questionnaire; however no responses were received by RQIA.

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

- staff duty rotas from 3 to 16 February 2020
- care records of four residents
- accident/incident records from May 2019 to January 2020
- a sample of governance records including audits of adverse incidents, hand hygiene, falls and complaints

Areas for improvements identified at the last care inspection were reviewed and an 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 the last care inspection dated 17 May 2019

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 20. – (1) **Stated:** First time	The registered person shall having regard to the size of the residential care home, the statement of purpose and the number and needs of residents – (a) ensure that at all times suitably qualified, competent and experienced persons are working at the home in such numbers as are appropriate for the health and welfare of residents.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been met. Please see section 6.2.2 for further information.	
Area for improvement 2 **Ref:** Regulation 3 (1) (a) (b) and (c); Schedule 1 **Stated:** First time	The registered person shall ensure that services are delivered in accordance with the statement of purpose as approved by the Regulation and Quality Improvement Authority at the time of registration. This is in relation to the maintenance of separate documentation and reports from the nursing home, such as Annual Quality Care Review report, minutes of relatives' meetings and care plan documentation.	**Met**

	Action taken as confirmed during the inspection: This area for improvement has been met. Please see section 6.2.5 for further information.	

6.2 Inspection findings

6.2.1 Environment

The home was clean, warm and tidy.

Observation of practice and discussion with the manager confirmed there were safe and healthy practices in the home to minimise the risk of infection.

6.2.2 Staffing

Since the last care inspection the manager advised that staffing levels had not been increased. However, staff had changed how various tasks were undertaken to ensure care was delivered in a more organised way. We saw throughout the inspection that while staff were busy they were well organised.

No concerns regarding staffing levels were raised by residents, relatives or staff during the inspection.

We noted that the staff duty rota did not include the hours worked by the registered manager; and the manager agreed to rectify this immediately.

During discussion with the manager two areas relating to the residential care home's night time staffing levels and the management of medication changes required further consideration by the manager. Following discussion with the home's pharmacy and senior care inspectors we contacted the manager with further advice regarding the management of warfarin. The manager has since confirmed that additional training is being provided to residential care staff in relation to medication management.

6.2.3 Care delivery

As we said previously, we saw care being delivered in a calm and organised way. Residents looked well cared for and were dressed in clean, comfortable clothing. Staff attended to residents needs in a prompt and caring manner and demonstrated knowledge and understanding of each resident's individual needs, wishes and preferences.

There was enough staff available to support residents to engage in their preferred activities. This included attending the hairdresser, enjoying visits from family and friends, reminiscence therapy and socialising with other residents in the lounge.

We observed part of the serving of the lunch time meal. Staff supported residents to make their way to the dining room while other residents preferred to enjoy their meal in their bedroom. There were friendly and cheerful interactions between residents and staff, and the home's cook

came out from the kitchen to serve the meal and to check if residents were enjoying their food. Staff were aware of residents' individual dietary needs and preferences. Residents told us they enjoyed their meals and snacks and always "got enough to eat".

A small number of residents told us that they had been waiting a while for lunch to be served; this feedback was shared with the manager for review and action as required.

6.2.4 Accidents and incidents

Review of accidents and incidents records confirmed that these were managed appropriately. Medical advice was sought from district nursing, GPs and the ambulance service as required.

One incident had not been notified to RQIA; when this was brought to the attention of the manager the incident was notified to us following the inspection therefore an area of improvement was not required at this time.

6.2.5 Care records

Care records were person centred and well organised. Needs assessments and care plan documentation had been reviewed in line with the home's Statement of Purpose. Care records reflected the individual needs of each resident.

A small number of documents, such as the Personal Emergency Evacuation Plans, referred to another care home. This was brought to the attention of the manager for them to address.

There was evidence that residents and/or their relatives were involved in the care planning process, as the majority of care plans and consent forms were signed.

We noted on occasions, daily notes recorded "inform nurse in charge". This was discussed with the manager who clarified this should be "person in charge" and the manager agreed that this way of recording would be amended.

6.2.6 Residents' views

We received positive feedback from residents during and after the inspection. We received seven responses to our questionnaires and all who responded were either very satisfied or satisfied that the care in the home was safe, effective and compassionate and that the service was well led. Specific comments made by residents during and after the inspection included:

- "Staff couldn't be better. I get anything I need, day or night. I was another home, but this is better."
- "I'm happy, the food is lovely."
- "Very happy."
- "Very clean. Don't think they (staff) could do anymore."

6.2.7 Relative's views

We spoke with one relative during the inspection. They were highly complimentary about the care provided in the home and said:

- “I’m very happy; mum is very well cared for. Val (manager) is a great girl. I feel reassured with mum in here; I have no complaints and there is great communication from staff.”

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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