# Unannounced Care Inspection Report
# 10 January 2017

# Northfield House

**Type of service: Residential Care Home**
**Address: 3 Church Lane, Northfield Road, Donaghadee**
**Tel No: 028 9188 2509**
**Inspector: Patricia Galbraith**

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

## 1.0 Summary

An unannounced inspection of Northfield house took place on 10 January 2017 from 09.30 to 14.00.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

**Is care safe?**

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

No requirements or recommendations were made in relation to this domain.

**Is care effective?**

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.

No requirements or recommendations were made in relation to this domain.

**Is care compassionate?**

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.

No requirements or recommendations were made in relation to this domain.

**Is the service well led?**

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.

No requirements or recommendations were made in relation to this domain.

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

## 1.1 Inspection outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 0 | 0 |

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mary Courtney, senior carer, 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.

## 1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection.

## 2.0 Service details

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|---|---|
| **Registered organisation/registered person:**<br>South Eastern Health and Social Care Trust | **Registered manager:**<br>Angela Cartwright |
| **Person in charge of the home at the time of inspection:**<br>Mary Courtney, Senior Carer | **Date manager registered:**<br>8 September 2009 |
| **Categories of care:**<br>I - Old age not falling within any other category<br>MP - Mental disorder excluding learning disability or dementia<br>MP (E) - Mental disorder excluding learning disability or dementia – over 65 years<br>LD - Learning Disability<br>PH - Physical disability other than sensory impairment<br>PH (E) - Physical disability other than sensory impairment – over 65 years<br>SI – Sensory Impairment<br>TI – Terminally ill | **Number of registered places:**<br>41 |

## 3.0 Methods/processes

Prior to inspection we analysed the following records: the previous inspection report, notifications of accidents and incidents since the previous care inspection.

During the inspection the inspector met with 14 residents, four staff and one visiting professional.

The following records were examined during the inspection:

- Staff duty rota
- Staff supervision and annual appraisal schedules
- Staff training schedule/records
- Three resident's 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
- Equipment maintenance / cleaning records
- Accident/incident/notifiable events register
- Minutes of recent residents' meetings / representatives' / other
- Monthly monitoring report
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.

## 4.0 The inspection

### 4.1 Review of requirements and recommendations from the most recent inspection dated 23 August 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the inspector at the next inspection.

## 4.2 Review of requirements and recommendations from the last care inspection dated 23 August 2016

| Last care inspection statutory requirements | | Validation of compliance |
|---|---|---|
| **Requirement 1**<br><br>**Ref**: Regulation29.-(4) (c) & Schedule 4 .5<br>**Stated:** Second time<br><br>**To be completed by: 28September 2016** | The registered person shall ensure that reports of visits undertaken under regulation 29 are completed in line with legislation.<br><br>**Action taken as confirmed during the inspection**:<br>The visits under regulation 29 had been completed in line with legislation. | **Met** |

## 4.3 Is care safe?

The senior carer 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 registered manager 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 carer and staff 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.

Discussion with the senior carer confirmed that no staff have been recruited since the previous inspection, therefore staff personnel files were not reviewed on this occasion.

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

Discussion with staff confirmed that they were aware of the new 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 carer, 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 carer confirmed there were risk management procedures in place relating to the safety of individual residents. Discussion with the senior carer 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 carer confirmed there were restrictive practices employed within the home, notably locked doors, keypad entry systems, lap belts, mattress alarms, pressure alarm mats, alarm tags etc. Discussion with the senior carer regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required.

Inspection of care records confirmed there was a system of referral to the multi-professional team when required. Behaviour management plans were devised by specialist behaviour management teams from the trust and noted to be regularly updated and reviewed as necessary.

The senior carer and examination of accident and incident records confirmed that when individual restraint was employed, the appropriate persons / bodies were informed.

The senior carer confirmed there were risk management policy and procedures in place. Discussion with the senior carer and review of the home's policy and procedures relating to safe and healthy working practices confirmed that these were appropriately maintained and reviewed regularly e.g. COSHH, fire safety etc.

The senior carer confirmed that equipment and medical devices in use in the home were well maintained and regularly serviced.

Staff training records confirmed that all staff had received training in infection prevention and control (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 carer reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with trusts 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 home was fresh smelling, clean and appropriately heated. There are plans in place for refurbishment of the home to begin early in 2017.

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 carer 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 and all recommendations were noted to be addressed.

Review of staff training records confirmed that staff completed fire safety training twice annually. A fire drill was completed every six months. 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 / monthly and were regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place.

**Areas for improvement**

No areas for improvement were identified during the inspection in relation to this domain.

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| **Number of requirements** | 0 | **Number of recommendations** | 0 |

## 4.4 Is care effective?

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

A review of three 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 (e.g. manual handling, bedrails, nutrition, falls, where appropriate) were reviewed and updated on a regular basis or as changes occurred.

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 observed to be signed by the resident and/or their representative. Discussion with staff confirmed that a person centred approach underpinned practice. For example one resident likes to go to the local public house.

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 carer 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 and the annual quality report. For example the refurbishment of the home was highlighted in the monthly monitoring visits.

The senior carer 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. The senior carer and staff confirmed that management operated an open door policy in regard to communication within the home.

Residents spoken with and observation of practice evidenced that staff were able to communicate effectively with residents, their representatives and other key stakeholders. Minutes of resident and/or their representative meetings were reviewed during the inspection. 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 senior carer confirmed that arrangements were in place, in line with the legislation, to support and advocate for residents.

One comment received from a resident was as follows:

- ‘‘staff always at hand to get what you want or need”

**Areas for improvement**

No areas for improvement were identified during the inspection in relation to this domain.

| **Number of requirements** | 0 | **Number of recommendations** | 0 |
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## 4.5 Is care compassionate?

The senior carer 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, and residents confirmed that residents' spiritual and cultural needs, including preferences for end of life care, were met within the home. Discussion with residents, their representatives and staff confirmed that action was taken to manage any pain and discomfort in a timely and appropriate manner. This was further evidenced by the review of care records for example, a care plan had been put in place for management of pain.

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 carer and residents confirmed that consent was sought in relation to care and treatment. Discussion with residents, 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.

The senior carer and staff confirmed that residents were listened to, valued and communicated with in an appropriate manner. Residents confirmed that their views and opinions were taken into account in all matters affecting them.

Discussion with staff, and residents, 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. For example the last residents' meeting had been held on 14 November 2016.

Discussion with staff and residents, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. During a discussion with staff regarding activities for residents it was explained that while it is a requirement for the home to consult residents about their social activities and make arrangements to enable them to engage in local, social and community activities. Residents have a right to choose whether or not or to what degree they participate in activities.

Arrangements were in place for residents to maintain links with their friends, families and wider community. For example the home had organised a Christmas party and a number of local schools came into the home for a number of carol services.

Comments received from residents were as follows:

- "You get more than you need here"
- "You never have to ask twice for anything to be done"
- "The food is good"
- "No problems with staff they are all good"

**Areas for improvement**

No areas for improvement were identified during the inspection in relation to this domain.

| **Number of requirements** | 0 | **Number of recommendations** | 0 |
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## 4.6 Is the service well led?

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, Poster / leaflet etc. Discussion with staff confirmed that they were knowledgeable about how to receive and deal with complaints.

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.

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.

The senior carer confirmed that they were aware of the "Falls Prevention Toolkit" and were using this guidance to improve post falls management within the home.

There were quality assurance systems in place to drive quality improvement which included regular audits and satisfaction surveys.

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

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.

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 carer 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 certificate was displayed appropriately.

Review of governance arrangements within the home and the evidence provided within the returned RQIA Quality Improvement Plan (QIP) confirmed that the registered provider responds to regulatory matters in a timely manner.

Review of records and discussion with the senior carer and staff confirmed that any adult safeguarding issues were managed appropriately and that reflective learning had taken place. The senior carer 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. The senior carer confirmed that staff could also access line management to raise concerns and that 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.

The senior carer confirmed that there were arrangements in place for managing identified lack of competency and poor performance for all staff. There were also open and transparent methods of working and effective working relationships with internal and external stakeholders.

Staff spoken with during the inspection made the following comments:

- "I love working here there is good team work"
- "residents' are well cared for and all staff try and ensure residents get what they need"

**Areas for improvement**

No areas for improvement were identified during the inspection in relation to this domain.

| Number of requirements | 0 | Number of recommendations | 0 |
|---|---|---|---|

## 5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards.

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