Unannounced Care Inspection

Name of Service and ID:	**Mulhern Close Residential Home (11109)**
Date of Inspection:	**31 August 2014**
Inspectors' Names:	**Lynn Long and John McAuley**
Inspection ID:	**IN020449**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
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1.0 General information

Name of Service:	Mulhern Close Residential Home (11109)
Address:	58 Coolnagard Avenue Omagh BT78 1GA
Telephone number:	02882250382
E mail address:	manager.mulhern@inspirewellbeing.org.uk
Registered Organisation/ Registered Provider:	Inspire Wellbeing Limited Mr Peter McBride
Registered Manager:	Mr William Morrow registration pending
Person in charge of the home at the time of inspection:	Mr. Michael McMenamin – Team Leader then later joined by Ms Kerri Gregg – Area Manager and Mr Kevin Miley former registered manager
Categories of care:	RC-LD, RC-LD(E)
Number of registered places:	12
Number of residents accommodated on Day of Inspection:	10 plus 2 residents in hospital
Scale of charges (per week):	£1,711 - £3,206
Date and type of previous inspection:	Unannounced inspection 1 and 6 August 2014
Date and time of inspection:	31 August 2014 10am – 1.30pm
Name of Inspectors:	Lynn Long and John McAuley

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect residential care homes. A minimum of two inspections per year are required.

This is a report of an unannounced secondary care inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the inspection

The purpose of this unannounced inspection was to ensure that the service is compliant with relevant regulations and minimum standards and other good practice indicators and to consider whether the service provided to service users was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of residential care homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Residential Care Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Residential Care Homes Minimum Standards (2011)

Other published standards which guide best practice may also be referenced during the inspection process.

4.0 Methods/Process

Specific methods/processes used in this inspection include the following:

- Discussion with the locality manager and registered manager
- Examination of records
- Observation of care delivery and care practice
- Discussion with residents and staff
- Inspection of the premises
- Evaluation of findings and feedback

5.0 Inspection focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to establish the level of compliance achieved with respect to the following DHSSPS Residential Care Homes Minimum Standard:

- Standard 25 – Staffing
- Standard 12 – Meals and mealtimes
- Standard criterion 20.1, and 20.15 – in respect of Management and control of operations.

The inspector has rated the home's Compliance Level against each criterion and also against the standard. The table below sets out the definitions that RQIA has used to categorise the home's performance:

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report.
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report.
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report.
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report.
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

6.0 Profile of service

Mulhern Close Residential Care Home is situated in Coolnagard, Omagh. Accommodation for residents is provided in single rooms. The home is a series of four purpose built bungalows interlinked by a walkway.

Communal lounges and dining areas are provided in each bungalow. A number of communal sanitary facilities are available throughout the home.

The home is registered to provide care for a maximum of 12 persons under the following categories of care:

Residential care

LD	Learning Disability
LD(E)	Learning Disability – over 65 years

7.0 Summary of inspection

This secondary unannounced care inspection of Mulhern Close was undertaken by Lynn Long and John McAuley on Sunday 31 August 2014 between the hours of 10am and 1:30pm. The team leader Michael McMenamin was in charge of the home and assisted the inspectors on their arrival to the home. The home's managerial staff, the area manager Kerri Gregg and the former registered manager Kevin Miley came to the home and made themselves available, including for verbal feedback at the conclusion of the inspection.

The requirements and recommendations made as a result of the previous inspection on 1 and 6 August 2014 were not examined on this occasion as the timescales to address the matters had not been reached.

The focus of this unannounced inspection was on Standards 25, 12 and a selection of standard criterion of standard 20 of the DHSSPS Residential Care Homes Minimum Standards.

During the inspection the inspectors met with residents and staff, observed care practice, examined a selection of records and carried out a general inspection of the residential care home environment.

In discussion with residents, in accordance with their capabilities, they indicated that that they were happy and content with their life in the home. No obvious concerns were identified in respect of interactions with residents.

Discussions with staff indicated that there were on going issues of poor staff morale. These issues related to the workload and multi-tasking of roles, the employment of non-permanent staff, and the general terms and conditions of employment relating to payment of overtime and non-sociable hours.

Comments received from residents, representatives, staff and visiting professionals are included in section 10.0 of the main body of the report.

The areas of the environment viewed by the inspector presented as generally clean, although there were areas identified as needing attention. The décor and furnishings of the

home were of a good standard but had a clinical appearance in that areas lacked warmth and personalisation. Further detail of the general environment is in section 10.0 of this report.

Observations of care practices throughout this inspection found that staff interacted with residents in a polite, warm, friendly manner**.** The atmosphere in the home was relaxed with residents observed to be comfortable and content. Issues relating to restrictive practices were found. These were in relation to locking of bedroom doors and the general furnishings of the environment. A requirement has been made for these practices to be reviewed with subsequent appropriate action. The details of these practices are discussed in the main body of this report.

A review of the staffing arrangements in the home was undertaken. A number of issues were identified. Ancillary staff are not employed in Mulhern Close Residential Home. There is an expectation that the support staff employed undertake an array of "mixed duties". These includes personal care, activity provision, catering and domestic duties. Support staff stated during discussions, that as a result of current staffing levels and the expectation they undertake "mixed duties" they found it difficult to ensure residents' needs were met or that other tasks were completed to the necessary standard. Care staffing hours are clearly diluted with staff having to undertake additional duties of catering, housekeeping and laundry. Additional concerns were further identified in that one resident had been assessed as requiring nursing care since March 2014. However there were no changes in the staffing compliment to accommodate this prolonged period of transition. The team leader confirmed that during the evening, night duty and weekends only one team leader is on duty and is in charge of the home. It was identified that the team leader's role is congested and task focused. As a result of this there are no arrangements in place to ensure supervision and governance of support staff working with residents. Despite a requirement being made previously in relation to the team leader's role it was confirmed that nothing has changed in relation to the skill mix. In examining the skill mix of staff, the provision of one team leader during the evening, night duty and weekends was not considered to be adequate, in terms of meeting the residents' assessed needs and the layout of the home.

A review of the arrangements for meals and mealtimes identified a number of issues which do not meet with best practice guidance outlined in the Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014). The week three menu cycle was reviewed. It identified that staff were deviating from the planned menu on a regular basis. Staff identified a number of reasons for the deviations which included staff not having the knowledge and skills to prepare and cook certain choices, the wrong meat or poultry being defrosted or issues with the supply of ingredients due to the ordering processes. The pictorial menu did not reflect what was being served to residents. Desserts are not included in the menu and staff confirmed that desserts are not served. Two residents were identified as being on a pureed diet. However, it was confirmed that outside of the three main meals of the day the serving of nutritious snacks for these residents is sporadic and dependent both on availability of appropriate snacks and the support staff on duty. Potatoes and vegetables for the lunch time meal are prepared by staff who have worked night duty. The potatoes and vegetables can be peeled and prepared and sitting in water for periods of up to 13 hours. On occasion's periods of greater than 12 hours are evident between supper and breakfast. The pictorial menu identified that two choices of meals are served. However, the temperature records confirmed that only one meal choice is prepared. A record of the food prepared and served at each meal time is not retained. A number of issues were identified in relation to the cleanliness in two of the kitchens. Uncovered food was observed on the work surfaces and milk had been left out of the fridge. There were no cakes, buns or fresh baking for residents. Staff confirmed that a food order was due to be

delivered later the same day. Staff advised that home baking is rarely provided and cited support staff knowledge and skills and/or time to undertake these tasks as the reason for this.

Following the inspection, the issues identified in relation to staffing and meals and mealtimes were reported to senior management in RQIA as a serious concern. A decision was taken to hold an intention to issue a notice of failure comply meeting in respect of Regulation 12, Quality of care and other service provision and Regulation 20, Staffing as outlined in The Residential Care Homes Regulations (Northern Ireland) 2005. Mr Peter McBride, responsible individual and Mrs Margaret Cameron, a newly appointed company director, was invited to attend a meeting at RQIA on 8 September 2014.

The outcome of the meeting resulted in enforcement action being taken by RQIA. RQIA issued two Notices of Failure to Comply on 8 September 2014 to the registered provider. A follow up inspection will be undertaken on expiry of the notices to ensure that the actions required have been addressed in full.

In addition to the failure to comply notices being issued six requirements and one recommendation were made, details can be found in the main body of the report and the attached Quality Improvement Plan (QIP).

The inspectors would like to thank the residents, and staff for their assistance and co-operation throughout the inspection process.

8.0 The requirements and recommendations issued as a result of the previous inspection on 1 and 6 August 2014 were not reviewed on this occasion.

9.0 Standards

STANDARD 25 - STAFFING **The number and ratio of staff at all times meet the care needs of residents.**	
Criterion Assessed: 25.1 At all times the staff on duty meets the assessed care, social and recreational needs of residents, taking into account the size and layout of the home, the statement of purpose and fire safety requirements.	**COMPLIANCE LEVEL**
Inspection Findings:	
The staffing levels in the home at the time of this unannounced inspection consisted of; • 1 x team leader • 7 x support workers • 1 x support worker employed on an one to one basis with a resident who was in hospital • 1 x monitoring officer, although this role is supernumerary and not included in the overall staffing calculation. These staffing levels continue throughout the day and are only reduced at night duty, when they consist of; • 1 x team leader – on a sleep over basis • 3 x support workers with a further 1 x support worker employed to work on an one to one basis with a resident who is in hospital. Managerial staff are employed during the week days on office hours basis. In examining the skill mix of staff, the provision of 1 x team leader during evening, night duty and weekends was not considered to be adequate, in terms of meeting the residents' assessed needs and the layout of the home. A requirement has been made for the skill mix of staff to be increased for these periods.	Moving towards compliance

Criterion Assessed: 25.2 The number and ratio of staff to residents is calculated using a method that is determined by the Regulation and Quality Improvement Authority. Students and volunteers working in the home are not taken into account in the overall staffing calculation.	**COMPLIANCE LEVEL**
Inspection Findings:	
The numbers of staff employed on each shift was found to be in keeping with the minimum staffing guidance. However as highlighted in 25.4 the care staffing hours were clearly diluted with staff having to undertake mixed duties of catering, housekeeping and laundry. Added concern was further identified in that one resident was assessed as nursing care needs since March 2014. However there were no changes in the staffing compliment to accommodate this prolonged period of transition. These issues of improvement are highlighted in the quality improvement plan to be addressed.	Not compliant

STANDARD 25 - STAFFING The number and ratio of staff at all times meet the care needs of residents.	
Criterion Assessed: 25.3 There is a competent and capable person in charge of the home at all times.	**COMPLIANCE LEVEL**
Inspection Findings:	
An assessment tool to assess the competency and capability of any member of staff with the responsibility of being in charge of the home has been devised. However this assessment tool has yet to be implemented with all staff who have this responsibility, as found evident with the team leader in charge of the home at the time of this inspection. Added to this staff training in challenging behaviours and RESPECT were not up to date, including the team leader, who was in charge of the unit.	Moving towards compliance
Criterion Assessed: 25.4 Administrative and ancillary staff are employed to ensure that minimum standards relating to their respective responsibilities are fully met.	**COMPLIANCE LEVEL**
Inspection Findings:	
An administrator has been recruited and is waiting to start employment. An activity therapist has been recruited and is waiting to start employment. Ancillary roles of cooking / catering, housekeeping and laundry are undertaken by care staff in each of the units. From direct observations there was found to be a detrimental impact to ensuring that minimum standards relating to respective responsibilities are fully met. For example a support worker was observed in one unit to be preparing a Sunday lunch time dinner. During this time the support worker was observed also to be attending to a resident's personal care needs and preparing a breakfast for this resident., who was assessed as having significant care needs. The impact on meals and mealtimes and housekeeping are discussed later in this report.	Not compliant

Discussions with staff, confirmed that there were issues of poor staff morale. The identified issues relating to staff morale were, the workload and multi-tasking of roles, the employment of non-permanent staff, and the general terms and conditions of employment relating to payment of overtime and non-sociable hours. These issues were discussed with Ms Gregg and Mr Miley and a requirement has been made in relation to staffing issues.	
STANDARD 25 - STAFFING **The number and ratio of staff at all times meet the care needs of residents.**	
Criterion Assessed: 25.5 Records are kept of all staff that includes name, date of birth, previous experience, qualifications, starting and leaving dates, posts held and hours of employment.	**COMPLIANCE LEVEL**
Inspection Findings:	
This standard criterion was not reviewed on this occasion.	Not reviewed
Criterion Assessed: 25.6 A record is kept of staff working over a 24-hour period and the capacity in which they worked.	**COMPLIANCE LEVEL**
Inspection Findings:	
A review of the home's duty rota found this to be maintained appropriately. However it was noted that a date had been recorded that the registered provider had worked in the home 9am – 5pm when there was contrary evidence that the registered provider was elsewhere.	Substantially compliant

STANDARD 25 - STAFFING The number and ratio of staff at all times meet the care needs of residents.	
Criterion Assessed: 25.7 Time is scheduled at staff or shift changes to handover information regarding residents and other areas of accountability.	**COMPLIANCE LEVEL**
Inspection Findings:	
There is time scheduled between shift changes of staff for handover reports and other areas of information of accountability.	Compliant
Criterion Assessed: 25.8 Staff meetings take place on a regular basis and at least quarterly. Records are kept that include: - □ The date of all meetings □ The names of those attending □ Minutes of discussions □ Any actions agreed.	**COMPLIANCE LEVEL**
Inspection Findings:	
Staff meetings were reported to take place on a monthly basis. The records of these meetings were not reviewed on this occasion. However discussions with two members of staff informed the inspector that staff had a negative view on these meetings as these were not enriching the problems relating to the staff morale.	Substantially compliant

STANDARD 23 - STAFF TRAINING AND DEVELOPMENT Staff are trained for their roles and responsibilities.	
Criterion Assessed: 23.1 Staff who are newly appointed, agency staff and students are required to complete structured orientation and induction.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussions with the two agency staff members of staff on duty confirmed that they had received a structured induction to the home and there was supporting documentation of same in place.	Compliant

STANDARD 12 - MEALS AND MEALTIMES Residents receive a nutritional and varied diet in appropriate surroundings at times convenient to them.	
Criterion Assessed: 12.1 Residents are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences. Full account is taken of relevant guidance documents or guidance provided by dieticians and other professionals and disciplines.	**COMPLIANCE LEVEL**
Inspection Findings:	
A review of the arrangements for meals and mealtimes identified a number of issues which do not meet with best practice guidance outlined in the Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014). Ancillary staff are not employed in Mulhern Close Residential Home. There is an expectation that staff employed undertake mixed duties including catering and domestic duties. One inspector discussed with staff the training that they have received to undertake catering duties. Staff indicated that they have completed an online course in basic food hygiene. Training in how to plan, prepare and cook the planned menu is not provided. Staff confirmed during discussion that they are not equipped with the knowledge and skills that a trained cook would have. This lack of competence and training in relation to catering duties is reflected throughout this standard and is affecting the standard of meals and mealtimes for residents. Deviations from the menu and the reason for them were discussed with a number of staff. Staff identified a number of reasons for the deviations which included staff not having the knowledge and skills to prepare and	Not compliant

cook certain choices, the wrong meat or poultry being defrosted or issues with the supply of ingredients due to the ordering processes. There was no evidence that the menu had been planned taking account of the recently updated best practice guidance. Desserts are not included in the menu and staff confirmed that desserts are not served. Two residents were identified as being on a pureed diet. However, it was confirmed that outside of the three main meals of the day the serving of nutritious snacks for these residents is sporadic and dependent both on availability of appropriate snacks and the support staff on duty. Potatoes and vegetables for the lunch time meal are prepared by staff who have worked night duty. The potatoes and vegetables can be peeled and prepared and sitting in water for periods of up to 13 hours. A number of issues were identified in relation to the cleanliness in two of the kitchens. Uncovered food was observed on the work surfaces and milk had been left out of the fridge. One inspector enquired about the provision of home baking. Staff advised that home baking is rarely provided and cited support staff knowledge and skills and/or time to undertake these tasks as the reason for this.	
Criterion Assessed: 12.2 Residents are involved in planning the menus.	**COMPLIANCE LEVEL**
Inspection Findings:	
There was no evidence to confirm that residents had been involved in planning the menus.	Not compliant

Criterion Assessed: 12.3 The menu either offers residents a choice of meal at each mealtime or when the menu offers only one option and the resident does not want this, an alternative meal is provided. A choice is also offered to those on therapeutic or specific diets.	**COMPLIANCE LEVEL**
Inspection Findings:	
The pictorial menu did not reflect what was being served to residents. The menu indicated that the meal for the day was a roast dinner. However, it was not specific to the type of roast being served. The picture displayed included stuffing, roast potatoes and Yorkshire puddings. However, none of these items were served with the meal. A review of the three weekly menu identified that there were two choices for each meal, with the exception of a Sunday when a roast dinner was served. However, the temperature records confirmed that only one meal choice is prepared and staff confirmed during discussion that only one meal was cooked each day. There was no evidence to suggest that residents were being offered a choice.	Not compliant

STANDARD 12 - MEALS AND MEALTIMES
Residents receive a nutritional and varied diet in appropriate surroundings at times convenient to them.

Criterion Assessed: 12.4 The daily menu is displayed in a suitable format and in an appropriate location so that residents and their representatives know what is available at each mealtime.	**COMPLIANCE LEVEL**
Inspection Findings:	
A pictorial menu is displayed but as detailed in 12.3 the menu displayed did not accurately reflect what was for dinner nor evening meal.	Not compliant
Criterion Assessed: 12.5 Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals, and fresh drinking water is available at all times.	**COMPLIANCE LEVEL**
Inspection Findings:	
Staff confirmed that breakfast, lunch and dinner are served at conventional times. As discussed previously outside of the main meals the serving of nutritious snacks for residents on a pureed diet is sporadic and dependent both on availability of appropriate snacks and the support staff on duty. A review of provisions identified limited provisions for snacks. Staff confirmed that fluids are served at each meal time and mid-morning, mid-afternoon, and in the evening.	Moving towards compliance

On occasion's periods of greater than 12 hours are evident between supper and breakfast.	
Criterion Assessed: 12.6 Residents can have a snack or drink on request or have access to a domestic style kitchen.	**COMPLIANCE LEVEL**
Inspection Findings:	
A number of residents in Mulhern Close have limited communication and would be unable to express their desire for a drink or snack. One inspector reviewed the provisions in two kitchens. There was limited availability of provisions. There were no cakes, buns, home baking or milky puddings. A limited supply of plain biscuits was available. The fridges also had limited provisions. This was discussed with staff who indicated that the food order was due to be delivered from the local supermarket later that day. A domestic style kitchen is available in each of the three bungalows. However, the doors are locked for resident safety. Staff confirmed that residents can have access to the kitchen when supervised by staff. Provisions and stock control were discussed with Ms Gregg and Mr Miley at feedback as provisions must be available at all times .	Moving towards compliance

STANDARD 12 - MEALS AND MEALTIMES Residents receive a nutritional and varied diet in appropriate surroundings at times convenient to them.	
Criterion Assessed: 12.7 Menus provide for special occasions.	**COMPLIANCE LEVEL**
Inspection Findings:	
This criterion was not reviewed during this inspection.	Not reviewed
Criterion Assessed: 12.8 Residents are consulted and their views taken into account regarding the home's policy on "take away" foods.	**COMPLIANCE LEVEL**
Inspection Findings:	
This criterion was not reviewed during this inspection.	Not reviewed
Criterion Assessed: 12.9 Meals are served in suitable portion sizes, and presented in a way and in a consistency that meets each resident's needs.	**COMPLIANCE LEVEL**
Inspection Findings:	
Given the issues identified in relation to meals and mealtimes, staff training and staffing levels it is the view of the inspectors that this criterion is not met.	Not compliant

STANDARD 12 - MEALS AND MEALTIMES **Residents receive a nutritional and varied diet in appropriate surroundings at times convenient to them.**	
Criterion Assessed: 12.10 Staff are aware of any matters concerning residents' eating and drinking as detailed in each resident's individual care plan, and there are adequate numbers of staff present when meals are served to ensure: - □ Risks when residents are eating and drinking are managed □ Required assistance is provided □ Necessary aids and equipment are available for use.	**COMPLIANCE LEVEL**
Inspection Findings:	
A review of each individual's care plan was not undertaken. Staff were aware of some specific dietary needs of residents. However, inspectors are concerned that suitable time is not available to manage the risks for residents when eating and drinking, ensure a suitable diet is prepared and served and to provide the required assistance.	Not compliant
Criterion Assessed: 12.11 A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each resident is satisfactory.	**COMPLIANCE LEVEL**
Inspection Findings:	
As a result of the records retained any person inspecting the records would not be able to judge whether the diet for each resident is satisfactory.	Not compliant
Criterion Assessed: 12.12 Where a resident's care plan requires, or when a resident chooses not to eat a meal or is unable to eat a meal, a record is kept of all food and drinks consumed. Where a resident is eating excessively, a similar record is kept. Such occurrences are discussed with the resident, and reported to the registered manager or senior staff in charge of the home. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.	**COMPLIANCE LEVEL**
Inspection Findings:	
Care plans in relation to food and fluids were not reviewed on this occasion.	Not reviewed

STANDARD 12 - MEALS AND MEALTIMES Residents receive a nutritional and varied diet in appropriate surroundings at times convenient to them.	
Criterion Assessed: 12.13 Menus are rotated over a three-week cycle and revised at least six monthly, taking into account seasonal availability of foods and residents' views.	**COMPLIANCE LEVEL**
Inspection Findings:	
There was evidence of a three week menu cycle. There was no evidence to confirm that the menu has been revised six monthly, nor that it was taking into account seasonal availability of foods and resident views.	Not compliant
Criterion Assessed: 12.14 Variations to the menu are recorded.	**COMPLIANCE LEVEL**
Inspection Findings:	
The week three menu cycle was reviewed. It identified that staff were deviating from the planned menu on a regular basis. Deviations from the menu and the reason for them were discussed with a number of staff. Staff identified a number of reasons for the deviations which included staff not having the knowledge and skills to prepare and cook certain choices, the wrong meat or poultry being defrosted or issues with the supply of ingredients due to the ordering processes. As discussed in criterion 12.11 records of food are not retained. There were no records of the reason for variations to the menu.	Not compliant

STANDARD 20 - MANAGEMENT AND CONTROL OF OPERATIONS **Management systems and arrangements are in place that support and promote the delivery of safe, quality care services.**	
Criterion Assessed: 20.1 There is a defined management structure that identifies the lines of accountability, specifies roles and details responsibilities for areas of activity.	**COMPLIANCE LEVEL**
Inspection Findings:	
In examining the managerial lines of accountability in the home, the inspectors spoke with the home's management at the time of this inspection. Given the inspection findings, it was concluded that there are not clear lines of accountability and responsibility in place. In particular the role of the team leader was found to be inadequate in terms of actual cover outside of office hours, and there was a lack of evidence of accountability and monitoring of care in the actual bungalows. RQIA are concerned in relation to the overall governance arrangements in place to monitor the quality of care being provided to residents in Mulhern Close Residential Home. These issues were discussed with Mr Peter McBride, responsible individual and Mrs Margaret Cameron, the newly appointed company director, at the meeting at RQIA on 8 September 2014, who agreed to take these issues forward.	Moving towards Compliance
Criterion Assessed: 20.15 All accidents, incidents, communicable diseases, deaths, and events occurring in the home which adversely affect the wellbeing or safety of any resident are reported promptly to the Regulation and Quality Improvement Authority and other relevant organisations in accordance with legislation and procedures. A record is maintained of all adverse incidents.	**COMPLIANCE LEVEL**
Inspection Findings:	
The accident / incident reports from the 7 August 2014 were reviewed and found to be reported appropriately to the RQIA and the aligned resident's social worker. A monthly analysis of accidents / incidents is carried out. However the analysis for July was yet to be completed. This was discussed with Ms Gregg who confirmed that the person responsible for the accident/incident analysis had recently left the employment of the organisation. Ms Gregg confirmed that another individual would be identified to undertake the analysis of accidents/incidents. A recommendation has been made.	Substantially compliant

10.0 ADDITIONAL AREAS EXAMINED

10.1 Resident's consultation

The inspectors met with all the residents in the home at the time of this inspection. In accordance with their capabilities, all residents indicated/expressed that they were happy and content with their life in the home. However due to levels of dependencies, none of the residents could clearly articulate their views and opinions about the home. .

No obvious concerns were indicated.

10.2 Relatives/representative consultation

There were no visiting relatives / representatives in the home at the of this inspection.

10.3 Staff consultation

The inspectors spoke with five support workers and one team leader, as well as the home's management. Discussion with staff identified that there were issues of poor staff morale. Staff informed the inspectors that these related to the workload and multi-tasking of roles, the employment of non-permanent staff, and the general terms and conditions of employment relating to payment of overtime and non-sociable hours. Staff also informed the inspectors that they felt a good standard of care was being afforded but recent issues relating to whistle blowing disclosure about complaints about care delivery added to an atmosphere of general stress in the home. Issues of improvement have been identified with staffing and are detailed in the attached quality improvement plan to be actioned within timescale.

10.4 Visiting professionals' consultation

There were no visiting professionals in the home at the time of this inspection**.**

10.5 General environment

The inspectors viewed the home and inspected eight residents' bedrooms and communal areas.
In general the home was clean and tidy but there were areas on closer examination that needed to be thoroughly cleaned, due to dirt marks and stains. These areas included an unused communal lounge in the Bellflower unit and catering areas in two of the three units of the home. These issues further reinforce the requirement for staff performing mixed duties to cease. The general décor and furnishings were of a good standard. However there was a clinical appearance to communal areas and bedrooms as there was a lack of personalisation and warmth in the general detail of the décor.

10.6 Care practices

Observations of care practices throughout this inspection found that staff interacted with residents in a polite, warm, friendly manner**.** The atmosphere in the home was relaxed with residents observed to be comfortable and content. However there was observed to be clear

evidence that some members of permanent staff were busy multi-tasking in various roles of caring, house-keeping and catering.

10.7 Restrictive practices

There were a number of residents' bedroom doors that were locked and it was reported that some residents had keys to their own doors and it was to deter residents from entering one another's rooms. However all the room doors, including storage rooms and bathrooms appeared exactly the same and there were no differential appearance or identifying markers to aid residents into accidentally going into one another's room. The issue of locking of bedroom doors was identified at the previous inspection to the home. A requirement has been made for this practice to be reviewed.

The televisions in the communal lounges were in cased in Perspex covering to prevent damage. Added to this there was a lack of ornamental décor and soft furnishings in the lounges and general environment. These provisions were considered to act in overall appearance of a restrictive environment and deterred an atmosphere of homeliness. Such provision needs to be reviewed and subsequently acted upon for the wellbeing of the residents. A requirement has been made for the home to review its use of these restrictive practices.

10.8 Conclusion

Following the inspection, this matter was reported to senior management in RQIA as a serious concern, a decision was taken to hold an intention to issue a notice of failure comply meeting in respect of Regulation 12, Quality of care and other service provision and Regulation 20, Staffing as outlined in The Residential Care Homes Regulations (Northern Ireland) 2005. Mr Peter McBride, responsible individual, was invited to attend a meeting at RQIA on 8 September 2014.

The outcome of the meeting resulted in enforcement action being taken by RQIA. RQIA issued two Notices of Failure to Comply on 8 September 2014 to the responsible individual. A follow up inspection will be undertaken on expiry of the notices to ensure that the actions required have been addressed in full.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Kevin Miley and Ms Kerri Gregg, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to

John McAuley
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Quality Improvement Plan

Secondary Unannounced Care Inspection

Mulhern Close Residential Home

5 November 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the Deputy Manager, Ms Kerri Gregg either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Residential Care Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1) (a)	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 – • Ensure that at all times suitably qualified, competent and experienced persons are and weekend periods; • Care staffing hours, catering and ancillary duties must be adequately differentiated to enable each role and function to be effectively delivered; and • Sufficient care staff must be employed to ensure that the health and care needs of residents are met. Working at the home in such numbers as are appropriate for the health and welfare of residents In doing so, the registered person must; • Ensure that the skill mix of team leader / managerial must be reviewed and increase for the evening, night duty	Four	Suitably, qualified, competetent and experienced members of staff are on shift at all times within Mulhern Registered Residential Home. In addition, a second member of management staff (Deputy Manager /Team Leader) is on shift at weekends since 10/11/14. The shift is part of AM & PM hours. Additionally the Area Service Manager completes unannounced visits each month. A dedicated Cook has commenced within Mulhern from 19/11/14 (49 hours per week). A dedicated Cleaner has commenced work within Mulhern Registered Residential Home from 24/11/14 (35 hours per week). In absence of the cook (for purposes of days off, A/L etc) one of four staff members specifically trained in Food Hygiene will be allocated soley for cooking duties. In the	As per Notice of Proposal

				absence of the dedicated cleaner a staff member will be allocated soley for cleaning duties. Staff skill mix agreed with commissioning WHSCT to meet the needs of 12 residents (full occupancy): (7)Support Workers AM Shift, (7)Support Workers PM Shift (4) Support Workers Night Duty (1) Team Leader Sleep over (1) Activity Therapist (5 days) (1) Deputy Manager(5 days) (1) Manager(5 days) (1) Teamleader / Deputy Manager (Extra Sat & Sun) Although not a requirement from WHSCT, additionally from January, 2015, a part time administrative assistist will be employed to carry out basic administrative duties. This will enable all Management staff to spend more direct contact time with residents.	
2	12 (1) (5) (a) (b) (c) (d)	The registered person shall ensure that food	Three	Snacks and drinks are provided	As per Notice

	(e)	and drink – (a) are provided in adequate quantities and at appropriate intervals; (b) are properly prepared, wholesome and nutritious and meets their nutritional requirements; (c) are suitable for the needs of residents; (d) provide choice for the residents; (e) that the menu is varied at suitable intervals. In doing so, the registered person must; • Ensure that staff have training to equip them with the relevant knowledge and skills to undertake the duties allocated to them; • Implement robust systems and processes to ensure that adequate provisions are in place. The system must negate the need to continually deviate from the menu due to lack of • supply and/or the wrong food being defrosted; • Ensure that a variety of nutritious snacks are available;		at appropritate Intervals at least (3) times per day and as and when required Food is prepared by suitably qualified staff following guidelines from Nutritional Guidelines & Menu Check lists for Adults with Learning Disability.(Menus are reviewed 3 monthly) Two choices of meals are available at each meal time and displayed within each bungalow. Meal Choices are discussed with residents at residents meetings in accordance to their dietary requirements. All staff have completed Social Care TV Training which included a Competency test. Additionally, a further 4 staff members have completed Food Hygiene Course on 15/12/14 and will deputise for the cook during periods of days off, A/L etc. Two menu choices are offered	of Proposal

		• Ensure that residents, regardless of their dietary requirements, are provided with two or three snacks between meals; • Ensure accurate records of the food served are retained. This includes any deviations from the set menu; • Review the practice of food being prepared for long periods of time prior to cooking; • Ensure that the interval between the evening snack and breakfast the following morning is not more than 12 hours.		at each meal time. Any change from menu is discussed with Residents and a deviation form completed and available for inspection. A variety of two/three snacks are available for each resident between meals. Choice & variety is increased as food shopping is now completed three times per week. All food is prepared fresh by the allocated cook/sutiably qualified staff. From 18/11/14 Intervals that exceed 12 hours between meals are recorded within residents notes and reason for this.	
3	14 (5)	The registered person shall ensure that no resident is subject to restraint unless restraint	Two	A review of locking bedroom doors for each resident has	20 December 2014

		of the kind employed is the only practicable means of securing the welfare of that or any other resident and there are exceptional circumstances. In doing so the registered person must review the practice of locking bedroom doors, Perspex covering of televisions and overall lack of ornamental décor and soft furnishings in the environment. In reviewing such the registered person must take subsequent appropriate action for the benefit and wellbeing of residents, based on proportionate human rights and current good practice guidelines.		been completed on 08/09/14 by the WHSCT multi-disciplinary team and signed by full Multi Disciplinary team. This is will be reviewed by the multi-disciplinary team at each resident's review or more frequently if required in line with changing needs. In relation to perspex covering televisions, individualised risk assesments have been completed for each of the residents effected on 12/12/14 and has been signed by Multidisiplinary Team. Residents and families have been consulted on décor and furnishings within their home on 6/12/14. Based on proportinate human rights and current good practice, additional appropriate ornamental décor and soft furnishings have been chosen and purchased for the benefits and wellbeing of the residents.	
4	27 (2) (d)	The registered person shall, having regard to the number and needs of the residents, ensure that –	Two	MUlhern Registered residential Home is kept clean and is reasonably and tastefully	20 December 2014

		(d) all parts of the home are kept clean and reasonably decorated.		decorated in keeping with residents likes and wishes. A dedicated cleaner completes a thorough daily clean. Spot checks are completed on the curtains and dry cleaned as required since 20/12/14	
5	13 (1)	The registered person shall ensure that the residential care home is conducted so as – (a) To promote and make provision for the health and welfare of residents; Reference to this is made in that a review must be carried out in consultation with the resident and / or their representative to implement and put in place an individualised assessment to add comfort and well-being to the furnishment and décor of their rooms and the environment.	One	Each resident and their family members have been consulted regarding the personalisation and decoration of their bedrooms and communal areas within their home on 6/12/14. Each room has been decorated and furnished according to individual likes and wishes to ensure the comfort and well-being of each resident.	20 December 2014

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Susan McBride
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Peter McBride

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	John McAuley	5 January 2015
Further information requested from provider			