Unannounced Care Inspection Report
31 August 2016

Oriel House

31 August 2016

Type of service: Residential Care Home
Address: 30 Oriel Road, Antrim, BT41 4HP
Tel No: 028 94488161
Inspector: John McAuley

1.0 Summary

An unannounced inspection of Oriel House took place on 31 August 2016 from 10:30 to 14:00 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the residential care home was delivering safe, effective and compassionate care and if the service was well led. The inspection also sought to examine issues raised as a duty call complaint received on 22 August 2016.

Is care safe?

There were examples of good practice found during this inspection in relation to the home was clean and tidy with a good standard of décor and furnishings maintained.

Inspection of the internal environment identified that the home was kept safe, suitable for residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff.

No issues of improvement were identified with this domain.

Is care effective?

There were examples of good practice found during this inspection in relation to a review of residents' progress records along with accident and incident reports confirming that referral to other healthcare professionals was timely and responsive to the needs of the residents.

One area of improvement was identified. This was a recommendation to an issue of assessed need in relation to stoma care needing to be more detailed and informative in relation to prescribed care interventions.

Is care compassionate?

There were examples of good practice found during this inspection in relation to discussions with residents, staff and one visiting relative confirming that in their opinions that compassionate care was provided for.

No issues of improvement were identified with this domain.

Is the service well led?

There were examples of good practice found during this inspection in relation to discussions with the acting manager identifying that she had understanding of her role and responsibilities under the legislation.

One area of improvement was identified. This was a recommendation to providing all care staff additional training in stoma care.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Josephine Linton the acting manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 21 July 2016..

2.0 Service details

Registered organisation/registered person: Teresa Thompson	**Registered manager:** Josephine Linton
Person in charge of the home at the time of inspection: Josephine Linton	**Date manager registered:** Josephine Linton - application received - "registration pending".
Categories of care: I - Old age not falling within any other category MP - Mental disorder excluding learning disability or dementia PH - Physical disability other than sensory impairment	**Number of registered places:** 8

3.0 Methods/processes

Prior to inspection we analysed the following records: the previous inspection report, accident and incident notifications and duty log records.

During the inspection the inspector met with eight residents, three members of staff and one resident's relative.

The following records were examined during the inspection:

- Induction programme for new staff
- Sample of competency and capability assessments
- Staff training records
- One resident's care files
- Residents' progress records
- Infection control records
- Cleaning schedule records
- 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 21 July 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 21 July 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 20(3) **Stated:** First time **To be completed by:** 16 August 2016	The registered person must ensure a competency and capability assessment is completed for any staff member with the responsibility of being in charge of the home in the absence of the registered manager.	**Met**
	Action taken as confirmed during the inspection: An inspection of the competency and capability assessments was undertaken. These were found to be appropriately in place.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 29.1 **Stated:** First time **To be completed by:** 16 September 2016	The registered person should seek to have the fire safety assessment updated by a competent fire safety assessor.	**Met**
	Action taken as confirmed during the inspection: A fire safety risk assessment was undertaken on 27 July 2016 by a competent fire safety assessor.	

4.3 Is care safe?

The acting manager 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 and staff.

On the day of inspection the following staff were on duty:

- 1 x acting manager
- 1 x care assistant
- 1 x cook

Review of completed induction records and discussion with the acting 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 was provided.

The acting manager 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. A review of a sample of staff competency and capability assessments were reviewed and found to satisfactory.

Discussions with the acting manager 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 acting manager 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.

The acting manager confirmed that no restrictive practices were undertaken within the home and on the day of the inspection none were observed.

Review of the infection prevention and control policy and procedure confirmed that this this was in line with regional guidelines. Staff training records confirmed that all staff had received training in infection prevention and control on October 2015; in line with their roles and

responsibilities. Discussion with staff established that they were knowledgeable and had understanding of infection prevention and control 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 infection prevention and control procedures.

Hand hygiene was a priority for the home and efforts were applied to promoting good standards of hand hygiene among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

The acting manager reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with the home's 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 clean and tidy with a good standard of décor and furnishings maintained.

Inspection of the internal environment identified that the home was kept safe, suitable for residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff.

The home had an up to date fire risk assessment in place dated 27 July 2016.

Review of staff training records confirmed that staff completed fire safety and fire safety drills training twice annually. 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 regularly. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place.

Areas for improvement

There were no areas identified for improvement.

Number of requirements:	0	Number of recommendations:	0

4.4 Is care effective?

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

A review of one resident's care records was undertaken. 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. The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly. However an issue of assessed need in relation to stoma care needed to be more detailed and informative in relation to prescribed care interventions. A recommendation was made with regard to this.

Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate.

Records were stored safely and securely in line with data protection.

The acting manager 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.

Discussion with residents and observation of practice evidenced that staff were able to communicate effectively with residents.

Minutes of resident and/or their representative meetings were available for inspection.

A review of residents' progress records along with accident and incident reports confirmed that referral to other healthcare professionals was timely and responsive to the needs of the residents.

Areas for improvement

There was one area of improvement identified. This was an issue of assessed need in relation to stoma care needing to be more detailed and informative in relation to prescribed care interventions.

Number of requirements:	0	Number of recommendations:	1

4.5 Is care compassionate?

The acting manager confirmed that there was a culture/ethos within the home that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

Discussion with residents, staff and one visiting relative confirmed their opinions that compassionate care was provided for.

In accordance with their capabilities all the residents informed the inspector that they were happy with their life in the home, their relationship with staff , activities and provision of meals. Some of the comments made included statements such as;

- "I love it here"
- "All the staff are marvellous"
- "The care are staff are simply excellent"
- "I am very well looked after. No problems"

The inspector also met with one visiting relative who spoke in positive terms about the provision of care and the kindness and support received from staff.

Discussion with residents, one visiting relative and staff along with observation of practice and interactions demonstrated that residents were treated with dignity and respect. Staff confirmed their awareness of promoting residents' rights, independence and dignity. Staff were also able

to demonstrate how residents' confidentiality was protected. For example, staff knocked doors before entering residents' bedrooms and were sensitive when dealing with handover of verbal reports.

At the time of this inspection residents were found to be comfortable, content and at ease in their environment and interactions with staff. Residents were watching television, reading. enjoying the company of one another or resting. An appetising dinner time meal was provided for in a nicely appointed dining room.

The acting manager and staff confirmed that residents were listened to, valued and communicated with in an appropriate manner. Discussion with residents confirmed that their needs were recognised and responded to in a prompt and courteous manner by staff.

Areas for improvement

There were no areas identified for improvement.

Number of requirements:	0	Number of recommendations:	0

4.6 Is the service well led?

The acting manager confirmed that she was recently appointed to her role in the home and an application has been sent to RQIA for approval of registered manager's status. Discussions around this role and responsibilities took place during this inspection.

The health and social care needs of residents were met in accordance with the home's Statement of Purpose and the categories of care for which the home was registered with RQIA.

A range of policies and procedures were in place to guide and inform staff.

There was a complaints policy and procedure in place which was in accordance with the legislation and DHSPPS guidance on complaints handling. Residents and/or their representatives were made aware of how to make a complaint by way of the Residents' Guide and display information. Discussion with the acting manager confirmed that she was knowledgeable about how to receive and deal with complaints.

There was an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. 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.

Inspection of staff training records confirmed that staff were provided with mandatory training. An identified issue of additional training for staff in stoma care was recommended.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability. Discussion with the acting manager identified that she had understanding of her role and responsibilities under the legislation. The acting manager confirmed that the registered provider was kept informed regarding the day to day running of the home. This was primarily by the registered provider's working shifts on a weekly basis in the home.

The acting manager confirmed that the home operated in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration was displayed.

The home had a whistleblowing policy and procedure in place. The acting manager confirmed that staff could also access line management to raise concerns and to offer support to staff.

The acting manager 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.

Areas for improvement

There was one area of improvement identified. This was in relation to providing all care staff additional training in stoma care.

Number of requirements:	**0**	**Number of recommendations:**	**1**

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Josephine Linton the acting manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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 care home. 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSPPS Residential Care Homes Minimum Standards, August 2011. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to care.team@rqia.org.uk for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 23.4 **Stated:** First time **To be completed by:** 1 October 2016	The registered provider should seek to provide training for all care staff on stoma care.
	Response by registered provider detailing the actions taken: Stoma Care training held on the 20th September for staff. Certificates awarded as recommended.
Recommendation 2 **Ref**: Standard 6.2 **Stated:** First time **To be completed by:** 1 October 2016	The registered provider should revise and update the identified care plan on stoma care, so it is detailed and informative in its prescribed care interventions.
	Response by registered provider detailing the actions taken: Care Plan for Stoma care updated and implemented with individual's consent as recommended.

Please ensure this document is completed in full and returned to** care.team@rqia.org.*uk* **from the authorised email address

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews