Unannounced Care Inspection Report
24 and 27 November 2020

Ralph's Close

Type of Service: Residential Care Home
Address: Gransha Park, Clooney Road, Londonderry, BT47 6TF
Tel No: 028 7186 4332 / 028 7186 4322
Inspectors: Jane Laird and Phil Cunningham

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for

2.0 Profile of service

This is a registered residential care home which provides care for up to 16 residents with a learning disability. The home is divided in to four areas (house 1, 2, 3 and 4).

3.0 Service details

Organisation/Registered Provider: Western Health and Social Services Trust (WHSCT) **Responsible Individual:** Dr Anne Kilgallen	**Registered Manager and date registered:** Lisa Rowley - Acting Manager
Person in charge at the time of inspection Saul Simpson, Deputy Manager	**Number of registered places:** 16
Categories of care: Residential Care (RC) LD - Learning Disability	**Total number of residents in the residential care home on the day of this inspection:** 15

4.0 Inspection summary

An unannounced care inspection took place on 24 November 2020 from 10.40 to 18.30 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk. In response to this, RQIA decided to undertake an inspection to this home.

The following areas were examined during the inspection:

- staffing arrangements
- infection prevention and control (IPC) measures
- care delivery
- care records
- the home's environment
- management, leadership and governance arrangements.

As a result of the care inspection, RQIA were concerned regarding the management, leadership and governance arrangements within the home. There was a lack of robust systems to regularly review the quality of care and other services provided by the home. This included, but is not limited to, infection prevention and control measures, risk management, governance audits, maintenance of duty rotas, the oversight and management of the home's environment, fire safety and the recording and reporting of notifiable events specific to the premises.

These deficits had the potential to impact on the health, safety and well-being of residents and quality of care delivered in the home and as a result a focused inspection was undertaken on 27 November 2020 by the estates inspector in support of this inspection.

As a consequence, a serious concerns meeting was held on 7 December 2020 at RQIA, to discuss our concerns. The meeting was attended via video conference by Karen O'Brien, director of mental health and learning disability, Western Health and Social Care Trust

(WHSCT), Christine McLaughlin, assistant director, Maire Boyle, acting head of service and Maureen McGeehan, community service manager, on behalf of the responsible individual, Dr Anne Kilgallen.

At the meeting the responsible individual's representatives acknowledged the failings and discussed the actions that had been taken, since the inspection, to achieve full compliance with the required regulations, including the implementation of new management arrangements. They also provided a detailed action plan with a full account of the actions and arrangements made to ensure the necessary improvements are completed. Following this meeting a decision was made to take no further enforcement action at this time.

A further inspection will be undertaken to validate sustained compliance and drive necessary improvements.

Areas requiring improvement were identified as outlined in the quality improvement plan (QIP). Please refer to section 7.0.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, and enhance practice and residents' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*15	*9

*The total number of areas for improvement includes one regulation and one standard which have been stated for a second time. One regulation and two standards have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Saul Simpson, deputy manager and Maureen McGeehan, community service manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this inspection by way of a serious concerns meeting at RQIA.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

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

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

Questionnaires and 'Tell us' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

The following records were examined during the inspection:

- duty rota for all staff for weeks commencing 16 November 2020 and 23 November 2020
- records confirming registration with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- three residents' care records
- a sample of governance audits/records
- staff competency and capability assessments for taking charge of the home in the absence of the manager
- complaints ledger
- incident and accident records
- staff medicines management competency assessments
- a sample of monthly monitoring reports for September 2020 and October 2020
- fire risk assessment
- legionella risk assessment
- hot and cold water temperatures
- a sample of documents relating to the premises and maintenance management of firefighting equipment, emergency lighting, alarm systems, fire doors and weekly fire alarm test activation.

Areas for improvement identified at the last care and finance inspection were reviewed and an assessment of compliance was recorded as met, partially met, not met and carried forward for review at the next inspection.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspections

The most recent inspection of the home was an unannounced care inspection undertaken on 5 March 2020.

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 19 (2) Schedule 4 (1) **Stated:** First time	The registered person shall ensure that each resident has a record of the furniture and personal possessions which they have brought into the room they occupy. (Records of residents' personal property should be kept up to date over time).	**Not met**
	Action taken as confirmed during the inspection: On discussion with staff and review of a sample of care records evidenced that this area for improvement has not been met. This area for improvement has not been met and has therefore been stated for a second time.	
Area for improvement 2 **Ref**: Regulation 5 (1) (a) (b) **Stated:** First time	The registered person shall ensure that each resident or their representative is provided with an individual written agreement setting out the terms and conditions of their residency in the home.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	
Area for improvement 3 **Ref:** Regulation 27 (2) (d) **Stated:** Second time **To be completed by:** 1 May 2020	The registered person shall ensure that the sofa in house 3 is made good or replaced.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment and discussion with staff evidenced that the sofa in house 3 had been replaced.	
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 18.2 & Appendix 2 **Stated:** First time	The registered person shall ensure that the home has a written policy and procedure addressing transport services. A copy of the policy should be easily accessible for the relevant staff members and a copy should be kept for reference, in the vehicle used to provide transport services to patients.	**Partially met**

	Action taken as confirmed during the inspection: There was a written policy and procedure within the home regarding transport services. On review of the homes vehicle, a copy of the transport policy was not available. This area for improvement is only partially met and has therefore been stated for a second time.	
Area for improvement 2 **Ref**: Standard 4.6 **Stated:** First time	The registered person shall ensure that the resident or their representative is given written notice of all changes to the resident's agreement and these are agreed in writing by the resident or their representative. Where the resident or their representative is unable to sign or chooses not to sign, this is recorded.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	
Area for improvement 3 **Ref**: Standard 4.2 **Stated:** First time	The registered person shall ensure that the content of the home's generic patient agreement is compared with the minimum content of a resident agreement as set out within standard 4.2 of the Residential Care Home Minimum Standards. The generic agreement should be reviewed and updated accordingly.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	
Area for improvement 4 **Ref**: Standard E53 **Stated:** First time	The registered person shall ensure that appropriate storage is provided for clean linen.	**Met**
	Action taken as confirmed during the inspection: Review of linen cupboards throughout the home evidenced that clean linen was stored appropriately.	

6.2 Inspection findings

6.2.1 Staffing Arrangements

On arrival to the home we were greeted by the deputy manager and staff who were helpful and attentive. There was a pleasant and calm atmosphere throughout the home and we could see that there was enough staff to respond to the needs of the residents and to provide the correct level of support.

The deputy manager confirmed that staffing levels for the home were safe and appropriate to meet the number and dependency levels of residents accommodated. Review of staff duty rotas evidenced a number of deficits with the maintenance of the rota. For example: the person in charge of the home in the absence of the manager was not recorded; job titles/roles and the hours worked by staff were not clearly documented. This was discussed with management and identified as an area for improvement.

A discussion with staff confirmed that they felt supported in their roles and were satisfied with current staffing levels. However, staff discussed challenges with short notice absence during a recent COVID-19 outbreak. Staff confirmed that staffing levels have recently returned to normal and the situation is "much better." Comments from staff included:

- "Love my job."
- "Good induction."
- "No staff area which needs addressed."
- "Estates issues are often not addressed in a timely manner."
- "We all work really well together to make sure the residents' are kept well and safe."
- "I love working here."

We also sought staff opinion on staffing via the online survey. There were no responses received within the time frame allocated.

We reviewed a sample of competency and capability assessments for staff in charge of the home in the manager's absence and found that these had not been updated since August 2018. The importance of ensuring that these assessments are reviewed and updated regularly to ensure that staff remain competent was discussed with management and an area for improvement was stated.

Review of three senior care assistant files evidenced that medicine competency assessments had not been reviewed for one employee since 2013 and 2018 for two other employees. This was discussed with management and identified as an area for improvement.

We requested a sample of staff recruitment files and were advised that these records were held by the human resource department for the WHSCT and that the manager did not have access to these records. While we accepted this explanation we discussed the importance of the manager having oversight of the recruitment process to ensure they are satisfied that staff have been recruited safely in line with regulations and that a checklist of the manager's oversight process is maintained in the home for inspection. This was identified as an area for improvement.

Review of records identified that staff registration checks for NISCC/NMC had not been completed since 13 December 2019. We requested that a review of all staff working within the home and as recorded on the duty rota be completed and forwarded to the inspector following the inspection. This confirmation was received by email on 26 November 2020. A review of the records submitted evidenced that they had not been signed/dated by the person who competed the check; the full names of staff were not recorded; the monitoring check did not verify if the employee was active on the relevant register and a significant number of staff recorded on the duty rota had not been included on the registration monitoring list and an area for improvement was stated. During the serious concerns meeting on 7 December 2020, full details of staff registration status were provided.

Discussion with management identified that the staff mandatory training matrix was in the process of being updated. We requested that a copy of the updated mandatory training matrix be forwarded to the inspector. This was received by email on 26 November 2020. A review of the information submitted evidenced that the dates of training recorded were in advance of the current date on most entries; the matrix did not include the full names of staff; a significant number of staff recorded on the duty rota was not included as required. Other mandatory training such as; adult safeguarding, Mental Capacity Act (MCA) (Northern Ireland) 2016 deprivation of liberty safeguards (DoLS), infection prevention and control, first aid or Management of Actual and Potential Aggression (MAPA) were not included. We were therefore unable to determine if all staff had received their mandatory training. This was identified as an area for improvement. During the serious concerns meeting on 7 December 2020; full details of staff training status was provided.

6.2.2 Infection prevention and control (IPC) measures

Upon entering the home, the inspector's temperature and contact tracing details were obtained by the senior care assistant who advised that this process was completed on all persons entering the home, in line with the current COVID-19 guidelines for visiting care homes.

We were advised by staff that temperature checks were being completed on all residents and staff, twice daily, and that any concerns or changes were reported to the manager and/or senior carer in charge.

Staff were knowledgeable regarding the symptoms of Covid-19 and how to escalate any changes in a resident's usual presentation to the person in charge. Staff also said that if they themselves felt unwell, they would inform the person in charge and isolate, at home, as per regional guidance.

Observation of staff practices evidenced that they were not consistently adhering to appropriate infection prevention and control measures, including the use of gloves and aprons within communal areas and entering the kitchen without removing their PPE and washing their hands. Outside the Laundry and Kitchen areas we observed that the PPE stations were empty, there was no hand sanitising gel available and there was no clinical waste bin for staff to dispose of their PPE. In addition; residents equipment, personal clothing and towels were observed within communal bathrooms; black bin bags were being used on a resident's bedroom door and windows to black out the light; staff were observed having their break within a residents' dining room; and a staff member was wearing their face mask below their chin. These deficits were discussed in detail with management and identified as an area for improvement.

6.2.3 Care delivery

Staff demonstrated a detailed knowledge of residents' wishes, preferences and assessed needs and of how to provide comfort if required. Residents were well presented, and had been supported by staff in maintaining their personal care in a timely and discreet manner. There was a pleasant, relaxed atmosphere in the home throughout the inspection and staff were observed to have caring, cheerful and friendly interactions with residents.

We observed the serving of the lunch time meal and saw that staff attended to the residents' needs in a prompt and timely manner. We saw that staff wore the appropriate PPE and sat beside residents when assisting them with their meal. However a daily menu, in a format suitable for residents, was not displayed within any of the dining rooms and an area for improvement was stated.

Staff spoke of the importance of communication with families due to limited visiting and staff were helping residents to keep in touch via alternative methods such as video and telephone calls and found this was generally working well. Visiting arrangements were in place in a designated area of the home and on a scheduled basis.

We observed staff throughout the inspection using a 'fob key' to gain access to communal bathrooms/toilets. On discussion with staff they explained that these doors were kept locked due to potential risks to residents. Residents could not access communal bathrooms/toilets without seeking permission from staff. Review of a sample of resident care files evidenced that this had not been recorded and/or considered as a deprivation of residents' liberty. Details were discussed with management and identified as an area for improvement. During the meeting on the 7 December 2020 RQIA were given assurances that the fob key access to communal bathrooms/toilets had been deactivated and was no longer required and that relevant MCA/DoLS training was being arranged for staff as part of their mandatory training.

6.2.4 Care Records

We reviewed of a sample of resident care records and identified a number of deficits as detailed below:

- inconsistencies in two identified residents' care records regarding the recommended diet/fluid consistencies as per the International Dysphagia Diet Standardisation Initiative (IDDSI) terminology
- conflicting information between residents' dietary information held in the dining room, speech and language therapist SALT assessments and care plans for two identified residents'
- hospital passports for three residents' did not include the recommended dietary/fluid type
- a care plan for one resident was noted to lack sufficient detail regarding their assessed elimination needs
- a resident with weight loss did not have a care plan and/or risk assessment to monitor their weight.

Specific examples were discussed in detail with management who acknowledged the shortfalls in the documentation and agreed to communicate with care staff the importance of accurately recording information within residents' care records. An area for improvement was made.

We further identified that some care plans and risk assessments had not been reviewed since August 2013, March 2019 and July 2019. This was discussed with the deputy manager who advised that care plans and risk assessments had been updated on the computer but had not been printed off and put into resident folders. During the inspection some of the documents were provided. These had not been signed by the home staff or care manager and a number of care plans and risk assessments were still required to be reviewed and updated. We discussed the importance of establishing a system to ensure that these records are kept under review and within the residents care file to assist staff in the delivery of each resident's assessed care needs. This was identified as an area for improvement which is discussed further in section 6.2.6 below.

6.2.5 The home's environment

The home was fresh smelling, neat and tidy with the majority of communal areas such as lounges, dining rooms and corridors were kept clear and free from obstruction. Residents' bedrooms were found to be personalised with items of memorabilia and special interests. However, not all areas of the home were maintained to an acceptable standard as detailed below:

- walls and floor coverings around the base of a number of toilets were damaged
- toilet seats were missing within identified en-suites and a communal bathroom
- moisture damage was observed within a number of en-suites and to the ceilings of identified bedrooms and a lounge.

The above deficits were discussed in detail with management who advised that repair work had been delayed due to COVID-19 but that the work would recommence as restrictions were relaxed. This was identified as an area for improvement.

There was also a lack of oversight in relation to ensuring the cleanliness and fitness of the environment as detailed below.

- shower heads were stained and there was no system for their regular cleaning
- significant build-up of lime scale was observed on water taps throughout the home and a toilet within a communal bathroom was covered over by a wooden board
- the laundry rooms were cluttered with a build-up of dust and debris to washing machines and tumble dryers
- access to wash hand basins within laundry rooms were obstructed with equipment
- ceiling light fixtures were also observed to have cobwebs and debris throughout various locations of the home.

These deficits were discussed in detail with management who removed the wooden board from the toilet within the identified bathroom during the inspection and advised that a deep clean would be completed within the home to address the above shortfalls. This was identified as an area for improvement. During the meeting on the 7 December 2020 the responsible individual's representatives confirmed that a deep clean of the home had taken place with additional cleaning hours allocated. Shower heads and toilet seats had been replaced and a meeting with the landlord had been scheduled to review all other environmental issues.

During discussions with staff it was identified that staff did not have a designated staff room and described how they had their breaks/meals in the residents' dining rooms. A number of

recreational rooms were also being used to facilitate staff breaks and/or the storage of PPE. RQIA had not been made aware of the change of purpose of these rooms. The importance of rooms being used for the purpose that they are registered for was discussed with management. We also discussed the importance of implementing zones within the home for staff to ensure that the regional guidance is adhered to. Following the inspection, the manager provided written confirmation that the repurposing of residents' areas was a temporary measure because of the Covid-19 pandemic arrangements and confirmed that staff breaks were no longer facilitated within resident dining rooms. This will be reviewed at a future inspection.

We observed cleaning chemicals accessible to residents within an unlocked staff changing room and brought this to the attention of management and an area for improvement was made specific to the control of substances hazardous to health (COSHH).

We observed a number of other unnecessary and avoidable risks to residents and brought these to the immediate attention of the deputy manager. For example, razors used for shaving were observed unsecured and accessible to residents; rooms with staff food/belongings, kettles and microwaves were also found to be unlocked and accessible to residents. This was identified as an area for improvement.

Concerns regarding fire safety measures were observed throughout the inspection. We observed a fire door propped open at the commencement of the inspection and we discussed this with the deputy manager to address with staff immediately. Despite this, fire doors continued to be propped open throughout the inspection rendering them ineffective in the event of a fire. We also observed a number of fire doors that were unable to close effectively; a fire exit door was obstructed with a wheelchair and identified fire doors had unacceptable gaps between the top of the door and the door frame when closed. We further identified that fire awareness training was only being completed once a year and not in accordance with twice yearly requirements. Fire safety was discussed in detail with management and an area for improvement was made.

During the premises inspection on 27 November 2020 the estates inspector discussed the care inspection findings further with management who advised that a fire risk assessment had been completed in November 2020 and that the WHSCT's Fire Safety Adviser had confirmed that the seals on the top of identified fire doors were satisfactory. The estates inspector requested a copy of the fire risk assessment which had an action plan with timeframes for the manager to address. Assurances were provided by management that a further assessment of the seal to the top of fire doors would be completed by the landlord and the actions within the fire risk assessment would be addressed within the specified timeframes. This will be reviewed at a future inspection.

The estates inspector reviewed a sample of maintenance records which confirmed that regular checks were being carried out on firefighting equipment, emergency lighting, alarm systems, fire doors and weekly fire alarm test activation. Following the inspection management forwarded certificates to RQIA to validate that the servicing of the fire alarm and emergency lighting had been completed in line with current regulations.

Maintenance records also included regular checks on hot and cold water. A legionella risk assessment was completed on 5 August 2020 and there was confirmation that cold water storage tanks had been disinfected on 23 January 2020. We requested records regarding the flushing of seldom used water outlets and were advised that this was being completed by

domestic staff; however, they were not maintaining a record. The manager advised that this had been implemented following the inspection. This will be reviewed at a future inspection.

6.2.6 Management, leadership and governance arrangements

Given the inspection findings, discussion with management and review of governance records it was clearly evidenced that the governance and management arrangements were insufficiently robust to ensure the health and welfare of the residents accommodated within Ralph's Close. It was concerning that the recently appointed acting manager had not received an induction to ensure that they were fully aware of the systems, processes and responsibilities specific to managing a registered residential care home. This was identified as an area for improvement.

Audits were either not available and/or not completed to monitor or manage the home's environment, IPC measures or as mentioned above in section 6.2.4 there was no system to ensure that care records were being reviewed/updated. An area for improvement was identified in relation to quality governance audits.

Since the previous care inspection on 5 March 2020 there have been several changes in management within the home, each position being in an acting capacity with recruitment ongoing for a registered manager. During the meeting on the 7 December we were advised that the community service manager would be taking on the day to day management of the home as the acting manager until a suitably qualified manager was recruited. We were also assured that the new acting manager would receive an induction into their role.

On discussion with staff and review of the record of estates requests; issues that had been reported several weeks previously had not been addressed. Notifiable events had not been submitted to RQIA regarding incidents such as a water leak within a boiler room; occasions where heating and hot water were not available and a fault with the locking mechanism of medical room doors. This was discussed with the manager and identified as an area for improvement.

We requested a copy of the most recent Regulation 29 monthly monitoring reports and were advised by the deputy manager that these were not available within the home and that they did not have access to them. We discussed the importance of maintaining these records within the home for residents, their representatives, staff and trust representatives with management and an area for improvement was identified.

During the serious concerns meeting on 7 December 2020 RQIA were assured, through discussion, that there was an increased awareness in the importance of a robust governance system and process. We were told that a new system had been implemented to monitor the progress with audit outcomes which will focus on the quality of the service provision.

As stated previously RQIA were provided with a robust and detailed action plan as part of the serious concerns meeting held. We were satisfied that the appropriate action had been taken to address the immediate issues identified with ongoing review dates to address all of the actions required to bring the home into compliance with the regulations and standards.

Areas of good practice

Evidence of good practice was found in relation to the friendly, supportive and caring interactions by staff towards residents and we were assured that there was compassionate care delivered in the home.

Areas for improvement

Nineteen new areas for improvement were identified during the inspection. Details can be found throughout the body of the report and in the Quality Improvement Plan (QIP) in relation to maintenance of staff duty rota, competency and capability assessments, medicine competency assessments, oversight of staff recruitment checks, registration checks, staff mandatory training, IPC, menu display, restrictive practice, care records, fitness of the premises, cleanliness of premises, control of substances hazardous to heath (COSHH), risk management, fire safety, induction, quality governance audits, reporting of notifiable events and availability of monthly monitoring reports.

	Regulations	Standards
Total number of areas for improvement	13	6

6.3 Conclusion

During the inspection, we observed positive interactions between staff and residents. Residents were well presented, and supported by staff who were observed to have caring, cheerful and friendly interactions with residents.

However, serious concerns were highlighted in regards to the lack of managerial oversight and governance processes within the home; health and welfare of residents; infection prevention and control practices; the internal environment; risk management and fire safety practices.

The responsible individual was invited to attend a meeting with RQIA via video teleconference on 7 December 2020 to discuss the inspection findings and their plans to address the issues identified. During the meeting the representatives provided an action plan detailing the deficits identified during the inspection with the person responsible for completing the action and the established time frames. We were satisfied that the appropriate action had been taken to address the immediate issues identified with ongoing review dates to address all other actions.

A further inspection will be undertaken to validate the areas for improvement identified and to seek assurance of the sustained compliance with the regulations and standards.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Saul Simpson, acting deputy manager and Maureen McGeehan, community service manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

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

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref**: Regulation 5 (1) (a) (b) **Stated:** First time **To be completed by:** 7 June 2018	The registered person shall ensure that each resident or their representative is provided with an individual written agreement setting out the terms and conditions of their residency in the home. Ref: 6.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 2 **Ref:** Regulation 19 (2) Schedule 4 (1) **Stated:** Second time **To be completed by:** 27 December 2020	The registered person shall ensure that each resident has a record of the furniture and personal possessions which they have brought into the room they occupy. (Records of residents' personal property should be kept up to date over time). Ref: 6.1
	Response by registered person detailing the actions taken: A copy of the residents' property has been recorded and added to their file. A new system of recording this in property books is in the process of been implemented in each house. This will be completed by the end of February. Team leaders will ensure that this is kept up to date, to be overseen by the manager.on a quarterly basis.
Area for improvement 3 **Ref:** Regulation 20 (3) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure competency and capability assessments are completed and up to date for staff who have responsibility of being in charge of the home in the absence of the manager. Ref: 6.2.1
	Response by registered person detailing the actions taken: All competency and capability assessments for the senior staff are on file. It has been agreed that the Deputy Manager is responsible for updating this file.

Area for improvement 4 **Ref:** Regulation 21 (1) (c) (ii) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure a robust system is in place to ensure staff are registered with NISCC/NMC. Ref: 6.2.1
	Response by registered person detailing the actions taken: NISCC database is now in place with a new column added to reflect the renewal date of each member of staff. This will be monitored monthly by the admin staff and brought to managers/seniors attention. This will be maintained by admin staff and overseen by manager and Deputy manager of facility.
Area for improvement 5 **Ref:** Regulation 21 (1) (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that staff receive mandatory training relevant to their role and a record of this training is kept within the home and available for inspection. Ref: 6.2.1
	Response by registered person detailing the actions taken: A new training matrix is in place: This reflects up to date and planned training for all staff as per RQIA mimimum standards and WHSCT employment regulations. This database is maintained daily by Admin team and overseen by Registered manager of the facility to ensure that this is maintained and kept up to date. A RAG rating system is in place to alert Admin when training is due for renewal.
Area for improvement 6 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance. With specific reference to: • the correct use of PPE • hand hygiene • availability of PPE outside laundry/kitchen • storage of equipment residents clothing and towels Ref: 6.2.2
	Response by registered person detailing the actions taken: Western Health and Social Care infection control department have trained two PPE champions within Ralph's Close. Training was carried out by Trust Infection Control. PPE audit is carried out weekly, recorded within the Environmental Audit

	records. Monitoring Officers will review PPE audit during Reg 29 visit. All staff are following the PHA guidelines regarding the use of PPE. This is being monitored by senior staff. Hand hygiene audits take place on a weekly basis by the band 6. The file is kept in manager's office. There are daily environmental audit files kept at the front desk of each house. The seniors on duty oversee this audit daily, then at the end of each month the audited sheets are filed in a central file in the main office. Senior staff will report any issues raised/encountered during the environmental audit to the Manager. 12 Dani stations (PPE Stations) have been erected throughout the building. A bin and hand sanitizers are kept in the laundry rooms for disposal of PPE before leaving the laundry room. Storage of residents clothing and towels are kept within the residents bedrooms. The Infection control nurse has agreed to do an unannounced spot check visit to Ralphs Close during covid and feedback to the Manager who will follow up on any issues raised.
Area for improvement 7 **Ref**: Regulation 15 (2) (a) (b) **Stated:** First time **To be completed by:** 27 December 2020	The registered person shall ensure that care plans and risk assessments are reviewed regularly and updated to reflect the current needs of residents. With specific reference to ensuring care records contain: • the recommended diet/fluid consistencies as per the International Dysphagia Diet Standardisation Initiative (IDDSI) terminology • dietary information held in the dining room, care plan and risk assessment to contain consistent information to reflect the speech and language therapist SALT assessment • hospital passports to include the recommended dietary/fluid type • to contain details regarding residents assessed elimination needs • where a resident has been identified with weight loss a relevant care plan and risk assessment is implemented to monitor their weight. Ref: 6.2.4
	Response by registered person detailing the actions taken: Managerial Audit: All the residents files have been audited by the manager. A copy of the individual audits have been placed on each file for actioning.

	Care plans and risk assessments are reviewed every 6 months through the Care management process. The team are in the process of developing Ralphs Close person centred care plans in all files. A senior member of staff has been delegated solely to improve the structure and content of all the files to ensure robust governance in all aspects of assessed needs. Care plan work shops have commenced weekly with a peer residential manager and peer team leaders from another residential establishment within the Trust, with a view to bench marking and improving standards within Ralphs Close Hospital passports have been updated to highlight dietary/fluid types. Weight charts are incorporated into the care files and reviewed within the Care Management Process.
Area for improvement 8 **Ref**: Regulation 27 (2) (b) **Stated:** First time **To be completed by:** 27 December 2020	The registered person shall ensure that the environmental issues identified during this inspection are addressed. With specific reference to: • walls and floor coverings around the base of identified toilets • toilet seats are replaced to identified en-suites and communal bathroom • moisture damage to identified walls within en-suites and to ceilings within identified bedrooms and a lounge are investigated and repaired. Ref: 6.2.5
	Response by registered person detailing the actions taken: Damp patches were observed within a number of en-suites and to the ceilings of identified bedrooms and a lounge. Omega have assessed this, the manager of Choice will arrange for the damp areas to be stain blocked and painted, but has advised that surfaces need to be dry in order to carry this out work. There was damage to the walls within a number of en-suite bathrooms and to floor coverings around the base of a number of toilets. Manager of Choice has contracted out this job. Registered manager has contacted Manager of Choice. This work has commenced on 29/1/2021. A fire exit door was obstructed with a wheelchair and the door to an en-suite and communal bathroom were also identified as not being able to close properly. The bathroom door was attended to and the wheelchair removed.

Area for improvement 9 **Ref**: Regulation 27 (2) (b) (d) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the environmental issues identified during this inspection are addressed. With specific reference to: • staining/lime scale is removed from shower heads and water taps throughout the home and a system for their regular cleaning is implemented • the laundry rooms and equipment such as washing machines and tumble dryers are maintained and clutter free • wash hand basins within laundry rooms are accessible to staff • cobwebs and debris from ceiling light fixtures are cleaned throughout the home. Ref: 6.2.5
	Response by registered person detailing the actions taken: A meeting took place with the Manager of Support Services and the manager of Ralphs Close on the 18/01/2021 to address cleaning of the home. An action from this meeting was that all 4 houses would get a further deep clean. A further deep clean of all 4 house took place on the 21/01/2021. Additionality of 15 cleaning hours per week have been added to the current cleaning rota and Ralphs close staff also to ensure the cleanliness of the home is maintained. Registered manager/Deputy Manager oversees this and addresses same during daily walk around. Areas for improvement or maintenance are noted. The Manager shares any issues with the senior for each house so that issues/concerns are followed up. Both managers have agreed to meet monthly to ensure a regular review and audit of cleaning and decontamination of the home. The support service onsite supervisor completed a full inspection of the deep clean with the Residential Manager. Daily environmental audits are completed and overseen by the senior on duty. Daily walk arounds and weekly spot checks are carried out by the manager. Laundry rooms are maintained and clutter free. Cobwebs and debris have been cleaned from ceiling light fixtures throughout the home. All staff report issues to estates services/Choice and actioned in a timely manner. Progress can be reviewed and monitored on Trust Intranet.

Area for improvement 10 **Ref**: Regulation 14 (2) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all chemicals are securely stored in keeping with COSHH legislation to ensure that residents are protected at all times from hazards to their health. Ref: 6.2.5
	Response by registered person detailing the actions taken: All chemicals have been stored away in keeping with the COSHH legislation.
Area for improvement 11 **Ref:** Regulation 27 (2) (t) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall, having regard to the number and needs of the residents, ensure that a risk assessment to manage health and safety is carried out and updated when necessary. With specific reference to storage of: • razors • kettles, microwaves • staff belongings Ref: 6.2.5
	Response by registered person detailing the actions taken: Residents do not have access to razors as they are now stored away. A locked cupboard has been ordered for each resident to lock away razors in their own rooms. The kettle and microwaves have been removed from the recreational room. The recreation room has been changed to a temporary staff room and this room is locked. The residents do not access this room. Senior management are currently in the process of sourcing a porter cabin to use as a staff room. This will require a business case to secure the funding. Choice housing have agreed to this being placed onsite. Ralph's Close risk assessment has been updated to reflect same. RQIA have also been advised of this temporary arrangement.
Area for improvement 12 **Ref:** Regulation 27 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that: • an assessment is completed on seals at the top of identified fire doors and remedial measures completed where necessary • fire doors are maintained to operate effectively • fire doors are not propped open • all staff receive fire awareness training twice yearly. Ref: 6.2.5

	Response by registered person detailing the actions taken: The Manager of Choice has agreed to address the issue with seals, to be discussed at the Contract Review meeting on the 8/2/21. This should ensure that Fire Doors will operate effectively. The issue and safety concerns regarding fire doors being propped open has been addressed with staff. This will be monitored on a daily basis. All staff have completed Fire Awareness Training. A matrix to review all staff mandatory training has been established. Training will be reviewed and planned by the Manager with the support of admin staff.
Area for improvement 13 **Ref**: Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the newly appointed acting manager is provided with a robust induction programme. Ref: 6.2.6
	Response by registered person detailing the actions taken: RC's Residential Manager was provided and supported with an Induction from a registered manager of WH&SCT Adult Disability residential home along with support from the Head of Service
Area for improvement 14 **Ref**: Regulation 30 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that RQIA are notified of any event in the home in accordance with Regulation 30. Ref: 6.2.6
	Response by registered person detailing the actions taken: RQIA will receive a report of all notifiable events relating to estates, care, medicines and finance in the home in accordance with regulation 30
Area for improvement 15 **Ref**: Regulation 29 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that reports produced following monthly monitoring visits are maintained within the home and accessible to residents, their representatives, staff and trust representatives. Ref: 6.2.6
	Response by registered person detailing the actions taken: All monthly monitoring visits are up loaded onto share point and also printed on a central file situated in the manager's office (middle shelf). The monitor will review and discuss updates/actions from the previous monitoring visit with the Manager.

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4.6 **Stated:** First time **To be completed by:** 24 August 2018	The registered person shall ensure that the resident or their representative is given written notice of all changes to the resident's agreement and these are agreed in writing by the resident or their representative. Where the resident or their representative is unable to sign or chooses not to sign, this is recorded. Ref: 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 2 **Ref**: Standard 4.2 **Stated:** First time **To be completed by:** 24 August 2018	The registered person shall ensure that the content of the home's generic patient agreement is compared with the minimum content of a resident agreement as set out within standard 4.2 of the Residential Care Home Minimum Standards. The generic agreement should be reviewed and updated accordingly. Ref: 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 3 **Ref**: Standard 18.2 & Appendix 2 **Stated:** Second time **To be completed by:** 27 December 2020	The registered person shall ensure that the home has a written policy and procedure addressing transport services. A copy of the policy should be easily accessible for the relevant staff members and a copy should be kept for reference, in the vehicle used to provide transport services to patients. Ref: 6.1
	Response by registered person detailing the actions taken: The home has a copy of the transport policy/ Fleet and Transport management Strategy on file in the managers office and also on each bus. This file is accessible for all relevant staff members.
Area for improvement 4 **Ref**: Standard 25.6 **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall ensure that the staff duty rota records the job role of staff working in the home, the hours worked and the person in charge in the absence of the manager. Ref: 6.2.1
	Response by registered person detailing the actions taken: All abbreviations have been keyed on the duty rota. The rota states the job role, the hours worked and who the person in charge is in the absence of the manager/deputy manager.

Area for improvement 5 **Ref**: Standard 30.3 **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall ensure staff who manage medicines are competent. Ref: 6.2.1
	Response by registered person detailing the actions taken: All senior staff who manage medicines are all deemed competent. Same has been recorded on file and available in the managers office.
Area for improvement 6 **Ref**: Standard 19.2 **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall ensure that the manager has oversight of the recruitment process including pre-employment checks and that a record of this oversight is maintained in the home for inspection. Ref: 6.2.1
	Response by registered person detailing the actions taken: A Certifate of employment eligibility (CEE) for all staff are on file in the manager's office.
Area for improvement 7 **Ref**: Standard 12.4 **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall ensure a daily menu is displayed in an area and format which residents can see and understand. Ref: 6.2.3
	Response by registered person detailing the actions taken: An action stemming from the meeting held with the Support service manager was that, The head Chef would provide staff training on Catering, menus, nutrition, ordering of meals. This training took place on the 22/01/2021. Going forward it will be the responsibility of senior staff to order the food for the residents rather than it being an admin role. This will ensure a more person-centred approach. Registered Manager will meet with the support services manager monthly to ensure governance of all support services within Ralphs Close. This includes governance around environmental cleanliness and catering. Next meeting will take place on the 29/01/2021. Whiteboards are ordered for each of the dining rooms, the daily menus will be displayed on these. During the meeting the manager of support services highlighted that the menus have just changed, therefore she will start taking photographs of the meals, which will take two weeks to complete, she will then give them to staff for the whiteboards. Daily menus will be displayed in each of the dining rooms. This is to be implemented by the end of February 2021.

Area for improvement 8 **Ref**: Standard 27 E32 **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall ensure that communal bathroom doors are accessible to residents without the use of a fob key. Ref: 6.2.3
	Response by registered person detailing the actions taken: The fob key has been deactivated in all communal bathrooms.
Area for improvement 9 **Ref**: Standard 20 **Stated:** First time **To be completed by:** 27 December 2020	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to: • Care records • IPC • Hand hygiene • Environment Ref: 6.2.4 and 6.2.6
	Response by registered person detailing the actions taken: Care Records The manager will ensure that a care file is audited on a fortnightly basis. This will ensure that files are audited a least once a year. All senior staff have been provided with an auditing tool and have audited each care file. This has been supplemented by a full managerial audit of all care records. The manager has delegated two senior members of staff to work with their team on all the care files. This peer support and learning will be overseen by Ralphs close manager and Deputy manager. The senior staff members have commenced work with each keyworker. The aim is to streamline files, ensure file accuracy and develop person centred care plans which are focused on the care within Ralphs Close. Ongoing review will focus on weekly evaluation of care files by Team leaders and fortnightly care audits by Deputy Manager or Manager. Ralphs Close Manager is working closely with another WHSCT Residential manager to improve care plan standards and benchmark against other facilities. A group has been formed within Registered manager Ralphs Close, Residential manager of other facility and their team leader. The aim is to develop Ralphs close staff's knowledge and competence in the care planning area. This

	will continue until the end of February 2021. IPC Hand Hygiene audits are completed by band 6 weekly and are recorded. They are available in the manager's office. 12 Dani stations (PPE Stations) have been erected throughout the building. A bin and hand sanitizers are kept in the laundry rooms for disposal of PPE before leaving the laundry room. The Infection control nursehas agreed to do an unannounced spot check visit to Ralphs Close while Covid remains. The manager does a walk around each morning to ensure all staff are adhering to the PHA guidelines of wearing PPE. The managerial audit book is completed by the manager after spot checks. At the request of the manager a visit was carried out on the 15/12/2020 by the IPC Nurse. The IPC Nurse gave good advice on the governance of PPE. The IPC nurse did a walk around, she advised on areas for improvement to ensure compliance with IPC standards.

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

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