Unannounced Care Inspection Report
30 June 2016

Ralph's Close

Type of Service: Residential Care Home
Address: Gransha Park, Clooney Road, Londonderry, BT47 6TF
Tel No: 028 7186 4332
Inspector: Laura O'Hanlon

1.0 Summary

An unannounced inspection of Ralph's Close took place on 30 June 2016 from 10.30 to 16.45.

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

Is care safe?

Three requirements were made. These related to the need to:

- ensure that staff appraisals are completed on an annual basis
- ensure that fire safety training is completed twice annually
- ensure the fire safety weekly checks are completed

Is care effective?

There were no areas for improvement identified. There were examples of good practice found throughout the inspection in relation to care records and communication between residents, staff and other key stakeholders.

Is care compassionate?

There were no areas for improvement identified. There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing residents.

Is the service well led?

One area for improvement was identified. A requirement was made to ensure that monthly monitoring reports are completed on a monthly basis and a report made available for inspection.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	4	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Desy Carton, 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 previous QIP there were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered provider: Western Health and Social Care Trust Elaine Way	**Registered manager:** Desy Carton
Person in charge of the home at the time of inspection: Desy Carton	**Date manager registered:** Acting Manager
Categories of care: LD - Learning Disability	**Number of registered places:** 16
Weekly tariffs at time of inspection: £494.00	**Number of residents accommodated at the time of inspection:** 14

3.0 Methods/processes

Prior to inspection we analysed the following records: the previous inspection report, the returned QIP and the accident/incident notifications.

During the inspection the inspector met with 13 residents, two relatives, six members of the care staff and the registered manager.

Five representative views and eight staff views questionnaires were left in the home for completion and return to RQIA.

The following records were examined during the inspection:

- Three care records
- Duty rota for week beginning 27 June 2016
- Supervision and appraisal records
- Record of a completed induction programme
- Mandatory training records
- A staff competency and capability assessment
- Policy on adult safeguarding
- Fire safety records
- Records of residents and staff meetings
- Record of complaints
- Accident and incidents records
- Monthly monitoring reports

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 22 June 2016

The most recent inspection of the home was an unannounced medicines management inspection. The report was issued to the home on 28 June 2016 and this QIP will be validated by the specialist inspector at their next inspection

4.2 Review of requirements and recommendations from the last care inspection dated 12 January 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 14.5 **Stated:** First time **To be Completed by:** 12 April 2016	The registered person should ensure that opportunities are created to develop a care plan for residents to specify their recorded wishes and any other specific arrangements at the time of death.	**Met**
	Action taken as confirmed during the inspection: Discussion with the acting manager and review of care records confirmed that the staff in the home are discussing this issue at care management reviews and care will be implemented on this basis.	

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, residents' representatives and staff.

On the day of inspection the following staff were on duty – 14 support workers, three senior support workers, a deputy manager and the acting manager.

Review of a completed induction record 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, supervision and appraisal of staff were regularly provided. A record of supervision completed in June 2016 was contained in two staff files. The acting manager confirmed that staff supervision was up to date.

Three records of staff appraisals were reviewed and were found to be last undertaken in March 2015. A requirement was made to ensure staff appraisals are completed annually.

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 one staff competency and capability assessment found this to satisfactory.

Discussion with the acting manager confirmed that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005 and that records were retained at the organisation's personnel department.

The adult safeguarding policy and procedure was consistent with current regional guidance and included definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed.

Discussion with staff confirmed that they were aware of the new regional adult safeguarding guidance (Adult Safeguarding Prevention Protection in Partnership, July 2015) and a copy was available for staff within the home. Staff were knowledgeable and had a good understanding of adult safeguarding principles. They were also aware of their obligations in relation to raising concerns about poor practice and to whistleblowing.

A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff. Adult safeguarding training was completed on 29 June 2016 by 12 staff members.

The acting manager reported there were currently no safeguarding issues in the home. A review of accident and incidents notifications, review of care records and complaints confirmed this. The acting manager described how any suspected, alleged or actual incidents of abuse would be fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records would be retained.

The acting manager confirmed that there were risk management procedures in place relating to the safety of individual residents. Discussion with the acting manager identified that the home did not accommodate any individuals whose needs could not be met. Review of care records identified that an individual care needs assessment and risk assessments were obtained prior to admission of residents to the home. Care needs assessment and risk assessments (e.g. manual handling, restrictive interventions, where appropriate) were reviewed and updated on a six monthly basis or as changes occurred.

The acting manager confirmed that areas of restrictive practice employed within the home included locked doors in all units with fob entry systems and the use of specific interventions tailored to meet individual needs. Discussion with the acting manager regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required.

Inspection of care records confirmed that there was a system of referral to the multi-disciplinary team when required; it was noted that behaviour management plans were devised by specialist behaviour management teams from the Trust and that the behaviour management plans were regularly reviewed and updated as necessary.

Discussion with the acting manager and examination of accident and incident records confirmed that when individual restraint was employed, the appropriate persons were informed.

Inspection of 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 (IPC) procedures.

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

A general inspection of the home was undertaken to examine the bedrooms, the shared bathrooms, the communal lounges and the dining areas. The residents' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated.

Inspection of the internal and external environment identified that the home and grounds were kept tidy, safe, suitable for and accessible to residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff, including those with sensory impairments. Discussion with the acting manager confirmed that action plans were in place to reduce the risk where possible.

The acting manager confirmed that the home had an up to date fire risk assessment in place. A review of the fire safety risk assessment dated 13 April 2016. Discussion with the acting manager confirmed that he is currently in the process of addressing any recommendations identified.

Review of staff training records confirmed that staff completed fire safety training was completed in April, May and June 2016. Prior to this fire safety training was last completed in May and June 2015. A requirement was made to ensure that fire safety training is completed twice annually.

The last record of a completed fire drill was dated 24 February 2013. The acting manager subsequently confirmed by email that a drill exercise and walk through was completed on 8 June 2016 rather than an evacuation, due to the needs of the residents and the level of fire protection within the houses. The acting manager confirmed this was agreed by the fire officers. The acting manager reported that a written record is maintained of this exercise.

The weekly fire alarm and emergency light checks were not consistently maintained over the last six months. A requirement was made to ensure this fire safety issues are addressed.

Areas for improvement

Three requirements were made. This related to the need to:

- ensure that staff appraisals are completed on an annual basis
- ensure that fire safety training is completed twice annually
- ensure the fire safety weekly checks are completed

Number of requirements	**3**	**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 three care records confirmed that these were maintained in line with the legislation and standards. They included up to date multi-disciplinary assessments, life history, comprehensive risk assessments, care plans and a daily statement of health and well-being of the resident.

Care records were updated regularly to reflect the changing needs of the resident. Residents and/or their representatives were encouraged and enabled to be involved in the assessment and care planning and review process, where appropriate. Discussion with staff and review of care records confirmed that a person centred approach underpinned practice.

The care records reflected strong multi-professional input into the service users' health and social care needs.

The acting manager confirmed that 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 key stakeholders. These included pre-admission information, multi-professional team reviews, staff meetings and staff shift handovers. Discussion with the acting manager, staff and relatives confirmed that management operated an open door policy in regard to communication within the home.

Representatives spoken with and observation of practice evidenced that staff were able to communicate effectively with residents, representatives and other key stakeholders.

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

The acting manager confirmed that arrangements were in place, in line with the legislation, to support and advocate for residents. There are currently two independent advocates who visit the home approximately eight times each month to ensure the needs of the residents are met. A report is compiled by the advocates and was available for inspection.

Areas for improvement

There were no areas for improvement identified within this domain.

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

4.5 Is care compassionate?

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

Discussion with staff, confirmed that residents' spiritual and cultural needs, including preferences for end of life care, were met within the home. The acting manager shared a recent experience when a resident in the home passed away. The acting manager reported that a wake was organised in the home and residents were assisted in this process. One resident led this process and was involved in the funeral ceremony. This is to be commended.

Another resident had recently experienced the death of his mother earlier in 2016. A staff member has painted a family tree mural on a wall in the resident's bedroom. On the branches are photographs of the resident and his mother. This practice is commendable.

A review of care records confirmed that action was taken to manage pain and discomfort in a timely and appropriate manner.

Discussion with representatives, staff and observation of interactions demonstrated that residents were treated with dignity and respect. Staff confirmed their awareness of promoting residents' independence and of maintaining dignity.

Discussion with staff, representatives, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. Arrangements were in place for residents to maintain links with their friends, families and wider community.

The acting manager confirmed that residents were listened to, valued and communicated with in an appropriate manner. The two relatives spoken with reported that during the entire hospitalisation of their relative, a staff member from the home stayed at the hospital to ensure that there was effective communication between the resident and hospital staff. This is to be commended.

Discussion with staff, residents, representatives and observation of practice confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff.

The acting manager confirmed that residents were provided with information, in a format that they could understand, which enabled them to make informed decisions regarding their life, care and treatment.

Areas for improvement

There were no areas for improvement identified within this domain.

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

4.6 Is the service well led?

The acting manager confirmed that there were management and governance systems in place to meet the needs of residents.

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.

A range of policies and procedures were in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff.
The acting manager confirmed that policies and procedures were systematically reviewed every three years or more frequently should changes occur.

Residents and their representatives were made aware of the process of how to make a complaint by way of the complaints procedure displayed in each residents' bedroom. Review of the complaints records established that there were clear arrangements for the management of complaints from residents and any other interested parties. Records of complaints included details of the investigation undertaken, all communication with complainants, the result of any investigation, the outcome and the action taken to address the issues raised.

A review of accidents/incidents and notifiable events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures.

A review of the monthly monitoring visits was undertaken. It was noted that from October 2015 to May 2016 (eight months) only five monthly monitoring visits were completed. A requirement was made to ensure that such visits are undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005 and a report produced and made available for residents, their representatives, staff, trust representatives and RQIA.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability within the overall structure. Discussion with the acting manager identified that he had understanding of his 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.

Staff spoken with confirmed that they were familiar with organisational and management structure and with their lines of professional accountability. Staff were aware of their individual responsibility in relation to raising concerns.

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

Review of notifications of accidents and incidents and the returned RQIA Quality Improvement Plan (QIP) confirmed that the registered provider/s responded to regulatory matters in a timely manner.

The acting manager confirmed that there were effective working relationships with internal and external stakeholders. The acting manager confirmed that staff could also access line management to raise concerns and to offer support to staff. Discussion with staff confirmed that there were good working relationships and that management were responsive to suggestions and/or concerns raised.

There were also open and transparent methods of working and effective working relationships with internal and external stakeholders.

Areas for improvement

One area for improvement was identified. A requirement was made to ensure that monthly monitoring reports are completed on a monthly basis and a report made available for inspection.

Number of requirements	1	Number of recommendations:	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Desy Carton, 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 premises. 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.

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 DHSSPS Residential Care Homes Minimum Standards, August 2011. They promote current good practice and if adopted by the registered provider 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 stated. The registered provider should confirm that these actions have been completed and return completed QIP to *care.team@rqia.org.uk* for review 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	
Statutory requirements	
Requirement 1 **Ref**: Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** 31 August 2016	The registered provider must ensure that staff appraisals are completed annually. In addition to this a matrix system should be implemented to assist with the process of audit.
	Response by registered provider detailing the actions taken: Staff appraisal was behind due to Deputy Mangers vacating posts. This is being rectified with new staff now in post and staff appraisal to be completed forthwith. Matrix system exists for training and will incorporate appraisal. This is closley linked with an area of work already identified by the Trust to link supervision and appraisal processes more closely.
Requirement 2 **Ref**: Regulation 27 (4) (e) **Stated:** First time **To be completed by:** 31 December 2016	The registered provider must ensure that fire safety training is completed twice annually by all staff.
	Response by registered provider detailing the actions taken: Staff fire rraining was up-to-date however logged in the Fire File for House 3&4. Fire training dates exist to show staff have been trained twice yearly as per requirement and that during these sessions the Fire Officer completes a fire drill /exercise/walk through with the staff.
Requirement 3 **Ref**: Regulation 27 (4) (d) (v) **Stated:** First time **To be completed by:** **31 July 2016**	The registered provider must ensure that the weekly fire safety checks are completed and recorded
	Response by registered provider detailing the actions taken: Weekly fire checks completed twice monthly due to staff historically responsible leaving. This combined with other staffing pressures and changes created a gap in this process. This has now been rectified as permanent staff now in place as of 14.06.16 to provide and maintain same.
Requirement 4 **Ref**: Regulation 29 (3) **Stated:** First time **To be completed by:** 1 July 2016	The registered provider must ensure that monthly monitoring reports are completed on a monthly basis and a report made available for inspection.
	Response by registered provider detailing the actions taken: Monthly monitoring visits are undertaken on a monthly basis. Due to the high volume of work and considerable pressures in other parts of the system, it is noted that there have been a number of gaps in the writing up and uploading of some reports. This will be rectified and a new schedule of monitoring visits has now been identified. Realistically the standard that we can apply to carrying out a monthly monitoring visit is that it should be enacted by the end of the first week of the following

	month to review the previous month's activity and written up within the next week. The Head of Service and Community Services Manager have previously identified a need to review the monitoring form and to make the monitoring visit more purposeful. With the introduction of two new Deputy Managers, the Head of Service is currently reviewing this for discussion with the Ralphs Close Management Team and the Community Services Manager to inform how the process is undertaken going forward. This is to be completed and in place on time for the September monitoring visit.

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

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