Unannounced Care Inspection Report
4 June 2019

Colorado

Type of Service: Residential Care Home
Address: 120 Lisnagole Road, Lisnaskea, BT92 0QF
Tel No: 028 6772 1486
Inspector: John McAuley

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 nine residents within the categories of care listed on its certificate of registration and detailed in 3.0.

3.0 Service details

Organisation/Registered Provider: Colorado **Responsible Individual(s):** Eileen Elizabeth Scott	**Registered Manager and date registered:** Eileen Elizabeth Scott 01 April 2005
Person in charge at the time of inspection: Diane Keys, Senior Care Assistant then joined by Trudie Ritchie, Deputy Manager	**Number of registered places:** 9
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia PH - Physical disability other than sensory impairment PH (E) - Physical disability other than sensory impairment – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 9

4.0 Inspection summary

This unannounced inspection took place on 4 June 2019 from 10.20 to 13.40.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the nice homely atmosphere and ambience in the home and the cleanliness and upkeep of the environment. Good practice was also found in relation to the maintenance of care records, the unhurried organised manner in which duties were carried out and the availability and support of management.

One area of improvement was identified during this inspection. This was in relation to the need for risk assessment on all free standing wardrobes.

Residents described living in the home as being a good experience/in positive terms. Some of the comments made included statements such as; “I am very happy here. I just love it here” and “You’d travel far to find a place like this. It’s a lovely home. Simply first class. All the carers couldn’t do enough for you. The food is gorgeous.”

Comments received from residents, people who visit them and staff during the inspection, are included in the main body of this report.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Trudie Ritchie, deputy manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent inspection dated 13 August 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 13 August 2018.

No further actions were required to be taken following the most recent inspection on 13 August 2018.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including estates and pharmacy issues, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with residents, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

During the inspection a sample of records was examined which included:

- staff training schedule and training records
- staff induction and competency and capability records
- two residents' records of care
- complaint records
- compliment records
- accident/incident records
- RQIA registration certificate

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 the last care inspection dated 13 August 2018

No areas of improvement were identified with the previous care inspection on 13 August 2018 and the previous medicines management inspection on 30 July 2018.

6.2 Inspection findings

6.3.1 Health and Social Care

An inspection of a sample of two residents' care records and residents' progress records was undertaken. Added to this discussions were had with staff and management in respect of residents' needs and their abilities to meet these needs. From this it was confirmed that the general health and social care needs are understood by staff. Staff had knowledge of individual residents' prescribed care interventions that promoted health and well-being.

A record was maintained of residents' aligned health care professionals and their contact details. A record was also maintained of residents' contact with their health care professionals, such as visits to the dentist, GP and speech and language therapist. The resident's next of kin and aligned named worker were kept informed of health care appointments and follow up care.

Issues of assessed need, such as pain, had a corresponding recorded statement of care given with effect of same.

The sample of care records inspected confirmed that these were maintained in line with the regulations and standards. Care records were maintained in an organised methodical manner. They included an up to date assessment of needs, life history, risk assessments, care plans and daily/regular statement of health and well-being of the resident. Care needs assessment and risk assessments, for example falls, nutrition and restrictive practices were reviewed and updated on a regular basis or as changes occurred.

The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents.

Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. The care records contained signatures of their participation in this process.

The general health and welfare of residents is continually monitored and recorded. The aligned named workers are kept up-to-date on the resident's well-being or changes to it.

An individual agreement setting out the terms of residency was in place and this was appropriately signed.

6.3.2 The environment

The home was clean and tidy with good standard of furnishing and décor being maintained.

Communal areas were comfortable, nicely decorated and homely in appearance. Residents' bedrooms were comfortable and personalised.

The home was appropriately heated and fresh smelling.

The grounds of the home were very well maintained.

Some of the freestanding wardrobes posed a risk of a resident pulling on same in the event of a fall. These need to be individually risk assessed in accordance with current safety guidelines with subsequent appropriate action. This has been identified as an area of improvement in accordance with standards.

There were no other obvious health and safety risks observed in the internal and external environment.

6.3.3 Residents' views

Discussions with the nine residents at the time of this inspection confirmed that they were happy with their life in the home, their relationship with staff, provision of meals and the provision of activities and events. Residents were keen to express their praise and gratitude. Some of the comments made included statements such as;

- "I am very happy here. I just love it here"
- "You'd travel far to find a place like this. It's a lovely home. Simply first class. All the carers couldn't do enough for you. The food is gorgeous"
- "Everything is great here. No problems"
- "I simply think this place is like heaven. They treat me with such great respect"
- "I'm very happy here and couldn't think of a single fault"
- "There are lovely meals here. All good home cooking"

6.3.4 Relatives' views

Discussions with a visiting relative at the time of this inspection were very positive. This relative praised the provision of care and the kindness and support received from staff.

6.3.5 Staff views

Staff spoken with were positive about their roles and duties, training and managerial support. Staff also advised that they believed a good standard of care was provided for and if there were any concerns they would have no hesitation in reporting these to management.

6.3.6 Management arrangements

The responsible individual and registered manager lives adjacent to the home. Discussions were had with her with feedback given to her daughter, the deputy manager. The responsible individual/registered manager is in day to day management of the home as is the deputy manager.

6.3.7 Care practices

Staff confirmed that they were knowledgeable and had a good understanding of adult safeguarding principles. They were also aware of their obligations in relation to raising concerns about poor practice and whistleblowing.

Staff advised that they were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents. This was also evidenced by an inspection of staff training records.

The registered manager stated there were risk management procedures in place relating to the safety of individual residents and the home did not accommodate any individuals whose assessed needs could not be met.

Residents appeared content and at ease with their interactions with staff and their environment. Staff interactions were found to be polite, friendly and warm. Staff responded to residents' needs promptly and showed understanding of individual residents' needs, such as with mobility needs.

6.3.7 Accident and incidents

The home's accident, incident and notifiable events policy and procedure included reporting arrangements to RQIA. An inspection of these events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. A regular audit of accidents and incidents was undertaken and was inspected as part of the inspection process. The registered manager advised that learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

Areas of good practice

Areas of good practice were found in relation to feedback from residents, one visiting relative, general observations of care practices and staffs' knowledge and understanding of residents' needs and prescribed interventions.

Areas for improvement

One area of improvement was identified during this inspection. This was in relation to risk assessing all free standing wardrobes.

7.0 Quality improvement plan

The one area of improvement identified during this inspection is detailed in the QIP. Details of the QIP were discussed with Trudie Ritchie, Deputy Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager 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 care 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 DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 28.1 **Stated:** First time **To be completed by:** 4 July 2019	The registered person shall risk assessed all wardrobes in accordance with current safety guidelines with subsequent appropriate action. Ref: 6.3.2
	Response by registered person detailing the actions taken: Action taken on the 10th June Wardropes risk assessed in accordance with current safety guidelines and action taken as advised.

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

The Regulation and Quality Improvement Authority

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

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care