Unannounced Care Inspection Report
21 June 2018

Trevenna Lodge

Type of Service: Residential Care Home
Address: 1 Tully Road, Killadeas, Enniskillen, BT94 1RE
Tel No: 028 6862 1500
Inspector: Priscilla Clayton

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.

1.0 What we look for

2.0 Profile of service

This is a residential care home which is registered with RQIA to accommodate a maximum of nine residents. The home provides residential care for older people and those with a physical disability.

3.0 Service details

Organisation/Registered Provider: Trevenna Lodge **Responsible Individual:** Tom Corr	**Registered Manager:** Post vacant Tom Corr – Manager, Registered Provider
Person in charge at the time of inspection: Kathryn Ellis, Senior Care Assistant.	**Date manager registered:** Post vacant
Categories of care: Residential Care (RC) I – Old age not falling within any other category PH – Physical disability other than sensory impairment	**Number of registered places:** Total number comprising: 9 residents RC – I RC – PH

4.0 Inspection summary

An unannounced care inspection took place on 21 June 2018 from 10.00 to 15.30 hours.

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

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The manager of the home was off duty on the day of inspection. Kathryn Ellis, Senior Care Assistant, was in charge.

Evidence of good practice was found in relation to the ethos and culture of the home, staff training, communication, infection prevention control and general satisfaction expressed by residents in respect of the safe, effective, compassionate and well led care. No issues or concerns were raised or indicated by residents.

Areas requiring improvement were firstly in relation to the Statement of Purpose, stated for a second time; in regard to reflecting the current management arrangements (previous inspection) and secondly, inclusion of the registered categories of care, RC – I and RC-PH (older people and people with physical disability). Review and revision of staff induction programme was recommended to ensure greater detail is included. Consideration should be given to the recently published guidelines by Northern Ireland Social Care Council (NISCC) on the induction programme for care staff. Review and revision of the Resident Individual Agreement was recommended and a choking risk assessment conducted on one resident.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	5

Details of the Quality Improvement Plan (QIP) were discussed with Kathryn Ellis, Senior Care Assistant, as part of the inspection process. The timescales for completion commence from the date of inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records: the previous inspection report, the returned QIP, notifiable events, and written and verbal communication received since the previous care inspection.

During the inspection the inspector met with the senior care assistant in charge, eight residents, two staff and one visiting professional.

A total of ten questionnaires were provided for distribution to residents and/or their representatives to enable them to share their views with RQIA. A poster was provided for staff detailing how they could complete an electronic questionnaire. Two questionnaires from residents were returned to RQIA within the timescale. Bothe respondents indicated they were very satisfied that care provided was safe, effective, compassionate and well led. No issues or concerns were recorded.

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

- Staff duty rota
- Induction programme for new staff
- Staff supervision and annual appraisal schedules
- Staff training records
- Two residents' care files
- Service User Agreement
- Statement of Purpose
- Minutes of staff meetings
- Complaints and compliments
- Accident, incident, notifiable event records
- Annual Quality Review report
- Minutes of recent residents' meetings/ representatives' meetings/ other
- Evaluation report from annual quality assurance survey
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors,
- Sample of policies and procedures

Two of the three areas identified for improvement at the last care inspection were reviewed and assessment of compliance recorded as met.

The findings of the inspection were provided to Katheryn Ellis, Senior Care Assistant, at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 21 January 2018.

The most recent inspection of the home was an unannounced care inspection.

The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 25 January 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 25.8 **Stated:** First time	The registered person shall ensure that staff meetings take place on a quarterly basis. Ref: section 6.5	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and examination of minutes of staff meetings evidenced that meetings were held and recorded as recommended.	
Area for improvement 2 **Ref**: Standard 20.6 **Stated:** First time	The registered person shall ensure that the statement of purpose is updated to reflect the change in management arrangements. Ref: section 6.7	**Not met**
	Action taken as confirmed during the inspection: The Statement of Purpose submitted to RQIA following the previous inspection requires further amendment in regard to the inclusion of the current management arrangements.	

Area for improvement 1 **Ref**: Standard 19.2 **Stated:** First time **To be completed by:** 16 June 2017	The registered person shall ensure that before making an offer of employment: • Two written references are obtained • Any gaps in an employment record are explored and explanations are recorded. Ref: section 6.4	**Met**
	Action taken as confirmed during the inspection: The registered provider/manager (following the inspection) and senior care assistant explained that no new staff had been employed since the previous inspection and that this recommendation would be followed should new appointment be made.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The senior care assistant in charge advised that the staffing levels for the home were subject to regular review to ensure the assessed needs of the residents were met. Temporary or agency staff were not used in the home.

No concerns were raised regarding staffing levels during discussions with residents and staff. A review of the duty rota confirmed that it accurately reflected the staff working within the home on the day of inspection. Throughout the inspection residents were observed to be supervised by staff.

On arrival at the home all residents were up washed and dressed. The majority of residents were seated within the lounge reading watching television. One resident choose to remain in her bedroom. All residents were observed to be neatly dressed and groomed with personal care needs attended. Residents spoke freely with the inspector and were observed to be comfortable and content.

A review of completed induction records and discussion with the senior care assistant and one staff evidenced that an induction programme was in place. One recommendation made related to the provision of a comprehensive induction record of experience for new staff. Reference to the recent guidelines by Northern Ireland Social Care Council (NISCC) on induction for care staff was recommended.

Discussion with staff confirmed that mandatory training, supervision and annual appraisal of staff was regularly provided. Schedules and records of training, staff appraisals and supervision were reviewed during the inspection.

Discussion with the senior care assistant 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. One staff competency and capability assessment reviewed was found to be satisfactory.

The senior care assistant in charge advised that no staff were recruited since the previous inspection; therefore staff files were not reviewed on this occasion.

The senior care assistant in charge advised that Access NI enhanced disclosures was undertaken for all staff prior to the commencement of employment. Staff files reviewed confirmed that Access NI information was recorded and managed in line with best practice.

Arrangements were in place to monitor the registration status of staff with their professional body. Care staff spoken with advised that they were registered with the Northern Ireland Social Care Council (NISCC).

The adult safeguarding policy in place was consistent with the current regional policy and procedures. This included definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed.

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 whistleblowing. A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff.

Discussion with the senior care assistant, review of accident and incidents notifications, care records and complaints records confirmed that no alleged or actual incidents of abuse had arisen. The senior care assistant was aware of the procedure to follow should a referral be received.

The senior care assistant 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. A review of care records identified individual residents' care needs and risk assessments were obtained from the trust prior to admission.

The senior care assistant advised there were no restrictive practices undertaken in the home. There was no visual evidence of restrictive practice during the inspection.

There was an Infection Prevention and Control (IPC) policy and procedure in place which was in line with regional guidelines. Staff training records evidenced that all staff had received training in IPC in line with their roles and responsibilities. Discussion with staff established that they were knowledgeable and had understanding of IPC policies and procedures.

Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered. Personal Protective Equipment (PPE), e.g. disposable gloves and aprons, was available throughout the home. Observation of staff practice identified that staff adhered to IPC procedures.

Good standards of hand hygiene were observed to be promoted within the home among residents, staff and visitors. Notices promoting good hand hygiene were displayed in both written and pictorial formats.

The senior care assistant reported that there had been no outbreaks of infection within the last year and that should any such outbreak occur this would be managed in accordance with the home's policy and procedures, reported to the Public Health Agency, the trust and RQIA with appropriate records retained.

Accident and incident records viewed evidenced that there was a low occurrence of falls in the home. Fall risk assessments were completed and reviewed as required.

Residents were observed to be assisted and closely supervised as they moved around the home. Some residents used rollator frames to assist them when mobilising.

A general inspection of the home was undertaken and the residents' bedrooms were found to be individualised with photographs, memorabilia and personal items. The home was fresh-smelling, clean and organised. One area requiring attention related to the floor covering within one bedroom which was observed to be stained and worn in places. Following the inspection the registered manager informed the inspector that replacement carpet had been ordered.

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. No malodours were detected in the home.

The senior care assistant advised that the home's policy, procedures and risk assessments relating to safe and healthy working practices were appropriately maintained and reviewed regularly. For example; Control of Substances Hazardous to Health (COSHH), fire safety, hot surfaces and smoking.

The senior care assistant was unable to locate the home's fire risk and legionella assessment. An estates checklist was provided for the manager to complete and return to RQIA. This check list makes reference to the recording of details; Fire Risk Assessment, Legionella Assessment, equipment maintenance and Northern Ireland Adverse Incident Centre (NIAIC).

Review of staff training records confirmed that staff completed fire safety training twice annually. Fire drill had also been successfully provided. Records viewed included the names of staff who participated. Individual residents had a completed Personal Emergency Evacuation Plan (PEEP) in place.

Residents spoken with commented:

- "Very happy here and would not wish to move."
- "Care and food very good."
- "Staff always available to help if I need them."

Staff spoken with commented:

- “Staffing is satisfactory to meet the needs of residents.”
- “Resources are available to provide good care.”
- “Would refer any issues/changed needs to the GP or social worker for review.”

Comments received from one visiting professional included:

- “This is my first time in this home and I am not concerned in any way about the care provided, records reviewed and supporting information provided by staff and the resident I was visiting.”

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, supervision and appraisal, infection prevention and control.

Areas for improvement

One area recommended for improvement related to improvement in the induction programme of new staff with reference to NISCC guidelines on induction for care staff.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome

Discussion with the senior care assistant established that staff in the home responded appropriately to and met the assessed needs of the residents.

A review of two care records confirmed that these were maintained in line with the legislation and standards. They included an up to date assessment of needs, life history, risk assessments, care plans and daily/regular statement of health and well-being of the resident. Care needs assessment and risk assessments reviewed were updated on a regular basis or as changes occurred. One area of improvement identified related to review and updating the resident service user agreement to ensure details is in accordance with Standard 4 of The Residential Care Homes Minimum Standards (2011)

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. One resident was observed to have loose dentures when speaking. This was discussed with the senior care assistant. Records evidenced that dental checks on all residents were undertaken during May 2018. The senior care assistant agreed to undertake a choking risk assessment and with consent referral made to the dental practitioner.

Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were observed to be signed by the resident or their representative.

Discussion with staff confirmed that a person centred approach underpinned practice. Staff were able to describe in detail how the needs, choices and preferences of individual residents were met within the home.

A varied and nutritious diet was provided which met the individual and recorded dietary needs and preferences of the residents. The systems in place to regularly record residents' weights and any significant changes in weight were discussed with the senior care assistant who monitors the weights recorded each month. There were arrangements in place to refer residents to dietitians and speech and language therapists (SALT) as required. Guidance and recommendations provided by dieticians and SALT were reflected within the individual resident's care plans and associated risk assessments.

The senior care assistant advised that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. Audits of risk assessments, care plans, care review, accidents and incidents, environment, catering were not reviewed on this occasion.

No complaints had been received since the previous care inspection. This was evidenced in records reviewed.

The senior care assistant advised that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included pre-admission information, multi-professional team reviews, residents' meetings, staff meetings and staff shift handovers. Minutes of staff meetings and residents meetings were reviewed during the inspection.

Observation of practice evidenced that staff were able to communicate effectively with residents. The senior care assistant and staff confirmed that management operated an "open door" policy in regard to communication within the home.

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

Residents and staff spoken with during the inspection expressed satisfaction with the care provided. No issues or concerns were raised or indicated. Some comments made included:

- "Staff see to all of us and they are here when we need them, always very willing."
- "Good care and attention to all of us here."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records, and reviews, communication between residents, staff and other interested parties.

Areas for improvement

Two areas identified for improvement related to the undertaking of a choking risk assessment on one resident and with consent referral made to the dental practitioner and review and revision of the Service User Agreement.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

A range of policies and procedures was in place which supported the delivery of compassionate care.

The senior care assistant advised that staff in the home promoted a culture and ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

The senior care assistant, staff and residents advised that consent was always sought in relation to the provision of care and treatment. Discussion and observation of care practice and staff interpersonal communication indicated residents were treated with dignity and respect. Staff described their awareness of promoting residents' rights; independence, dignity and confidentiality were protected.

Discussion with staff and residents confirmed that residents' spiritual and cultural needs, were met within the home. Action was taken to manage any pain and discomfort in a timely and appropriate manner. This was further evidenced by the review of care records, for example, care plans were in place for the identification and management of pain, fall risk and nutrition, where appropriate. Residents who spoke with the inspector confirmed that staff were very good in this regard and would always respond if they had any pain or had any discomfort.

Discussion with residents and observation of practice confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff; residents' were listened to, valued and communicated with in an appropriate manner and their views and opinions were taken into account in all matters affecting them. For example residents were encouraged and supported to actively participate in the annual reviews of their care. Other systems of communication included, residents' meetings, annual reviews and informal daily discussions.

Residents were consulted with, at least annually, about the quality of care and environment. The findings from the consultation were collated into a summary report and action plan was made available for residents and other interested parties to read.

Discussion with staff, residents and observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. For example; outings, social outings, arts/crafts and reminiscence. Arrangements

were in place for residents to maintain links with their friends, families and wider community. For example church attendances, visits to town and visits out of the home with relatives.

Residents spoken with during the inspection made the following comments:

- "Staff are very attentive and respectful."
- "Choice of meals and activities and all other things."
- "If I had any pain I know the staff would see to it."

Staff spoken with during the inspection made the following comments:

- "All our residents are always treated with dignity and respect."
- "Residents consent is always obtained in regard to care and treatment."

Areas of good practice

There were examples of good practice found in relation to the culture and ethos of the home, listening to and valuing residents and taking account of the views of residents.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

The registered provider, currently manager of the home was on leave on the day of inspection. Kathryn Ellis, Senior Care Assistant was in charge and assisted by one care assistant and one domestic staff. The senior care assistant is currently undertaking QCF level 5 in leadership with completion expected during October 2018.

The senior care assistant outlined the management arrangements and governance systems in place within the home and stated that the needs of residents were met in accordance with the home's statement of purpose and the categories of care for which the home was registered with RQIA. The Statement of Purpose provided was discussed with the senior care assistant as the previously stated recommendation regarding management arrangements had not been addressed. In addition the category of care in which the home is registered with RQIA was not included.

A range of policies and procedures was in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff. The senior care assistant stated that policies and procedures were systematically reviewed every three years or more frequently as changes occurred.

There was a complaints policy and procedure in place which was in accordance with the legislation and Department of Health (DoH) guidance on complaints handling. Residents and/or their representatives were made aware of how to make a complaint by way of the Resident's Guide and information on display in the home complaints. RQIA's complaint poster was available and displayed in the home.

Review of the complaints records confirmed that arrangements were in place to effectively manage complaints from residents, their representatives or any other interested party. No complaints had been received since the previous inspection. Arrangements were in place to share information about complaints and compliments with staff.

The home retains compliments received, e.g. thank you letters and cards and there are systems in place to share these with staff.

There was an accident, incident and notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of these events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability. This was outlined in the home's Statement of Purpose and Residents Guide.

The senior care assistant advised that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the home confirmed that the current RQIA certificate of registration and employer's liability insurance certificate were displayed.

The home had a whistleblowing policy and procedure in place and discussion with staff confirmed that they were knowledgeable regarding this. The senior care assistant advised that staff could also access line management to raise concerns at any time and that staff would be offered support.

Discussion with the senior care assistant and staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised. There were open and transparent methods of working and effective working relationships with internal and external stakeholders.

Residents, staff and one visiting professional spoken with during the inspection gave positive responses in regard to the provision of residents' care and life in the home. No issues or concerns were raised or indicated.

Some comments made by residents included:

- "We know who to complain to if we were not happy about something"
- "Tom the manager is always about and speaks to us all the time."
- "I think the home is well run and we have all we need."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of accidents and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

One area identified for improvement related to the statement of purpose which requires to be updated.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Kathryn Ellis, Senior Care Assistant, 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: Ref NISCC guidelines on care staff induction. **Stated:** First time **To be completed by:** 30 September 2018	The registered person shall consider the implementation of recent published guidelines by Northern Ireland Social Care Council (NISCC) on the induction of care staff. Review of the induction template is necessary to ensure that a comprehensive programme of induction is provided. Ref: 6.4
	Response by registered person detailing the actions taken: Induction template has now been reviewed in line with the implementation of recent published guidelines by the NISCC on the induction of care staff and will be utilised as part of the induction process for all new care staff.
Area for improvement 2 **Ref**: Standard 20.6 **Stated:** Second time **To be completed by:** 31 July 2018	The registered person shall ensure that the statement of purpose is updated to reflect the change in management arrangements. The amended copy to be re - submitted to RQIA. Ref: 6.2
	Response by registered person detailing the actions taken: The statement of purpose has been updated to reflect that the term " Acting Manager" should be used to meet the legislative requirements as noted during the inspection.
Area for improvement 3 **Ref**: Standard 20.6 **Stated:** First time **To be completed by:** 31 July 2018	The registered person shall undertake a review of the Statement of Purpose, submitted to RQIA following the inspection, to ensure that information regarding the registered categories of care is included. The amended copy of the statement of purpose is to be re - submitted to RQIA. Ref: 6.7
	Response by registered person detailing the actions taken: The statement of purpose has been amended to ensure that the information regarding the registered categories are clearly identified.
Area for improvement 4 **Ref**: Standard 9.3	The registered person shall ensure that a choking risk assessment is undertaken on one resident and if necessary, with consent, referral made to the dental practitioner. Ref: 6.5

TR 31/7/18

Stated: First time **To be completed by:** 03 June 2018	**Response by registered person detailing the actions taken:** Choking risk assessment has been undertaken on one resident and with consent, a referral was made to the dental practitioner.

TLQ 31/7/18

Area for improvement 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 15 August 2018	The registered person shall ensure that the Resident Service User Agreement is reviewed and revised to ensure details as contained within Standard 4 is included. Ref 6.5
	Response by registered person detailing the actions taken: The resident Service User Agreement has been reviewed and revised to ensure details are as contained within Standard 4.

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

31/8/17

The Regulation and Quality Improvement Authority

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

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