Redford
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15 Redford Road
Cullybackey
BT43 5PR

Inspector: John Mc Auley
Inspection ID: IN023063

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Unannounced Care Inspection
of
Redford

07 July 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced inspection took place on 7 July 2015 from 10:30am to 2pm. Overall on the day of the inspection the home was found to be delivering safe, effective and compassionate care. No areas for improvement were identified during this inspection.

This inspection was underpinned by the Residential Care Homes Regulations (Northern Ireland) 2005, The DHSSPS Residential Care Homes Minimum Standards (2011), NICE guidelines on the management of urinary incontinence in women (September 2013), NICE guidelines on the management of faecal incontinence (June 2007) and Guidance and Audit Implementation Network (GAIN) guidelines available for palliative care.

1.1 Actions/ Enforcement Taken Following the Last Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last inspection.

1.2 Actions/ Enforcement Resulting from this Inspection

Enforcement action did not from the findings of this inspection.

1.3 Inspection Outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/ Registered Person: William James Wallace	**Registered Manager:** Trevor Gillen
Person in Charge of the Home at the Time of Inspection: Senior Care Assistant Paula Barr until 11:30 then Trevor Gillen	**Date Manager Registered:** November 2013
Categories of Care: RC-DE, RC-I, RC-PH(E)	**Number of Registered Places:** 18
Number of Residents Accommodated on Day of Inspection: 17	**Weekly Tariff at Time of Inspection:** £470

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standard and theme has been met:

Standard 14: The death of a resident is respectfully handled as they would wish.

Theme: Residents receive individual continence management and support.

4. Methods/ Process

Specific methods and processes used in this inspection include the following:

- Prior to inspection we analysed the following records; notification reports and previous inspection report.

- During the inspection we met with all the residents, five staff, management and one visiting relative.

- We inspected the following records; residents' care records, accident/ incident reports, and policies and procedures and aligned guidance available to the standards inspected.

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 7 October 2014. The completed QIP was returned and approved by the inspector.

5.2 Review of Requirements and Recommendations from the last Care Inspection

Previous Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 19 (1) (a) Schedule 3(3)(k)	The registered person shall- (a) Maintain in respect of each resident a record which includes the information, documents and other records specified in schedule3 relating to the resident; **Schedule 3(3)(k)** A contemporaneous note of all care and services provided to the resident, including a record of his condition and any treatment or other intervention. Reference to this is made in that, in recording of a resident's condition the use of terms such as "unsettled" and "very unsettled" must be recorded in clear detail on how the behaviour actually presented, and that care/ treatment was given and effect of same.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of residents' care records confirmed that there was good detail recorded of assessed need, care / treatment given and effect of same.	

Previous Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 10.7	Restraint is only used as a last resort by appropriately trained staff to protect the resident or other persons when other less restrictive strategies have been unsuccessful. Records are kept of all instances when restraint is used. Restraint to this is made, in that policy and procedure on restraint and restrictive practices needs to be put in place that reflects current guidance, legislation and human rights. This policy and procedure once developed needs to be shared for learning with all staff.	**Met**
	Action taken as confirmed during the inspection: The policy and procedure on restraint and restrictive practises had been amended accordingly.	

5.3 Standard 14: The death of a resident is respectfully handled as they would wish

Is Care Safe? (Quality of Life)

Residents can and do spend their final days of life in the home. This is unless there is a documented health care need that prevents this.

In our discussions with staff and the registered manager in respect of this area of care, they advised that they considered care as compassionate**.** Staff confirmed how with the resident's wish, other residents and staff who wished to comfort a resident who was dying were enabled to. Other residents and staff have the opportunity to pay their respects and are provided with support if needed.

Staff also explained to us that other residents are informed in a sensitive manner of the death of a resident.

We noted that within the home's policy, when a death of a resident occurs, their belongings are handled with care and respect. The room is permitted to be vacant. The resident's next of kin or family take the lead in dealing with the deceased resident's belongings at a sensitive and convenient time after the burial.

We inspected a sample of compliment cards. Some were received from families of deceased residents. In these correspondences there were nice messages of praise and gratitude received during this period of care.

The spiritual needs of the resident were assessed. In our discussions with staff we confirmed they had knowledge and understanding of residents' spiritual requests and choices at this time of care.

Is Care Effective? (Quality of Management)

Residents can spend their final days in the home unless there are documented health care needs to prevent this.

A care plan is put in place for each resident who is receiving palliative care by district nursing services.

We inspected three residents' care records and could confirm that a care plan was in place pertaining to this need. Details included arrangements with spiritual care, if so wished.

Is Care Compassionate? (Quality of Care)

The home has policies and procedures pertaining to terminal and palliative care and death of a resident. These policies and procedures guide and inform staff on this area of care. There is associated guidance available for staff.

Training in this area of care is received in staff induction.

In our discussions with staff they demonstrated that they had knowledge and understanding of how to care for this area of need. Staff also advised us that there is a supported ethos with the management in the home.

Areas for Improvement

There were no areas of improvement identified with this standard inspected. The overall assessment of this standard considered this standard to be compassionate, safe and effective.

Number of Requirements:	**0**	**Number of Recommendations**:	**0**

5.4 Theme: Residents receive individual continence management and support

Is Care Safe? (Quality of Life)

Staff have received training in continence management in their induction. In our discussions with staff they also demonstrated knowledge and understanding of this area of care.

We inspected three residents' care records and found an individualised assessment and plan of care was in place. Issues of assessed need are referred to district nursing services. The district nurse in consultation with the resident and the home prescribes a plan of care. This plan of care includes provision of incontinence aids.

From our observations we found there to be adequate supplies of aprons, gloves and hand washing dispensers.

In our discussions with staff, general observations together with a review of care records we identified no mismanagement of this area of care, such as malodours or breakdown of skin integrity.

Is Care Effective? (Quality of Management)

The home has policies and procedures pertaining to the management of continence. There are also associated guidance and information available to staff.

Staff have received training in continence management in their programme of induction.

Identified issues of assessed need are reported to district nursing services, for advice and direction.

Is Care Compassionate? (Quality of Care)

From our discreet observations of care practices we found that residents were treated with care, dignity and respected when being assisted by staff. Continence care was undertaken in a discreet private sensitive manner.

Areas for Improvement

There were no areas of improvement identified with this standard inspected. The overall assessment of this standard considered this standard to be compassionate, safe and effective.

Number of Requirements:	**0**	**Number of Recommendations**:	**0**

Additional Areas Examined

5.5.1 Residents' Views

We met with all residents in the home. Many of the residents could clearly articulate their views. From which they expressed that they were happy with their life in the home, their relationship with staff, and the provision of meals.

Some of the comments made included statements such as;

"The cook is brilliant and provides lovely home baking"
"It's the next best thing to home"
"The staff both day and night are all great. They look after me very well"
"I am very happy here. They are all lovely"
"It's 1st class here"
"I couldn't complain about a thing".

5.5.2 Relatives' Views

We met with one visiting relative. This relative spoke with praise and gratitude about the care provided the kindness and support received from staff and the provision of meals. The relative also confirmed that they felt good confidence with the standard of care provided.

5.5.3 Staff Views

We met with five staff of various grades. All spoke on a positive basis about the workload, teamwork, training, managerial support and staff morale. Staff informed us that they felt a good standard of care was provided for.

Seven staff questionnaires were distributed after this inspection for return.

5.5.4 Staffing

The staffing levels at the time of this inspection consisted of;

- Registered manager from 11:30am
- One senior care assistant and three care assistants
- One cook and one domestic.

These levels were found to be appropriate to meet the residents' needs, taking account of the layout of the home at the time of this inspection.

5.5.5 General Environment

We found the home to be clean and tidy, with good housekeeping arrangements in place. The general décor and furnishings were of a reasonable standard.

Residents' bedrooms were comfortable with many facilitated with personal artefacts and memorabilia.

The grounds to the home were well maintained with good accessibility for residents.

5.5.6 Accident/ Incident Reports

We inspected these reports from the previous inspection. These were found to be appropriately managed and reported.

5.5.7 Care Practices

Throughout our discreet observations of care practices we noted residents being treated with dignity and respect. Care duties were organised.

Staff interactions with residents were found to be polite, friendly, warm and supportive.

A nice homely atmosphere was in place, with residents being comfortable, content and at ease in their environment and interactions with staff.

An appetising, well presented dinner time meal was provided for. Staff were found to assist with residents' needs in an appropriate manner.

Residents were found to be engaged in pastimes of choice such as socialising with one another, watching television or resting.

5.5.8 Fire Safety

We reviewed the home's most recent fire safety risk assessment, dated 9 January 2015. No recommendations were made from this assessment.

Fire safety training including fire safety drills were maintained on an up to date basis.

The records of fire safety checks in the environment were well maintained.

We observed no obvious risks within the environment in terms of fire safety, such as wedging opening of doors.

5.5.9 Complaints

A review of the record of complaints together with discussions with the registered manager confirmed that expressions of dissatisfaction are taken seriously and managed appropriately.

Areas for Improvement

There were no areas of improvement identified with these additional areas inspected. The overall assessment of these additional area examined considered these to be compassionate, safe and effective.

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Trevor Gillen	**Date Completed**	12TH Aug
Registered Person	William Wallace	**Date Approved**	12th Aug
RQIA Inspector Assessing Response	Alice McTavish	**Date Approved**	12 August 2015

Please provide any additional comments or observations you may wish to make below:

Please complete in full and returned to care.team@rqia.org.uk from the authorised email address

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations.