Unannounced Care Inspection Report
7 February 2017

Fairways - Duncreggan

Type of service: Residential care home
Address: 10 Mark Street, Portrush, BT56 8BT
Tel No: 02870824287
Inspector: Ruth Greer

1.0 Summary

An unannounced inspection of Fairways residential care home took place on 7 February 2017 from 9 45 to 14 30.

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

Is care safe?

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

No requirements or recommendations were made in relation to this domain.

Is care effective?

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

No requirements or recommendations were made in relation to this domain.

Is care compassionate?

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 and taking account of the views of residents.

No requirements or recommendations were made in relation to this domain.

Is the service well led?

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

No requirements or recommendations were made in relation to this domain.

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	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mary Coyles, senior care assistant in charge, as part of the inspection process and can be found in the main body of the report.

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 QIP there were no further actions required to be taken following the most recent inspection on 02 June 2016.

2.0 Service details

Registered organisation/registered person: Tony Dunlop	**Registered manager:** Sonia Bradley
Person in charge of the home at the time of inspection: Mary Coyles,senior care assistant	**Date manager registered:** 1 April 2005
Categories of care: LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 21

3.0 Methods/processes

Prior to inspection the following records were analysed: the report of the last care inspection and notifications of accidents/incidents to RQIA since that date.

During the inspection the inspector met with eight residents, two care staff and two senior staff.

The following records were examined during the inspection:

- Staff duty rota
- Sample of competency and capability assessments
- Staff training schedule/records
- Four resident's care files
- Complaints and compliments records
- Audits of risk assessments, care plans and care reviews;
- Accident/incident/notifiable events register
- Minutes of recent residents' meetings
- Fire safety risk assessment
- Fire drill records
- Programme of activities
- Policies and procedures manual

Questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA. Twenty questionnaires were returned within the requested timescale. Ten were returned from staff, nine from residents and one from a relative.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 01/02/17

The most recent inspection of the home was an announced premises inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 02/06/16

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 25.3 **Stated:** First time **To be completed by:** 9 July 2016	The registered person should review and amend the records of staff competency and capability assessments to specifically show that the staff member is assessed fit to manage the home in the absence of the manager. **Action taken as confirmed during the inspection**: The senior care assistant in charge of the home confirmed that her competency and capability assessment had been reviewed to include the responsibility of managing the home for periods when the registered manager was off duty.	**Met**

4.3 Is care safe?

The senior care assistant 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 and staff.

A review of the duty roster confirmed that it accurately reflected the staff working within the home. On the day the following staff were on duty:

Senior care assistant x 2
Care staff x 2
Domestic staff (including laundry) x 2
Catering x 1
Administrative x 1

Discussion with staff and a review of returned staff views questionnaires confirmed that mandatory training, supervision and appraisal of staff was regularly provided.

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; records of competency and capability assessments were retained. A sample of one completed staff competency and capability assessment was reviewed and found to satisfactory.

Staff recruitment records were reviewed at the last inspection. These records were not examined on this occasion.

Arrangements were in place to monitor the registration status of staff with their professional body.

The adult safeguarding policy and procedure in place was consistent with the current regional guidance and included definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed. A safeguarding champion has been established.

Discussion with staff confirmed that they were aware of the new regional guidance (Adult Safeguarding Prevention and 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 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 there had been no suspected, alleged or actual incidents of abuse. Confirmation was given that if this was the case the incident 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 senior care assistant confirmed there were risk management procedures in place relating to the safety of individual residents. Discussion with the registered manager identified that the home did not accommodate any individuals whose assessed needs could not be met. Review of care records identified that individual care needs assessments and risk assessments were obtained prior to admission.

A review of policy and procedure on restrictive practice/behaviours which challenge confirmed that this was in keeping with DHSSPS Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) and the Human Rights Act (1998). It also reflected current best practice guidance including Deprivation of Liberties Safeguards (DoLS).

The senior care assistant confirmed there were restrictive practices employed within the home, notably keypad entry systems, lap belts for specialist chairs and bed rails. Discussion with the senior care assistant 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 there was a system of referral to the multi-professional team when required. For example, records showed that a referral for a specialist bed, for a resident, had been made to community nursing and community occupational therapy. The bed was delivered on the day of the inspection. Behaviour management plans were devised by specialist behaviour management teams from the trust and noted to be regularly updated and reviewed as necessary.

Discussion with the senior care assistant and review of the home's policy and procedures relating to safe and healthy working practices confirmed that these were appropriately maintained and reviewed regularly.

The senior care assistant confirmed that equipment and medical devices in use in the home were well maintained and regularly serviced. On the day of the inspection the lift was broken. Engineers were due to call to repair the lift on that day. A risk assessment had been undertaken in relation to residents using the stairs.

A review of records showed that individual aids and appliances were regularly audited by the home and serviced by the supplier. For example moving and handling slings, specialist mattresses and chairs.

Review of the infection prevention and control (IPC) policy and procedure confirmed that this this was in line with regional guidelines. Staff training records confirmed 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. 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 throughout the home in both written and pictorial formats.

A general inspection of the home was undertaken and the residents' bedrooms were found to be personalised with photographs, memorabilia 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.

The home had an up to date fire risk assessment in place dated 27 June 2017 and there were no recommendations as a result.

Review of staff training records confirmed that staff completed fire safety training twice annually. Fire drills were completed every 6 months most recently on 15 November 2016. Records were retained of staff who participated and any learning outcomes. Fire safety records identified that fire-fighting equipment; fire alarm systems, emergency lighting and means of escape were checked weekly and were regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place.

Twenty completed questionnaires were returned to RQIA from residents, resident's representatives and staff. Respondents described their level of satisfaction with this aspect of care as very satisfied.

Comments received from residents included:

- "It's top of the form."
- "Just couldn't be better."

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

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

4.4 Is care effective?

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 four 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 statements of health and well-being of the resident.

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 home use an established and accredited assessment tool and individual plans of care are developed as a result of an assessed need. Care records reviewed had been signed by the resident and/or their representative. The general standard of care planning and recording was found to be good. Discussion with staff and observation of practice confirmed that a person centred approach underpinned practice. Staff were well aware of an individualised approach and care provided in the home is focussed on each resident's preferences as well as needs.

The senior care assistant confirmed 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 and accidents/ incidents (including falls) were available for inspection and evidenced that any actions identified for improvement were incorporated into practice. Senior care staff audit the care files which in turn are then audited by the registered manager.

The registered manager confirmed 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. 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. For example staff noted deterioration in one resident's ability to swallow. A referral had been made

to speech and language therapy and an assessment was arranged for the day following the inspection. In the meantime, the home was pureeing food and a care assistant was designated specifically to oversee the resident's care at meal times. This is good effective practice.

Twenty completed questionnaires were returned to RQIA from residents, resident's representatives and staff. Respondents described their level of satisfaction with this aspect of care as very satisfied.

Comments received from residents and staff included:

- "I like it here." (resident)
- "The girls are good."(resident)
- "Some of the residents wouldn't be able to tell if there was something wrong. That is why we have to be vigilant and act on their behalf." (staff)

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

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

4.5 Is care compassionate?

The senior care assistant confirmed 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.

A range of policies and procedures was in place which supported the delivery of compassionate care. Discussion with staff and residents confirmed that residents' spiritual and cultural needs, including preferences for end of life care. One resident was receiving end of life care and a comprehensive and detailed care plan was in place. The care plan had been generated with input from community staff and included the views of the resident's relative. The resident's relative lives outside the country and records showed that staff were in frequent contact with her to provide updates about her loved one's state of health.

Discussion with staff confirmed that action was taken to manage any pain and discomfort in a timely and appropriate manner. Many residents would be unable to verbalise that they were in pain. Staff were knowledgeable about the signs and trigger factors which indicated that a resident was in pain. There was further evidence by the review of care records that plans were in place for the recognition and management of pain.

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. The home had devised an innovative method of tactile prompts to communicate with a resident who had no sight, hearing or speech. For example, the resident would be given an item to feel to signify an activity. A plastic syringe identified to the resident that a G.P or nurse visit was due. This is sound individualised practice.

The senior care assistant, staff and residents confirmed that consent was sought in relation to care and treatment. Discussion with residents, their representatives and staff along with observation of care practice and social interactions demonstrated that residents were treated

with dignity and respect. Staff confirmed their awareness of promoting residents' rights, independence and dignity and were able to demonstrate how residents' confidentiality was protected. This was evident in the manner in which staff knocked bedroom doors before entering and the manner in which they assisted residents with personal care.

The registered manager and staff confirmed that residents were listened to, valued and communicated with in an appropriate manner. Residents confirmed that their views and opinions were taken into account in all matters affecting them.

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

There were systems in place to ensure that the views and opinions of residents, and or their representatives, were sought and taken into account in all matters affecting them. For example residents' meetings, suggestion box, annual reviews etc.

Discussion with staff, residents, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. Several residents attend day care facilities. Residents in the home were engaging with staff, going out for a walk, colouring in, watching T V and listening to music. Arrangements were in place for residents to maintain links with their friends, families and wider community.

Twenty completed questionnaires were returned to RQIA from service users, staff and relatives. Respondents described their level of satisfaction with this aspect of care as very satisfied.

Comments received from residents and staff included:

- "I like going out with staff I like taking photographs of old buildings." (resident)
- "We had a great Christmas and got lots of new stuff." (resident)
- "For some residents here we are the only family they have and we just want to do our best for them." (staff)

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

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

4.6 Is the service well led?

The senior care assistant outlined the management arrangements and governance systems in place within the home. These were found to be in line with good practice. 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. Staff confirmed that many residents have been in the home for decades and they are well known to the staff. There is also a very low staff turnover so staff and resident have built up a relationship over many years.

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. 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.
Review of the complaints records confirmed that arrangements were in place to effectively manage complaints from residents, their representatives or any other interested party. Records of complaints included details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction. Arrangements were in place to share information about complaints and compliments with staff. An audit of complaints was used to identify trends and to enhance service provision.

There was an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of accidents/incidents/notifiable 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 reviewed as part of the inspection process. Learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

There were quality assurance systems in place to drive quality improvement which included regular audits and satisfaction surveys.

There was a system to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

Discussion with the registered manager confirmed that information in regard to current best practice guidelines was made available to staff. Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents.

A monthly monitoring visit was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, trust representatives and RQIA to read if requested.

There was evidence of managerial staff being provided with additional training in governance and leadership. Learning from complaints, incidents and feedback was integrated into practice and fed into a cycle of continuous improvement.

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 registered manager confirmed that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration and employers liability insurance certificate were displayed.

Review of governance arrangements within the home and the evidence provided within the returned RQIA Quality Improvement Plan (QIP) confirmed that the registered provider/s respond to regulatory matters in a timely manner.

The home had a whistleblowing policy and procedure in place and discussion with staff established that they were knowledgeable regarding this. The registered manager confirmed that staff could also access line management to raise concerns they will offer support to staff.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised.

Twenty completed questionnaires were returned to RQIA from service users, staff and relative. Respondents described their level of satisfaction with this aspect of the service as very satisfied.

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

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

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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