Unannounced Care Inspection Report
13 September 2018

Andena

Type of Service: Residential Care Home
Address: 206-208 Ballymoney Road, Ballymena, BT43 5HG
Tel No: 028 2564 4767
Inspector: Bronagh Duggan

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 registered to provide care and accommodation for 36 persons in the categories of care cited on the home's certificate of registration and detailed in section 3.0 of this report.

3.0 Service details

Organisation/Registered Provider: Mr James Joseph McConville **Responsible Individual(s):** Mr James Joseph McConville	**Registered Manager:** Mrs Christina Ann Shields
Person in charge at the time of inspection: Assumpta Mc Keown, Deputy Manager	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years	**Number of registered places:** 36

4.0 Inspection summary

An unannounced care inspection took place on 13 September 2018 from 10.15 to 18.15.

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.

Evidence of good practice was found in relation to staff recruitment, induction, supervision, care records, communication between residents, staff and other interested parties the culture and ethos of the home, governance arrangements and maintaining good working relationships.

Areas requiring improvement were identified in relation to one wall covering, completion of a legionella risk assessment and for all staff to participate in a fire evacuation drill once a year.

Residents and their representatives confirmed that they were happy with their life in the home, their relationship with staff and the food provided.

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	1	2

Details of the Quality Improvement Plan (QIP) were discussed with Assumpta Mc Keown, Deputy 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 30 January 2018.

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 deputy manager, 23 residents, four staff and three residents' visitors/representatives.

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/information
- Staff competency and capability assessments
- Staff training schedule and training records
- Two staff files
- Four residents' care files
- The home's Statement of Purpose and Resident's Guide
- Minutes of staff meetings
- Complaints and compliments records
- Audits of care plans, accidents and incidents (including falls) NISCC registration
- Cleaning schedule information
- Accident, incident, notifiable event records
- Annual Quality Review report
- Minutes of recent residents' meetings
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- Programme of activities
- Sample of policies and procedures

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

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 most recent inspection dated 11 June 2018

The most recent inspection of the home was an unannounced medicines management inspection.

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

This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 30 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 5.5 **Stated:** First time	The registered person shall ensure the assessment and specific risk assessment is further developed for the identified resident. Ref: 6.5	**Met**
	Action taken as confirmed during the inspection: Review of records confirmed this had been updated accordingly.	
Area for improvement 2 **Ref**: Standard 9.2 **Stated:** First time	The registered person shall ensure a clear procedure is in place for staff to follow in the event of a resident sustaining a head injury. This should be in keeping with current best practice. Ref: 6.5	**Met**
	Action taken as confirmed during the inspection: A procedure was in place for staff to follow in the event of a resident sustaining a head injury.	

Area for improvement 3 **Ref**: Standard 25.8 **Stated:** First time	The registered person shall ensure staff meetings take place on a regular basis and at least quarterly. Ref: 6.5	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and review of staff meeting minutes confirmed these where happening on a regular basis.	

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 deputy manager advised that the staffing levels for the home 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. A review of the duty rota confirmed that it accurately reflected the staff working within the home.

A review of completed induction records and discussion with the deputy 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 annual appraisal of staff was regularly provided. Schedules and records of training, staff appraisals and supervision were reviewed during the inspection. The deputy manager advised annual staff appraisals would be completed for all staff by the end of the year.

Discussion with the deputy manager 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. Staff competency and capability assessments were reviewed and found to be satisfactory.

Review of the recruitment and selection policy and procedure confirmed that it complied with current legislation and best practice. Discussion with the deputy manager and review of two staff files confirmed that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005.

The deputy manager advised that AccessNI enhanced disclosures were undertaken for all staff prior to the commencement of employment. Staff files reviewed confirmed that AccessNI 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 (where applicable).

The adult safeguarding policy in place was consistent with the current regional policy and procedures. The role and function of the adult safeguarding champion (ASC) and the necessity to complete the annual ASC position report from 1 April 2018 to 31 March 2019 was discussed.

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.

The deputy manager confirmed there had been no recent suspected, alleged or actual safeguarding incidents in the home but if there were these would be reported promptly to the relevant persons and agencies for investigation in accordance with procedures and legislation; and that written records would be retained.

The deputy 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. The deputy manager confirmed the home would continuously liaise with the referring trust regarding any changes in residents needs. A review of care records identified that residents' care needs and risk assessments were obtained from the trust prior to admission.

The deputy manager advised there were restrictive practices within the home, notably the use of keypad entry systems, pressure alarm mats and the management of smoking materials. In the care records examined the restrictions were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required.

There was an infection prevention and control (IPC) policy and procedure in place. 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 throughout the home in both written and pictorial formats.

The deputy manager reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with home policy and procedures, reported to the Public Health Agency, the trust and RQIA with appropriate records retained.

"The Falls Prevention Toolkit" was discussed with the deputy manager and advice was given on the benefits of using this or a similar toolkit. Audits of accidents/falls were undertaken on a monthly basis and analysed for themes and trends.

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 appropriately heated. It was noted the plaster had come off the walling in an identified bathroom. This was identified as an area for improvement to comply with the standards.

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.

It was noted there was no legionella risk assessment in place in the home. This was identified as an area for improvement to comply with the regulations. This information was shared with the estates inspector for the home.

It was established that one resident smoked. A review of the care records for the resident identified that a risk assessment and corresponding care plan had been completed in relation to smoking.

The deputy manager advised that equipment and medical devices in use in the home were well maintained and regularly serviced. The need to ensure there was a system in place to regularly check the Northern Ireland Adverse Incidence Centre (NIAIC) alerts and action as necessary was discussed with the deputy manager.

The home had an up to date fire risk assessment in place dated 7 March 2018 and any recommendations had been actioned.

Review of staff training records confirmed that staff completed fire safety training twice annually. The most recent fire drill was completed on 26 February 2018 and records included the staff who participated and any learning outcomes. The need to ensure all staff participate in a fire evacuation drill at least once per year was discussed with the deputy manager. This was identified as an area for improvement to comply with the standards. 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 (PEEP) in place.

Areas of good practice

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

Areas for improvement

Three areas for improvement were identified during the inspection these related to the walling in an identified bathroom, completion of a legionella risk assessment and for all staff to participate in a fire evacuation drill once a year.

	Regulations	Standards
Total number of areas for improvement	1	2

6.5 Is care effective?

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

Discussion with the deputy manager established that staff in the home responded appropriately to and met the assessed needs of the residents.

There was a records management policy in place which includes the arrangements for the creation, storage, maintenance and disposal of records. Records were stored safely and securely in line with General Data Protection Regulation (GDPR) a policy relating to GDPR was available for staff to inform them of the recent changes.

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 statement of health and well-being of the resident. Care needs assessment and risk assessments (e.g. manual handling, nutrition, falls, where appropriate) were reviewed and updated on a regular basis or as changes occurred.

The care records 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.

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. For example if a resident prefers to have their meals in their room this would be facilitated.

Review of the menu showed a varied and nutritious diet was provided to meet the dietary needs and preferences of the residents. The dining area was spacious with the daily menu on display; dining tables were well presented with table clothes, cutlery, cups, saucers and floral decorations. Systems were in place to regularly record residents' weights and any significant changes in weight were responded to appropriately. 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 records.

Discussion with the deputy manager confirmed that wound care was managed by community nursing services. Staff advised that they were able to recognise and respond to pressure area damage observed on resident's skin and referrals would be made to the multi-professional team regarding any areas of concerns identified in a timely manner.

The deputy manager 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 care plans, accidents and incidents (including falls), medicines were available for inspection and evidenced that any actions identified for improvement were incorporated into practice. Further evidence of audit was contained within the annual quality review report.

The deputy manager 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 resident meetings were reviewed during the inspection. The deputy manager confirmed management were always available to speak with visitors to the home.

Observation of practice evidenced that staff were able to communicate effectively with residents. Discussion with the deputy manager and staff confirmed that management operated an open door policy in regard to communication within the home.

There were also systems in place to ensure openness and transparency of communication, for example, the annual quality review report, compliment letters and thank you cards were displayed on a notice board in a central art of 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.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 deputy manager 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 deputy manager, residents and their representatives advised that consent was sought in relation to care and treatment. Discussion and observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff described their awareness of promoting residents' rights, independence and dignity and explained how confidentiality was protected. For example staff were aware of the need to respect the confidentiality of residents and not to discuss outside of the home.

Discussion with staff, residents and their representatives confirmed that residents' spiritual and cultural needs, including preferences for end of life care, 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.

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; 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.

Information available in the home showed representatives 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 this information was available for interested parties to read.

Discussion with staff, residents, their representatives, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. For example an activities therapist is available in the home five days per week and residents can engage in a range of activities including arts and crafts, puzzles, sing a longs and armchair exercises if they so wish. Arrangements were in place for residents to maintain links with their friends, families and wider community. For example visitors are welcome to the home and musical entertainers would visit for various occasions.

Residents and residents' visitors/representatives spoken with during the inspection made the following comments:

- "We have whatever we need, I can't say anything bad." (resident)
- "I have no complaints whatsoever, its clean, friendly, everyone is very kind, just marvellous." (resident)
- "The staff are all very good, very caring. I have no complaints." (resident)
- "We have a good laugh it, it is great." (resident)

- "It is very good, home from home."(resident)
- "It is a great place, everyone is very pleasant, the home is lovely, the staff are great it couldn't be better." (resident)
- (My relative) is well looked after here and all her needs met. She is so settled, nothing is a problem they (staff) do try to accommodate. Staff are most helpful, the food is lovely. It has added to her life being here. I have only praise; it's the same for all the family. It is always clean and welcoming. (representative)
- "It's definitely home from home, staff are lovely, there is always staff about. There is a familiarity and social aspect too. They (staff) are tuned in to what residents need, its more than just a job, you feel staff genuinely care." (representative)

Areas of good practice

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.

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 deputy manager 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.

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.

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. 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. 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.
The home retains compliments received, e.g. thank you letters and cards many of these were displayed on a notice board in the home.

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. A regular audit of accidents and incidents was undertaken and was reviewed as part of the inspection process.

Discussion with the deputy 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.

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 deputy manager stated that the registered provider was kept informed regarding the day to day running of the home through regular visits to the home, telephone calls and emails.

The deputy manager reported that the management and control of operations within the home was in accordance with the regulatory framework. The returned QIP confirmed that the registered provider/s responded to regulatory matters in a timely manner. Inspection of the premises confirmed that the RQIA certificate of registration was displayed.

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

Discussion with 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.

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. The deputy manager confirmed staff had recently completed training in equality and diversity.

The deputy manager was advised on how to contact the Equality Commission for Northern Ireland for guidance on best practice in relation to collecting this type of data.

Areas of good practice

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.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Assumpta Mc Keown, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13.9 **Stated:** First time **To be completed by:** 13 November 2018	The registered person shall ensure a legionella risk assessment is completed and any recommendations are actioned accordingly. Ref: 6.4
	Response by registered person detailing the actions taken: Completed.
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 27.1 **Stated:** First time **To be completed by:** 27 October 2018	The registered person shall ensure the wall plaster in the identified bathroom is improved upon. Ref: 6.4
	Response by registered person detailing the actions taken: Repairs completed.
Area for improvement 2 **Ref**: Standard 29.6 **Stated:** First time **To be completed by:** 13 October 2018	The registered person shall ensure all staff participate in a fire evacuation drill at least once per year. Action taken on problems or defects is recorded. Ref: 6.4
	Response by registered person detailing the actions taken: Completed.

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

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