Unannounced Care Inspection Report
5 and 6 September 2019

Glens

Type of Service: Residential Care Home
Address: 63 Middlepark Road, Cushendall BT44 0SQ
Tel no: 028 2177 1588
Inspectors: Marie-Claire Quinn and Helen Daly

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for

2.0 Profile of service

This is a residential care home which is registered to provide care for up to 16 residents in the categories of care outlined in Section 3.0.

3.0 Service details

Organisation/Registered Provider:	Registered Manager and date registered:
Organisation/Registered Provider: Ms Paula Magee & Ms Geraldine Magee **Responsible Individuals:** Ms Paula Magee Ms Geraldine Magee	**Registered Manager and date registered:** Ms Geraldine Magee 1 April 2005
Person in charge at the time of inspection: Ms Geraldine Magee – 5 September 2019 Ms Siobhan McHugh – 6 September 2019	**Number of registered places:** 16 The home is registered to provide care for a maximum of three residents living with dementia.
Categories of care: Residential Care (RC) I - old age not falling within any other category MP - mental disorder excluding learning disability or dementia MP (E) - mental disorder excluding learning disability or dementia – over 65 years PH - physical disability other than sensory impairment PH (E) - physical disability other than sensory impairment – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 16 – 5 September 2019 15 – 6 September 2019

4.0 Inspection summary

An unannounced care inspection took place on 5 September 2019 from 11.40 to 15.55 and an unannounced medicines management inspection took place on 6 September from 11.00 to 14.00.

The inspection was undertaken by care and pharmacist inspectors.

The inspection assessed progress with all areas for improvement identified in the home during and since the last care and medicines management inspections and 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 staffing levels, staff training, the home's environment, person centred care planning and delivery, the culture and ethos of the home, dignity and privacy, listening to and valuing the resident and their representatives, management arrangements and governance arrangements and quality improvement.

In relation to medicines management, there was evidence of good practice regarding the management of controlled drugs, antibiotics and care planning in relation to pain.

An area for improvement was made under regulation as the home is operating outside their registered categories of care. A variation application has been submitted to RQIA.

Residents told us they were very happy living in the home and felt well looked after.

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

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	0

Details of the Quality Improvement Plan (QIP) were discussed with Ms Geraldine Magee, Registered Manager, and Ms Siobhan McHugh, 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 inspection dated 4 September 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 4 September 2018. No areas for improvement were identified during this inspection. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including medicines management, registration information, and any other written or verbal information received, for example serious adverse incidents.

During our inspection we:

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

Questionnaires and 'Have We Missed You' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with views of the home. We

received seven responses, all of whom stated they were very satisfied that the care in the home was safe, effective, and compassionate and that the service was well led. Specific comments are contained within the report. This feedback was shared with the management of the home following the inspection.

A poster was provided for staff detailing how they could complete an electronic questionnaire; however, no responses were received within the agreed two week time frame.

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

- staff duty rotas from 1 July 2019 to 31 August 2019, and 5 September 2019
- staff training audit 13 February 2019
- a sample of fire safety records
- accident and incidents records from 23 July 2019 to 4 September 2019
- the care records of three residents
- monthly monitoring reports dated 10 January 2019 and 5 March 2019
- quality improvement audit for 2018-2019
- care plan review audit 23 August 2019
- staff training and competency with regards to medicines management
- personal medication records, medicine administration records, medicines requested, received and transferred/disposed of
- management of medicines on admission and medication changes
- management of controlled drugs, warfarin, antibiotics, time-critical medicines, medication related incidents
- care planning in relation to distressed reactions, pain and self-administration
- medicine management audits
- storage of medicines
- stock control

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the last care and medicines management inspections dated 4 September 2018 and 19 April 2018

There were no areas for improvement made as a result of the last care inspection.

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 6

Stated: Second time</td><td>Where medicines are prescribed for the management of distressed reactions on a ‘when required’ basis, a care plan should be in place and details of the reason for and the outcome of administration should be recorded on every occasion; any regular administration should be reported to the prescriber.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We reviewed the management of distressed reactions for three residents.

Care plans directing the use of prescribed medicines were available. The reason for and outcome of administration were recorded.

There was evidence that regular use was referred to the prescriber for review.</td></tr>
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6.2 Inspection findings

6.3 Is care safe?

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

There were enough staff available to meet the needs of the residents on the days of inspection. Call bells or requests from residents were responded to promptly. No concerns about staffing levels were raised by residents, relatives or staff.

Residents told us:

- “The staff are very kind, you couldn’t ask for better.”
- “I’m very happy here. Staff come when you call them.”

Residents’ representatives told us:

- “The home is wonderful. My (relative) is very happy here.”
- “I can’t praise this place enough. I know my (relative) is safe here.”
- “Lovely staff. Excellent care. Always helpful.”

- "The Glens home is an excellent facility. It is kept very clean and the residents are very well looked after."

Discussion with staff and review of records confirmed that mandatory training was kept up to date. Staff felt they had received sufficient training to carry out their jobs safely. Staff were able to accurately describe how they would respond if they had any concerns regarding a resident's treatment, including adult safeguarding or whistle blowing procedures.

Staff told us:

- "I've been here 15 years; it's a lovely place to work."
- "I love working here. I like who I work with, residents and staff."

The home was clean, warm, tidy and appropriately decorated. Bedrooms reflected residents' personalities and interests. We identified some areas where the home could improve on infection prevention and control procedures. These were discussed with management and actioned immediately.

Residents had access to an outdoor area with a smoking area and seating. The home keeps chickens and a pet rabbit which is popular with residents.

Review of fire safety records was acceptable. Personal Emergency Evacuation Plans (PeePs) were in place for residents. Accidents and incidents were managed appropriately, including referral to multi-disciplinary professionals as needed.

Medicine management

Satisfactory systems for the following areas of the management of medicines were observed: medicine records, the management of the medicines on admission/re-admission, distressed reactions and self-administration.

The audits completed at the inspection showed that the majority of medicines had been administered as prescribed. However, two discrepancies were identified. The deputy manager was requested to investigate these discrepancies, inform the prescribers if necessary, and to forward the outcomes of the investigations including any action taken to prevent a recurrence to RQIA. Incident report forms which confirmed that appropriate corrective and preventative action had been taken were received by RQIA on 9 September 2019.

Mostly satisfactory systems were in place for the management of medication changes. The deputy manager was reminded that all medication changes must be clearly recorded on the personal medication records. This was actioned during the inspection and hence an area for improvement was not made.

Obsolete warfarin dosage directions were cancelled and archived during the inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, training, the home's environment, the management of controlled drugs, antibiotics and care planning in relation to pain.

Areas for improvement

No areas for improvement were identified within this domain during the inspection.

	Regulations	Standards
Total numb of areas for improvement	0	0

6.4 Is care effective?

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

Residents looked well cared for; staff ensured residents were comfortable and content at all times. Several residents enjoyed dozing in the lounge, and staff provided additional cushions and blankets. Any signs of pain or distress were addressed promptly by staff and with good effect. Relatives told us:

- "My (relative) is happy and comfortable here. I wouldn't want them to go anywhere else."
- "(Staff) know the patients' likes and dislikes."

Care records were in good order and contained sufficient detail on the needs, wishes and preferences of residents. A range of risk assessments were included and reviewed depending on the individual need of each resident. This helped to ensure that residents' Human Rights were considered, respected and upheld as much as possible.

Care plans were person centred and holistic, and focused on how staff can support residents to maintain their independence and choice. Care plans had been discussed and agreed with residents and/or their representatives.

The home's catering arrangements were good. Residents were offered a choice of hot and cold drinks throughout the day and snacks were available on request. Discussion with staff and review of records confirmed that the home effectively manages the nutritional needs of residents, including referral to specialist services as required. When we observed the lunch time meal, residents told us they loved the food in the home and got plenty to eat. One relative commented:

- "The home-made food is very nourishing and tasty."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to person centred care planning and delivery which considered and promoted residents' Human Rights.

Areas for improvement

No areas for improvement were identified within this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 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.

We saw staff engage with residents in a friendly, cheerful, and kind manner. Residents were confident in expressing their needs and wishes to staff; staff responded promptly and were supportive and reassuring. Residents told us:

- "Staff are kind, they curl my hair for me."
- "She (the manager) is very kind."

Care plans included a good level of detail on residents' social, cultural and religious needs and preferences. This incorporated residents' personalities and preferred routines. Care plans were regularly reviewed with residents to ensure they were accurate and up to date. Feedback from residents and their relatives was included in reviews; residents advised that they knew how to complain, were happy with their care and felt they were kept well informed about their care.

We saw staff deliver care in a way which respected residents' privacy, dignity and choice. When we spoke with staff, they demonstrated a good knowledge and understanding of residents' individual needs, wishes and preferences.

An activities board was on display in the home, but activities were flexible depending on the preferences of residents on the day. Residents enjoyed a game of 'Play Your Cards Right' after lunch. The home also maintains links with the local community, such as taking residents to a tea dance in a local parish hall.

Staff told us:

- "We take residents out when they want."
- "I like helping residents do their hair and nails. Sometimes we can be a bit pressed for time with activities but we always ask residents what they want to do – which is usually nothing! They do enjoy puzzles and quizzes and (resident) loves knitting."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing the resident and their representatives.

Areas for improvement

No areas for improvement were identified within this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 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.

Staff advised that there were clear management arrangements in the home, and that management were available, supportive and responsive. This included regular supervision.

The home's complaints policy and procedure was visible in the home, and the home had not received any complaints recently. Residents and their representatives advised they knew how to make a complaint and could approach staff if needed:

- "My (relative) is very sharp and could tell us if anything wasn't right, but we have no issues or concerns at all."
- "Very well run home."

Review of the home's most recent quality improvement audit report confirmed management were open and transparent. Feedback and suggestions for improvement were gathered and a plan developed to address this. Additional quality improvement was evident as the home's deputy manager had recently qualified as a social worker, and had improved staff training records by implementing personal development plans. This is good practice.

Monthly monitoring reports were completed regularly and were satisfactory. Additional managerial oversight was provided as the registered provider was scheduled on the rota several times over the summer months.

The home is currently only registered to provide care for a maximum of three residents living with dementia. Management immediately acknowledged and were accepting of the fact that they were currently operating outside their registration as they had admitted five residents with a diagnosis of dementia. The home has submitted a variation application to RQIA and must ensure that any new admissions to the home are within their registration.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management and governance arrangements and quality improvement.

Areas for improvement

One area for improvement was identified in relation to the home's registered categories of care.

	Regulations	Standards
Total number of areas for improvement	1	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 Ms Geraldine Magee, Registered Manager, and Ms Siobhan McHugh, 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.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 15. – (1) (e)

Stated: First time

To be completed by:
With immediate effect</td><td>The registered person shall not provide accommodation to a resident at the residential care home unless the home has been registered for the category of care appropriate to the resident's needs. This is in relation to the maximum number of residents admitted to the home with a diagnosis of dementia.

Ref: 6.6</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The home submitted a variation to the categories of care application and are now awaiting a new certificate of registration to include dementia for 5 identified individuals. The home shall not provide accommodation to a resident outside our categories of care.</td></tr>
</table>

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

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

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

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