Unannounced Care Inspection Report
6 September 2016

Glens

Type of service: Residential care home
63 Middlepark Road, Cushendall, BT44 0SQ
Tel No: 028 2177 1588
Inspector: Ruth Greer

1.0 Summary

An unannounced inspection of Glens residential home took place on 6 September 2016 from 10.30 to 15.45.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if Glens 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 induction and training, infection prevention,competency and capability assessments and the home's environment.

No requirements or recommendations were made in regard to the domain of safe care.

Is care effective?

There were examples of good practice found throughout the inspection in relation to care records and reviews, communication between the home and residents and families.

No requirements or recommendations were made in regard to the domain of effective care.

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 as individuals with a variety of different needs and preferences.

No requirements or recommendations were made in relation to the domain of compassionate care.

Is the service well led?

There were examples of good practice found throughout the inspection in relation to governance arrangements, quality improvement and maintaining a good working environment.

No requirements or recommendations were made in relation to the domain of a well led service.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and DHSPPS 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 Siobhan McHugh, deputy manager and Paula Magee, registered person, and 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

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Ms Paula Magee	**Registered manager:** Ms Geraldine Magee
Person in charge of the home at the time of inspection: Siobhan Mc Hugh, Deputy Manager	**Date manager registered:** 1 April 2005
Categories of care: 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	**Number of registered places:** 17

3.0 Methods/processes

Prior to inspection we analysed the following records: the report from the last care inspection and notifications of accidents and incidents.

During the inspection the inspector met with 12 residents, two care staff, one catering and one domestic staff, seven resident's visitors/representatives.

The following records were examined during the inspection:

- Staff duty rota
- Induction programme for new staff
- Staff supervision and annual appraisal schedules
- Sample of competency and capability assessments

- Staff training schedule/records
- Staff recruitment file(s)
- Four resident's care files
- The home's Statement of Purpose and Residents' Guide
- Minutes of recent staff meetings
- Complaints and compliments records
- Accident/incident/notifiable events register
- Annual Quality Review report
- Minutes of recent residents' meetings
- Evaluation report from annual service user quality assurance survey
- Fire safety risk assessment
- Fire drill records
- Programme of activities
- Policies and procedures manual

A total of 15 questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA. No questionnaires were returned within the requested timescale.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 April 2016

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.

4.2 Review of requirements and recommendations from the last care inspection dated 9 February 2016

No requirements or recommendations were made as a result of the previous care inspection.

4.3 Is care safe?

The deputy manager 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, residents' representatives and staff. On the day of inspection the following staff were on duty:

Deputy Manager x 1
Care staff x 2
Domestic x 1
Catering x 1

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 and a review of returned staff views questionnaires confirmed that mandatory training, supervision and appraisal of staff was regularly provided. A schedule for annual staff appraisals and staff supervision was maintained and was available for inspection.

The deputy manager and staff 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 review of a sample of staff competency and capability assessments were reviewed and found to comprehensive and well developed.

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

Enhanced Access NI disclosures were viewed by the registered manager for all staff prior to the commencement of employment.

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

The adult safeguarding policies and procedures in place were 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, the deputy manager, had been established.

Discussion with staff confirmed that they were aware of the new regional guidance (Adult Safeguarding Prevention 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 deputy manager, review of accident and incidents notifications, care records and complaints records confirmed that any suspected, alleged or actual incidents of abuse would be fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records were retained.

The deputy manager confirmed there were risk management procedures in place relating to the safety of individual residents. Discussion with the deputy 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. Care needs assessment and risk assessments, for example falls, nutrition etc. were reviewed and updated on a regular basis or as changes occurred.

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 deputy manager confirmed that restrictive practices were employed within the home, notably keypad entry systems, bed rails and pressure alarm mats. Discussion with the deputy manager regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required. It was noted that a template had been devised and completed for each resident in relation to any real or perceived deprivation of liberty (for example key padded door entry). The template had been signed by the resident, their next of kin and their community worker. This is commendable practice.

Inspection of care records confirmed there was a system of referral to the multi-disciplinary team when required.

The deputy manager confirmed that equipment and medical devices in use in the home were well maintained and regularly serviced. Records showed that the home employ an outside company to service and maintain equipment and this takes place 6 monthly.

Review of the infection prevention and control (IPC) policy and procedure (reviewed and updated in August 2016) 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.

Hand hygiene was a priority for the home and efforts were applied to promoting good standards of hand hygiene 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 trust or home policy and procedures, reported to the Public health agency, the trust and RQIA with appropriate records retained.

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. Discussion with the deputy manager confirmed that risk assessments and action plans were in place to reduce risk where possible. For example, in relation to radiators and windows.

The home had an up to date fire risk assessment in place dated 21 July 2016 and one recommendation was noted to be appropriately addressed. In addition the Northern Ireland Fire and Rescue Service (NIFRS) had undertaken an audit of the premises in August 2016.

Review of staff training records confirmed that staff completed fire safety training twice annually. 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.

Areas for improvement

There were no areas identified for improvement within the domain of safe care.

Number of requirements:	0	Number of recommendations:	0

4.4 Is care effective?

Discussion with the deputy manager 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 statement of health and well-being of the resident. The care records also reflected the multi-professional input into the resident's health and social care needs and were found to be updated regularly to reflect the changing needs of the resident. 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.

An individual agreement setting out the terms of residency was in place and appropriately signed. Records were stored safely and securely in line with data protection.

The deputy manager 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 falls were available for inspection and were undertaken and reviewed on a monthly basis. Further evidence of audit was contained within the annual quality report.

The deputy 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. The deputy manager and staff confirmed that management operated an open door policy in regard to communication within the home.

Residents and their representatives spoken with and observation of practice evidenced that staff were able to communicate effectively with residents, their representatives.
Minutes of resident and/or their representative meetings were available for inspection.

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. The care files were seen to contain a template for external professionals to record outcomes of any visit they made to the resident.

Some comments received from staff, residents and relatives were as follows:

- "I think this place is great"
- "The staff are all so kind"
- "This is a small place and we (staff) know all the residents really well"
- "There are always at least two alternatives for every meal and residents can request anything else they wish"

Areas for improvement

There were no areas identified for improvement in relation to the domain of effective care.

Number of requirements:	0	Number of recommendations:	0

4.5 Is care compassionate?

The deputy manager confirmed that there was a culture/ethos within the home that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

There were a range of policies and procedures in place which supported the delivery of compassionate care. 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. Discussion with residents confirmed that action was taken to manage any pain and discomfort in a timely and appropriate manner.

The deputy manager, residents and their representatives confirmed that consent was sought in relation to care and treatment. Discussion with residents, their representatives and staff along with observation of practice and interactions demonstrated that residents were treated with dignity and respect. Staff confirmed their awareness of promoting residents' rights, independence and dignity. Staff were also able to demonstrate how residents' confidentiality was protected. This was evidenced in the manner staff approached residents and in their response to questions from the inspector.

Discussion with staff, residents, and/or their representatives, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. The home employ an activity therapist and examples of crafts completed by residents were on show throughout the home. Arrangements were in place for residents to maintain links with their friends, families and wider community. Open visiting is encouraged within the home. During the inspection there were seven visitors in the home. All were offered tea and a snack.

The registered manager and staff confirmed that residents were listened to, valued and communicated with in an appropriate manner. 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 provided with information, in a format that they could understand, which enabled them to make informed decisions regarding their life, care and treatment. There was information on how to make a complaint on the back of each bedroom door.

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.

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

Residents and their representatives confirmed that their views and opinions were taken into account in all matters affecting them.

Some comments received from residents and their representatives were as follows:

- “My relative was in another home and didn’t settle, I’m amazed at how well she has settled here and it’s due to the staff care and attitude”
- “It’s really great we are always welcome to visit and offered tea”
- “The staff are the secret to the good care and friendly atmosphere”
- “You wouldn’t get better anywhere”

Areas for improvement

There were no areas identified for improvement in relation to the domain of compassionate care.

Number of requirements:	0	Number of recommendations:	0

4.6 Is the service well led?

The deputy manager outlined the management arrangements and governance systems in place within the home. These were found to be in line with good practice.

The health and social care 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 were 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 DHSPPS guidance on complaints handling. Residents and their representatives were knowledgeable about how to receive and deal with complaints.

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 available for inspection. Learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

The registered manager confirmed that they were aware of the Falls Prevention Toolkit and were using this guidance to improve post falls management within the home.

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 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. Discussion with the registered provider who was in the home for feedback on the inspection identified that she had understanding of her role and responsibilities under the legislation.

The deputy manager confirmed that the home operated in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration and employer's liability insurance certificate were displayed.

Review of notifications of accidents and incidents and the returned RQIA Quality Improvement Plan (QIP) confirmed that the registered provider/s respond to regulatory matters in a timely manner.

Review of records and discussion with the deputy manager and staff confirmed that any adult safeguarding issues were managed appropriately and that reflective learning had taken place. The deputy manager confirmed that there were effective working relationships with internal and external stakeholders. The home had a whistleblowing policy and procedure in place. Discussion with staff established that they were knowledgeable regarding the policy and procedure. The deputy manager confirmed that staff could also access line management to raise concerns and to offer support to staff. Discussion with staff confirmed that there were good working relationships and that management were responsive to suggestions and/or concerns raised.

The deputy manager confirmed that there were arrangements in place for managing identified lack of competency and poor performance for all staff. There were also open and transparent methods of working and effective working relationships with internal and external stakeholders.

Some comments received from residents and their representatives were as follows:

- "Management are really approachable"
- "I was in hospital but am glad to be home because the manager always takes me out for a meal for my birthday"
- "There is always someone in the office to sort out things for me"

Areas for improvement

There were no areas identified for improvement in relation to the domain of a well led service.

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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