



The Regulation and
Quality Improvement
Authority

Secondary Unannounced Care Inspection

Name of Establishment:	Englewood
Establishment ID No:	1356
Date of Inspection	7 May 2014
Inspector's Name:	Bronagh Duggan
Inspection No:	17313

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

GENERAL INFORMATION

Name of Home:	Englewood
Address:	5 Blackcave Crescent Drains Bay Larne BT40 1TY
Telephone Number:	028 2827 5847
E mail Address:	No email address
Registered Organisation/ Registered Provider:	Mrs Elizabeth Magee
Registered Manager:	Mrs Elizabeth Magee
Person in Charge of the home at the time of Inspection:	Mrs Elizabeth Magee
Categories of Care:	RC-I, RC-DE
Number of Registered Places:	3
Number of Residents Accommodated on Day of Inspection:	2
Scale of Charges (per week):	Trust Rates
Date and type of previous inspection:	24 September 2014 Secondary unannounced inspection
Date and time of inspection:	7 May 2014 10:10am to 1:55pm
Name of Inspector:	Bronagh Duggan

INTRODUCTION

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect residential care homes. A minimum of two inspections per year are required.

This is a report of a secondary inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

PURPOSE OF THE INSPECTION

The purpose of this inspection was to consider whether the service is compliant with relevant regulations and minimum standards and other good practice indicators and to consider whether the service provided to service users was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of residential care homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Residential Care Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Residential Care Homes Minimum Standards (2008)

Other published standards which guide best practice may also be referenced during the inspection process.

METHODS/PROCESS

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

- Discussion with the registered manager
- Examination of records
- Consultation with stakeholders
- File audit
- Tour of the premises
- Evaluation and feedback

INSPECTION FOCUS

The inspection sought to assess progress with the issues raised during and since the previous inspection and to establish the level of compliance achieved with respect to the following DHSSPS Residential Care Homes Minimum Standard/s:

Standard 6 – Care Plan

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Compliance statement	Definition	Resulting Action in Inspection Report
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

PROFILE OF SERVICE

Englewood is a small private residential home situated rurally in Drains Bay approximately two miles along the coast from Larne town. It is a single storey detached home with mature and private front and rear gardens with seating areas. The home is registered to accommodate three persons in categories I (Old and Infirm) and /or DE (Dementia) for two identified individuals.

Facilities for use by residents include single bedroom accommodation, lounge, dining room, kitchen and bathroom facilities.

There is adequate parking available for visitors.

The registered provider / manager of Englewood lives in the home although has separate private quarters from the residents.

SUMMARY

A secondary unannounced inspection was undertaken at Englewood Residential Care Home on 7 May 2014 between the hours of 10:10am and 1:55pm by Bronagh Duggan, inspector and reflects the position in the home at the time of inspection.

The inspector was met by the registered manager/provider Mrs Elizabeth Magee who was available for discussion and clarification throughout the duration of the inspection. Verbal feedback of the issues identified during the inspection was given to the registered manager, at the conclusion of the inspection.

The purpose of this inspection was to follow up on the requirement made during the previous inspection and to review the homes compliance with Standard 6 from the Residential Care Homes Minimum Standards focusing on Care Planning.

The inspection process consisted of speaking with the residents, reviewing care plans and other documentation available within the home, discussion with the registered manager and viewing the premises.

Follow up on the requirement made during the previous inspection in September 2013 identified that the home is moving towards compliance in this regard. Documentary evidence reviewed and discussion with the registered manager/ provider demonstrated that staff employed by the home have completed mandatory training and specific training in relation to dementia. With regard to staff employed in the home completing an appraisal this has yet to be carried out, this part of the requirement has been stated for the second time.

The home was found to be clean, tidy and fresh smelling on the day of inspection; hall ways were accessible for residents. Bathrooms, bedrooms and communal areas were found to be appropriately furnished.

Standard 6 Care Plan

Review of the two residents care plans and discussion with the registered manager / provider evidenced that residents have an individual and up to date care plan in place. Examination of these care plans evidenced that residents had been involved in the care planning process.

Care plans were comprehensive in nature, and were updated regularly to reflect any changes in the residents care. The home was found to be compliant with this standard.

Two care records were viewed in conjunction with the resident's individual care plans. The review identified that the records retained did not clearly demonstrate all personal care and support which had been provided on a daily basis and resident contact with their representatives. This was discussed with the registered manager and a recommendation has been made to develop daily progress records. A second recommendation has also been made to ensure that residents care records include easily accessed information for staff which identifies the contact details of the relevant health and social care professionals involved in providing services to the residents.

One requirement, which has been stated for the second time and two recommendations have been made as a result of this inspection, details can be found in the main body of the report and the attached Quality Improvement Plan (QIP).

The inspector wishes to acknowledge the full cooperation of the registered manager / provider and the residents throughout the duration of the inspection. The inspector would like to thank all those involved for their time, open and honest conversation and for the hospitality received.

FOLLOW-UP ON PREVIOUS ISSUES

NO.	REGULATION REF.	REQUIREMENTS	ACTION TAKEN - AS CONFIRMED DURING THIS INSPECTION	INSPECTOR'S VALIDATION OF COMPLIANCE
1.	20 (1) (c) (i)	<p>The registered person shall, having regard to the size of the residential care home, the statement of purpose and the number and needs of residents –</p> <p>(c) ensure that persons employed by the registered person at the home receive –</p> <p>(i) Appraisal, mandatory training and other training appropriate to the work they are to perform</p> <p>Reference to this is in respect of ensuring that all persons employed in the home are in receipt of training in dementia.</p>	<p>Up to date training certificates were available to reflect the completion of mandatory training and training in dementia for all persons employed in the home.</p> <p>Appraisal information was not available. The need for this to be completed with all persons employed in the home has been stated for the second time.</p>	<p>Moving towards compliance</p>

STANDARD 6 - CARE PLAN	
Each resident has an individual and up-to-date comprehensive care plan.	
Criterion Assessed: 6.1 Residents are encouraged and enabled to be involved in the care planning process, but when a resident is unable or chooses not to, this is recorded.	COMPLIANCE LEVEL
Inspection Findings:	
Review of the care plans of the two residents showed residents involvement in the care planning process. The two care plans were signed by residents and included information pertaining to their personal interests and likes and dislikes.	Compliant
Criterion Assessed: 6.2 An individual comprehensive care plan is drawn up as the assessment of the resident's needs is carried out, and includes details of: - <input type="checkbox"/> Any personal outcomes sought by the resident <input type="checkbox"/> The daily care, support, opportunities and services provided by the home and others <input type="checkbox"/> How specific needs and preferences are to be met if the resident is from a specific minority group <input type="checkbox"/> How information about the resident's lifestyle is used to inform practice <input type="checkbox"/> The resident's agreed daily routine and weekly programme <input type="checkbox"/> The management of any identified risks <input type="checkbox"/> Strategies or programmes to manage specified behaviours <input type="checkbox"/> Directions for the use of any equipment used to assist the delivery of care.	COMPLIANCE LEVEL
Inspection Findings:	
Examination of the two care plans identified that all the relevant information was included. The care plans referred to resident's specific needs and individual preferences, any medical conditions and risk assessments were also in place. The care plans were noted to have been updated accordingly.	Compliant

STANDARD 6 - CARE PLAN	
Each resident has an individual and up-to-date comprehensive care plan.	
Criterion Assessed: 6.3 The resident or their representative, where appropriate, sign the care plan along with the member of staff responsible for drawing it up and the registered manager. If the resident or their representative is unable to sign or chooses not to sign, this is recorded.	COMPLIANCE LEVEL
Inspection Findings:	
The two care plans viewed were both signed by the residents and the registered manager who drew up the care plans.	Compliant
Criterion Assessed: 6.4 A copy of the care plan is made available to the resident in a language and format suitable for them.	COMPLIANCE LEVEL
Inspection Findings:	
Copies of care plans are available to residents as they would like. The inspector spoke with two residents, one of whom clearly articulated their views in relation to their care.	Compliant
Criterion Assessed: 6.5 The care plan is presented at the post-admission review meeting, modified if necessary and agreed to by those attending.	COMPLIANCE LEVEL
Inspection Findings:	
Discussion with the registered manager and examination of care files identified that the care plans were included at the care review post admission review meeting. Care plans were agreed as necessary with input from the residents and professionals involved.	Compliant

STANDARD 6 - CARE PLAN Each resident has an individual and up-to-date comprehensive care plan.	
Criterion Assessed: 6.6 The care plan is kept up-to-date and reflects the resident’s current needs. Where changes are made to the care plan, the resident, or their representative where appropriate, the member of staff making the changes and the manager sign the revised care plan. When a resident or their representative is unable to sign or chooses not to sign, this is recorded.	COMPLIANCE LEVEL
Inspection Findings:	
The care plans viewed had been updated regularly to reflect residents changing needs. These included regular updating with changes in the health and wellbeing of residents.	Compliant
Criterion Assessed: 6.7 When restrictions from any risk assessment are in place, or there are behaviours likely to pose a risk for the resident or others, these are highlighted for those who have authorised access to the resident’s care plan.	COMPLIANCE LEVEL
Inspection Findings:	
The two care plans reviewed contained the relevant information required to meet their individual needs.	Compliant

ADDITIONAL AREAS EXAMINED

Resident's views

The inspector met both residents in the home at the time of this inspection. One resident clearly articulated his / her views in relation to life in the home. The information provided to the inspector by the resident was very complementary comments included:

- "It's like home from home. You won't get a better place than this, we are well looked after here".

The other resident could not clearly articulate his / her views but indicated to the inspector they were happy / content living in the home.

There were no issues or concerns about the care provided shown by the residents.

Records and reporting arrangements

Two care records were viewed in conjunction with the resident's individual care plans. The review identified that the records retained did not clearly demonstrate all personal care and support which had been provided. It was also identified that resident contact with their representatives was not included. These issues were discussed with the registered manager and a recommendation has been made to develop daily progress records and record information in relation to each resident on a daily basis.

A second recommendation has been made that residents care records include easily accessed information for staff which shows the contact details of the relevant health and social care professionals involved in providing services to the residents. This should be placed at the front of the residents care record.

Environment

The home is a domestic style detached bungalow, it was found to be clean, tidy and fresh smelling on the day of inspection with a good standard of furnishing and décor. Resident's bedrooms were found to be highly personalised with an emphasis on resident's individuality and personal preferences.

Care Practices

Due to the domestic style of the home it was not possible to discretely observe care practices. Residents however appeared relaxed and comfortable in the home; interactions were warm and friendly between the residents and the registered manager / provider. Residents were observed as being well groomed and nicely dressed, with obvious time and attention afforded to their appearance.

QUALITY IMPROVEMENT PLAN

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Elizabeth Magee, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

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

Bronagh Duggan
Inspector/Quality Reviewer

Date

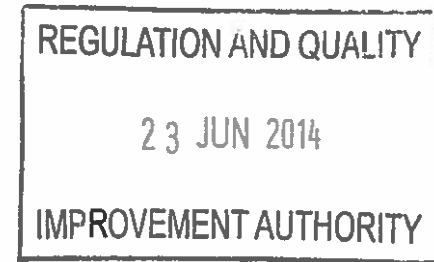


The Regulation and
Quality Improvement
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Quality Improvement Plan
Secondary Unannounced Care Inspection

Englewood

7 May 2014



The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Elizabeth Magee registered manager either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Residential Care Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	20 (1) (c) (i)	The registered person shall, having regard to the size of the residential care home, the statement of purpose and the number and needs of residents ensure that persons employed by the registered person at the home receive appraisal.	Two	<i>Statement of Purpose includes all relevant information required. Appraisal for Staff members has taken place.</i>	25 June 2014

Recommendations					
These recommendations are based on The Residential Care Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.					
No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	8.2	Daily progress records should be developed. The progress records should clearly demonstrate all personal care and support provided, and contact with residents representatives.	One	<i>Progress records include more information about each resident.</i>	25 June 2014
2.	8.4	Residents care records should include easily accessed information for staff which identifies the contact details of the relevant health and social care professionals involved in providing services to the residents. This should be placed at the front of the residents care record.	One	<i>Information of all care professionals involved with residents included in care records</i>	25 June 2014

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

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

SIGNED: Elizabeth Magee

NAME: ELIZABETH MAGEE
 Registered Provider

DATE 19 June 2014

SIGNED: Elizabeth Magee

NAME: ELIZABETH MAGEE
 Registered Manager

DATE 19 - June 2014

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Bronagh Ouggar	23 June '14
Further information requested from provider			