



Unannounced Care Inspection Report 8 September 2019



Clonmore House

Type of Service: Residential Care Home
**Address: 22-28 Crossreagh Drive, Rathcoole,
Newtownabbey, BT37 9DY**
Tel No: 028 9085 1153
Inspector: John McAuley

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 registered to provide care and accommodation for 42 persons who are older in age. The home is also registered to provide care for two persons on a day service basis.

3.0 Service details

Organisation/Registered Provider: Northern Health and Social Care Trust (NHSCT)	Registered Manager and date registered: Tracey McCartney – 1 April 2005
Responsible Individual(s): Dr Anthony Baxter Stevens	
Person in charge at the time of inspection: Caroline McQuilkin, senior care assistant	Number of registered places: 42 The home is approved to provide care on a day basis only to 2 persons
Categories of care: Residential Care (RC) I - Old age not falling within any other category	Total number of residents in the residential care home on the day of this inspection: 20

4.0 Inspection summary

This unannounced inspection took place on 8 September 2019 from 09.45 to 13.50 hours.

The inspection assessed progress with the one area of improvement identified in the home 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 the nice relaxed ambience in the home with residents clearly content and satisfied with provision of care, choice and kindness received from staff. Good practice was also found in relation to maintenance of working relationships, teamwork and governance.

One area requiring improvement was identified during this inspection. This was in relation to putting in place a risk assessment and corresponding care plan for any resident who smokes.

Residents described living in the home as being a good experience/in positive terms. Some of the comments made included statements such as; "Everything is brilliant. We are all treated well. I'd recommend here to anyone" and "They are very good to me. All very kind. All the workers couldn't be any better".

Comments received from residents, people who visit them and staff during 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	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Caroline McQuilkin, senior care assistant, 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 28 February 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 28 February 2019. Other than the one action detailed in the QIP no further actions were required to be taken. 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 findings from the previous inspections, registration information, and any other written or verbal information received, for example notification reports.

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. A poster was provided for staff detailing how they could complete an electronic questionnaire. No responses from these questionnaires were received in time for inclusion to this report.

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

- staff duty rotas
- staff training schedule and training records
- three residents' records of care
- complaint records
- compliment records
- governance audits/records
- accident / incident records

- reports of visits by the registered provider/monthly monitoring
- RQIA registration certificate

The one area of improvement identified at the last care inspection was reviewed and assessment of compliance recorded as met, partially met, or not 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 last care inspection dated 28 February 2019

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 27.8 Stated: First time	The registered person shall ensure that ensure that the scales used to weigh residents in the home are maintained and fit for purpose at all times.	Met
	Action taken as confirmed during the inspection: A new set of scales has been put in place and in working order.	

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.

Throughout this inspection residents in the home at the time of this inspection advised that they felt safe in the home and that staff were responsive to their needs and were kind and supportive. Staff also advised that there was adequate staffing in place to take account of resident dependencies and the size and layout of the home.

Staffing

Inspection of the duty rota confirmed that it accurately reflected the staff on duty at the time of this inspection.

The senior care assistant advised that staffing levels were in keeping with resident dependencies and the size and layout of the home. The staffing levels over the 24 hour period were discussed. Discussions with staff confirmed that they felt there was adequate staffing in place to meet residents' needs.

A competency and capability assessment is completed for any member of staff with the responsibility of being in charge in the absence of the registered manager.

Staff induction, supervision and appraisal

Discussions with staff confirmed that they had received a comprehensive programme of induction on appointment. An inspection of the programme of supervisions and appraisals found these were being maintained in a regular and up-to-date basis for all staff. Staff spoke positively about this provision.

A system of monitoring the registration details of care staff with the Northern Ireland Social Care Trust (NISCC) was in place. This was being audited on a monthly basis.

Staff training

Inspection of staff training records found that mandatory requirements and other training needs were being met. A matrix of staff training is in place which identifies when staff have last received their mandatory training and when up-date training is required.

Safeguarding

Discussions with staff confirmed that they had knowledge and understanding of safeguarding principals. Staff were aware of their obligations to report any concerns and advised that they found management to be approachable. They also advised that they would have no hesitation to report any concerns and that they would have confidence in management in dealing with such appropriately. Staff were knowledgeable of the Health and Social Care Trust's role in safeguarding and these contacts details were displayed.

Environment

The home was clean and tidy with a good standard of décor and furnishings being maintained, such as new furnishings in the dining rooms.

Residents' bedrooms were comfortable and personalised as per choice. Communal areas were nicely facilitated and provided a relaxing space for residents to enjoy. The grounds of the home were very well maintained.

There was good provision of infection prevention and control aids and equipment throughout the environment. Added to this there was accessible information available to residents, their representatives, visitors and staff on the need for good infection prevention and control practices.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, training, support and the environment.

Areas for improvement

There were no areas of improvement identified during the inspection in relation to this domain.

	Regulations	Standards
Total number 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.

Discussions with the senior care assistant in charge and staff confirmed that they had good knowledge and understanding of residents' needs and prescribed care interventions. Staff also advised that there was good communication and teamwork between staff members for the benefit of residents.

Care records

An inspection of a sample of two residents' care records was undertaken. The care records were methodical and detailed in the information recorded. These records also were largely maintained in line with the regulations and standards. Records included an up to date assessment of needs, life history, risk assessments and care plans. However an area of improvement was identified in that there was no risk assessment with corresponding care plan in place for any resident who smoke. This risk assessment and corresponding care plan needs to be carried out in accordance with current safety guidance taking account factors such as the resident's medical condition(s).

Care needs assessment and risk assessments, such as, safe moving and handling, nutrition, falls, were reviewed and updated on a regular basis or as changes occurred.

Care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents.

Progress records were well written and issues of assessed need had a recorded statement of care/treatment given, effect of same.

There was evidence that residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Signatures of participation in this process were included in the two care records inspected.

Effectiveness of care

Throughout this inspection there were examples of good delivery and effectiveness of care observed. Care practices such as infection prevention and control and assistance with mobility needs were found to be maintained in line with good practice.

Staff took time to interact with residents and consent was requested when seeking to undertake tasks with personal care or with assistance with mobility.

Residents were dressed well in matching clean attire. Glasses and walking aids were clean and appeared in good working order.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffs' knowledge and understanding of residents' needs, prescribed care interventions and how this impacted on the culture and ethos of the home.

Areas for improvement

One area of improvement was identified in relation to put in place a risk assessment and corresponding care plan for any resident who smokes.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

Throughout this inspection residents praised staff for their kindness, care and support. Residents advised that this was a good home to reside in and that that they felt a benefit to their health and well-being.

Residents' views

Residents spoke with praise and gratitude for the provision of care, the kindness and support received from staff, the provision of meals and the general ambience in the home. Some of the comments made by residents included statements such as;

- "Everything is brilliant. We are all treated well. I'd recommend here to anyone"
- "They are very good to me. All very kind. All the workers couldn't be any better"
- "Everything is okay here. No problems"
- "I am being looked after very well".

Relative’s views

A visiting relative advised that he was very happy with the care in the home and the staff were kind and supportive. The relative also advised that since his loved one’s admission to the home their health and well-being had improved greatly.

Care practices

Residents were observed to be comfortable, relaxed and at ease in their interactions with staff and with their environment. Some preferred to enjoy the company of one another in a communal sitting room, others choose to relax or partake in pastimes of choice in their bedrooms.

Staff interactions were polite, friendly, warm and supportive. Staff gave respect to residents by seeking their agreement in engaging in assistance with care. Choice was evident in the provision of residents’ meals and snacks, such as that available for the Sunday dinner or the provision of the mid-morning drinks.

Daily newspapers were available and the genre of the television programmes and choice of music on the radio was appropriate to the age group and taste of residents.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to feedback from residents and one visiting relative and the general observation of care practices and atmosphere in the home.

Areas for improvement

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

	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.

The senior care assistant in charge and was available to support and facilitate this inspection.

The home’s certificate of registration was displayed in a conspicuous place in the reception area.

Monitoring visits

An inspection of the last two months monitoring visits' reports (6 June 2019 and 19 July 2019) on the behalf of the responsible individual was undertaken. Both these visits were unannounced. The reports were recorded in good detail and had an action plan in place for any issues identified. Added to this there was corresponding evidence recorded in response to the action plan and dates of when actions had been addressed. The report for the monitoring visit for August had yet to be published.

Audits

A good programme of audits was in place. These included a manager's walkabout audit, falls, infection prevention and control, staff training, health and safety and audits of care records.

Complaints

Discussions with the senior care assistant together with an inspection of the records of complaint found that expressions of dissatisfaction were taken seriously and managed appropriately. The senior care assistant had good knowledge and understanding on how to deal with complaints. Complaints were welcomed as areas to improve on the quality of care and experience in the home.

The complaints procedure was readily displayed in the home for residents and their visitors.

Discussions with residents indicated that they felt comfortable about raising a concern or complaint and that they felt that such would be acted on positively.

Accident/incidents

An inspection of the last three months accidents/incident reports confirmed that these were managed appropriately and reported to the relevant persons, including the resident's next of kin, their aligned named worker and / or RQIA.

Staff views

Discussions with five members of staff during this inspection confirmed that they felt positive about their roles and duties, the staffing levels, support, teamwork and morale. Staff advised that a good standard of care was provided for and they would have no difficulties recommending the home. Staff also advised that if there were any concerns they would have no difficulties raising these with management and that they felt confident these would be acted on appropriately.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the governance arrangements and maintenance of good working relationships.

Areas for improvement

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

	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 Caroline McQuilkin, senior care assistant, 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 DHSSPS Residential Care Homes Minimum Standards, August 2011

Area for improvement 1
Ref: Standard 6.2
Stated: First time
To be completed by: 16 September 2019

The registered person shall put in place a risk assessment and corresponding care plan for any resident who smokes. This should reflect current safety guidance in relation to smoking taking into account the resident's assessed needs and medical condition(s).

Ref: 6.3

Response by registered person detailing the actions taken:
 The unit has in place a risk assessment for clients that smoke, This has now been amended to include the clients current medical conditions.



The Regulation and
Quality Improvement
Authority

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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