Unannounced Care Inspection Report
27 March 2017

Clonmore House

Type of service: Residential Care Home
Address: 22-28 Crossreagh Drive, Rathcoole, Newtownabbey, BT37 9DY
Tel No: 02890851153
Inspector: Patricia Galbraith

1.0 Summary

An unannounced inspection of Clonmore House took place on 27 March 2017 from 08.00 to 15.00.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home 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 training, supervision, adult safeguarding, infection prevention and control.

There were two new areas for improvement identified in this domain in relation to two notifications that had not been sent to RQIA in a timely manner, regarding a staffing issue and maintenance work on the lift in the home.

The other area identified was in relation to care records that did not accurately reflect residents care needs, nor did they have up to date risk assessments or daily progress notes. Two requirements were made in regard to these issues.

Two requirements have been stated for a second time in relation to the availability of documentation during inspection and the completion of competency and capability assessments for any staff member left in charge in the manager's absence.

Is care effective?

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

No requirements or recommendations were made in relation to this domain.

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 and taking account of the views of residents.

No requirements or recommendations were made in relation to this domain.

Is the service well led?

There were examples of good practice found throughout the inspection in relation to management of complaints and incidents, quality improvement and maintaining good working relationships.

No requirements or recommendations were made in relation to this domain.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	4	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Tracey McCullough, senior carer, 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.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 18 August 2016.

2.0 Service details

Registered organisation/registered person: Northern Health and Social Care Trust	**Registered manager:** Tracey McCartney
Person in charge of the home at the time of inspection: Tracey McCullough Senior carer	**Date manager registered:** 1 April 2005
Categories of care: I - Old age not falling within any other category	**Number of registered places:** 42

3.0 Methods/processes

Prior to inspection we analysed the following records: previous inspection report, returned quality improvement plan, and accident and incidents register.

During the inspection the inspector met with 15 residents, four staff, and two visiting professionals.

The following records were examined during the inspection:

- Staff duty rota
- Staff training schedule/records
- Four resident's care files

- Minutes of recent staff meetings
- Complaints and compliments records
- Audits of risk assessments, care plans, care reviews; accidents and incidents (including falls, outbreaks), complaints, environment, catering
- Infection control register/associated records
- Equipment maintenance / cleaning records
- Accident/incident/notifiable events register
- Minutes of recent residents' meetings / representatives' / other
- Evaluation report from annual service user quality assurance survey
- Monthly monitoring report
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc
- Individual written agreement
- Input from independent advocacy services
- Sample of policies and procedures

A total of 18 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 15 September 2016

The most recent inspection of the home was an announced premises inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 15 September 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 27-(4) (d) (v) Regulation **Stated:** Second time **To be completed by: 18 August 2016**	The registered person shall- ensure weekly fire checks are completed.	**Met**
	Action taken as confirmed during the inspection: Weekly fire checks had been completed.	

Requirement 2 **Ref:** Regulation 27-(4)(f) **Stated:** First time **To be completed by:** 18 September 2016	The registered person shall –ensure fire drills and practices are undertaken at suitable intervals. **Action taken as confirmed during the inspection**: Fire drills had been completed.	**Met**
Requirement 3 **Ref:** Regulation 19.-(2)-(b) **Stated:** First time **To be completed by:** 18August 2016	The registered person shall- ensure all relevant documentation is made available for inspection. This was in relation to complaints records which were not available on day of inspection. **Action taken as confirmed during the inspection**: Complaints records were available on this inspection. However copies of the notifications sent to RQIA were not available for inspection. Therefore this requirement will be stated for a second time in the quality improvement plan appended to this report.	**Not Met**
Requirement 4 **Ref**: Regulation 20.-(3) **Stated:** First time **To be completed by:** 25 August 2016	The registered person shall – ensure that competency and capability assessments are completed with all staff left in charge of the home in the managers absence. **Action taken as confirmed during the inspection**: Senior carer confirmed that competency and capability assessments were completed, however these were not available for inspection. Therefore this requirement will be stated for a second time in the quality improvement plan appended to this report.	**Not Met**
Requirement 5 **Ref**: regulation 16.-(b) **Stated:** First time **To be completed by:** 1September 2016	The registered person shall –ensure care records are kept under review and accurately reflect resident's needs. **Action taken as confirmed during the inspection**: The identified care records had been updated.	**Met**

Requirement 6 **Ref**: Regulation 15.-(1) (b) **Stated:** First time **To be completed by:** 19 August 2016	The registered person shall – ensure a copy of assessment is obtained prior to admission.	**Met**
	Action taken as confirmed during the inspection: A copy of assessment had been obtained prior to residents' admission.	

4.3 Is care safe?

The senior carer 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 and staff.

A review of the duty roster confirmed that it accurately reflected the staff working within the home.

Review of completed induction records and discussion with the senior carer 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 appraisal of staff was regularly provided. A schedule for mandatory training, annual staff appraisals and staff supervision was maintained and was reviewed during the inspection.

The senior carer 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; and that records of competency and capability assessments were retained. Samples of completed staff competency and capability assessments could not be reviewed as the registered manager was not on duty. This requirement has been stated for a second time in the quality improvement plan appended to this report.

Discussion with staff confirmed that they were aware of the new regional guidance (Adult Safeguarding Prevention and 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.

On review of notifications and discussion with the senior carer identified, it was noted not all notifications had been sent to RQIA in a timely manner. They were in relation to a staffing issue and work being carried out on the lift in the home. A requirement was made in this regard.

Review of four care records identified only one care file had risk management procedures in place relating to the safety of the individual resident. The need to ensure care assessments accurately reflect residents care needs and are kept under continual review was discussed with the senior carer. A requirement was made in this regard.

Discussion with the senior carer 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 were obtained prior to admission.

The senior carer confirmed there were restrictive practices employed. Discussion with the senior carer regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required.

Inspection of four care records confirmed there was a system of referral to the multi-professional team when required. Behaviour management plans were devised by specialist behaviour management teams from the trust and noted to be regularly updated and reviewed as necessary.

The senior carer confirmed that equipment and medical devices in use in the home were well maintained and regularly serviced.

Review of the infection prevention and control (IPC) policy and procedure confirmed that 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.

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 senior carer reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with trusts 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. The lift in the home was having major work carried out, this meant it was out of commission and residents could not use it. A temporary chair lift had been put in place. Due to the impact in the home setting RQIA should have been notified of the work. A requirement was made in this regard.

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 senior carer confirmed that risk assessments and action plans were in place to reduce risk where possible.

The home had an up to date fire risk assessment in place and all recommendations were noted to be appropriately addressed.

Review of staff training records confirmed that staff completed fire safety training twice annually. Fire drills were completed every 6 months. 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 / monthly and were regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place.

Areas for improvement

There were two new areas for improvement identified in this domain in relation to notifications that had not been sent in a timely manner to RQIA and care records did not accurately reflect residents care needs, nor did they have up to date risk assessments or daily progress notes. Two requirements were made in regard to these issues.

Number of requirements	2	Number of recommendations	0

4.4 Is care effective?

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

The care records did reflect the multi-professional input into the residents' health and social care needs Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were observed to be signed by the resident and/or their representative. Discussion with staff confirmed that a person centred approach underpinned practice. For example residents were able to go out with relatives regularly.

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 senior carer 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 care review, accidents and incidents (including falls, outbreaks), complaints, environment, catering were available for inspection and evidenced that any actions identified for improvement were incorporated into practice. Further evidence of audit was contained within the monthly monitoring visits reports.

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

Residents spoken with and observation of practice evidenced that staff were able to communicate effectively with residents, their representatives and other key stakeholders. Minutes of resident and/or their representative meetings were reviewed during the 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 senior carer confirmed that arrangements were in place, in line with the legislation, to support and advocate for residents. On the day of inspection a district nurse was in the home and confirmed there was good communication between the home and the multidisciplinary team.

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

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

The senior carer confirmed 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.

A range of policies and procedures were in place which supported the delivery of compassionate care. Discussion with staff, and residents confirmed that residents' spiritual and cultural needs, including preferences for end of life care, were met within the home. Discussion with residents, and staff confirmed that action was taken to manage any pain and discomfort in a timely and appropriate manner.

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.

The senior carer, and residents confirmed that consent was sought in relation to care and treatment. Discussion with residents and staff along with observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff confirmed their awareness of promoting residents' rights, independence and dignity and were able to demonstrate how residents' confidentiality was protected. For example staff ensured all information relating to residents was discussed in the office.

The senior carer and staff confirmed that residents were listened to, valued and communicated with in an appropriate manner. Residents confirmed that their views and opinions were taken into account in all matters affecting them.

Discussion with staff, residents, and observation of practice confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff.

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. For example residents' meetings.

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. An action plan was developed and implemented to address any issues identified.

Discussion with staff, and residents, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. For example residents confirmed they like to listen to music. Arrangements were in place for residents to maintain links with their friends, families and wider community. For example residents go out with their family members or friends. The home had organised a Christmas party. The residents on the day of inspection were enjoying listening to music.

Comments received from residents were as follows:

- “Staff are amazing.”
- “Staff cannot do enough for you.”
- “Staff go above and beyond their job I was worried coming here but I have been so well looked after I would recommend it to anyone.”

Areas for improvement

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

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The senior carer outlined the management arrangements and governance systems in place within the home. These were found to be in line with good practice. 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. 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 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 Residents Guide, Poster / leaflet etc. Discussion with staff confirmed that they 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.

A regular audit of accidents and incidents was undertaken and was reviewed as part of the inspection process. Learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

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. The registered manager had a file in her office which staff have access to.

Discussion with the senior carer 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.

A monthly monitoring visit was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, trust representatives and RQIA to read.

Learning from complaints, incidents and feedback was integrated into practice and fed into a cycle of continuous improvement.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability. The senior carer confirmed that the registered provider was kept informed regarding the day to day running of the home.

The senior carer confirmed that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration was displayed.

Review of governance arrangements within the home and the evidence provided within the returned RQIA Quality Improvement Plan confirmed that the registered provider/s respond to regulatory matters in a timely manner.

Review of records and discussion with the senior carer and staff confirmed that any adult safeguarding issues were managed appropriately and that reflective learning had taken place. The senior carer confirmed that there were effective working relationships with internal and external stakeholders.

The home had a whistleblowing policy and procedure in place and discussion with staff established that they were knowledgeable regarding this. The senior carer confirmed that staff could also access line management to raise concerns they will offer support to staff.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised.

The senior carer 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.

Residents and staff commented:

- “The manager always stops to talk.”
- “The mangers door is always open and staff can go at anytime to speak to the manager.”

Areas for improvement

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

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Tracey McCullough, senior carer, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Residential Care Homes Minimum Standards, August 2011. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP via the web portal for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref:** Regulation 19.-(2)-(b) **Stated: Second** time **To be completed by:** 30 April 2017	The registered provider shall- ensure all relevant documentation is made available for inspection. This was in relation to notification records which were not available on day of inspection.
	Response by registered provider detailing the actions taken: This has now been addressed. The electronic copy is available on the managers computerand in future photocopies of notification records have been and will continue to be printed and filed in the managers office to ensure they are available on the day of inspection.
Requirement 2 **Ref**: Regulation 20.-(3) **Stated: Second** time **To be completed by:** 30 April 2017	The registered provider shall – ensure that competency and capability assessments are completed with all staff left in charge of the home in the managers absence.
	Response by registered provider detailing the actions taken: This has now been addressed copies were held in each staff members supervision file but a copy will now be held in the training file
Requirement 3 **Ref:** Regulation 30.-(1)(d)(e)(g) **Stated:** First time **To be completed by:** 21 march 2017	The registered provider shall ensure all relevant notifications are sent to RQIA in a timely manner. This was in regard to two identified areas regarding staff issues and maintenance work on the homes lift.
	Response by registered provider detailing the actions taken: This has been identifed and discussed with line managers
Requirement 4 **Ref:** Regulation 14.-(1)(c) **Standard 5.2,5.5** **Stated:** First time **To be completed by:** 22 March 2017	The registered provider shall ensure residents' care assessments accurately reflect their care needs and are kept under continual review.
	Response by registered provider detailing the actions taken: This issue has been addressed and discussed with all of the staff team. Risk /care assesment have been completed on all residents.

Please ensure this document is completed in full and returned via the webportal

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