Unannounced Care Inspection Report
25 November 2018

Sunnymead

Type of Service: Residential Care Home
Address: 12 Portadown Road, Armagh, BT61 9EE
Tel No: 028 3752 3866
Inspector: Priscilla Clayton

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.

1.0 What we look for

2.0 Profile of service

This is a residential care home registered to provide care and accommodation for 39 persons in the categories of care cited on the home's certificate of registration and detailed in section 3.0 of this report.

3.0 Service details

Organisation/Registered Provider: Sunnymead (Armagh) Ltd **Responsible Individual:** Linda Margaret Nesbitt	**Registered Manager:** Brenda Nesbitt
Person in charge at the time of inspection: Andrea Barns Key Senior Care Assistant until 13.00 hours Brenda Nesbitt, registered manager, from 13.00 hours.	**Date manager registered:** 03 June 2015
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years LD - Learning Disability PH - Physical disability other than sensory impairment	**Number of registered places:** 39 Total number comprising: 12 – RC - I 05 – RC - DE 05 – RC – MP (E) 02 - RC - LD Also approved to accommodate day care provided the maximum number of service users/residents does not exceed 39.

4.0 Inspection summary

An unannounced care inspection took place on 25 November 2018 from 12.00 to 17.00 hours.

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

The inspection assessed progress with any areas for improvement identified 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 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. There were also examples of good practice found throughout the inspection in relation to governance arrangements, management of accidents and incidents, therapeutic activities, quality improvement and maintaining good staff working relationships.

There were no areas identified which require improvement.

Residents and their representatives who spoke with the inspector said they were very happy with the care provided. No issues or concerns were raised or indicated during the inspection.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Brenda Nesbitt, registered manager, 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.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the most recent inspection on 23 May 2018.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records: the previous inspection report, notifiable events, and written and verbal communication received since the previous care inspection.

During the inspection the inspector met with the registered manager, two senior care assistants, 17 residents, five staff, and three resident's representatives.

A total of 10 questionnaires were provided for distribution to residents and/or their representatives to enable them to share their views with RQIA. A poster was provided for staff detailing how they could complete an electronic questionnaire.

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

- Staff duty rota
- Staff induction programme
- Staff supervision and annual appraisal schedules
- Staff training schedule and training records
- Three residents' care files
- Minutes of staff meetings
- Minutes of residents meetings
- Complaints and compliments records
- Infection control policy
- Accident, incident, notifiable event records

- Audits, Annual Quality Review report
- Reports of visits by the registered provider
- Fire safety risk assessment (12 March 2018)
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- Programme of activities
- Policies and procedures

An inspection of the home was undertaken.

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 most recent inspection dated 23 May 2018

The most recent inspection of the home was an unannounced care inspection.

6.2 Review of areas for improvement from the last care inspection dated 23 May 2018

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

6.3 Inspection findings

6.4 Is care safe?

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

The registered manager advised that the staffing levels for the home were subject to regular review to ensure the assessed needs of the residents were met. Temporary/agency staff were/were not used in the home. Any turnover of staff was kept to minimum, where possible, and was monitored by the management of the home.

No concerns were raised regarding staffing levels during discussion with residents, residents' representatives and staff. A review of the duty rota confirmed that it accurately reflected the staff working within the home.

A review of completed induction records and discussion with the registered manager 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 annual appraisal of staff was regularly provided. Schedules and records of training, staff appraisals and supervision were reviewed during the inspection.

Discussion with the registered 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.

The registered manager advised that two new staff had been recruited since the previous care inspection and that recruitment was in accordance with Regulation 21 (1) (b), Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005. Records were not reviewed as these where retained within the organisation's personnel department.

The registered manager advised that Access NI enhanced disclosures was undertaken for all staff prior to the commencement of employment. Staff files reviewed confirmed that Access NI information was recorded and managed in line with best practice.

Arrangements were in place to monitor the registration status of staff with their professional body (where applicable). Care staff spoken with advised that they were registered with the Northern Ireland Social Care Council (NISCC). The key senior care assistant advised that records of the registration of staff were retained and closely monitored.

Discussion with the registered manager, review of accident and incidents notifications, care records and complaints records confirmed that no suspected, alleged or actual incidents of abuse had arisen since the previous care inspection.

The registered manager stated there were risk management procedures in place relating to the safety of individual residents and the home did not accommodate any individuals whose assessed needs could not be met. A review of care records identified that resident care needs and risk assessments were obtained from the trust prior to admission.

The registered manager advised there were restrictive practices within the home, notably the use of locked doors, keypad entry systems, lap belts on wheel chairs, CCTV at the front exit door and pressure alarm mats. The registered manager confirmed that the home was registered with Information Commissioners' Office (ICO) in respect of the CCTV. In the care records examined restrictions were appropriately documented.

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. Personal Protective Equipment (PPE), for example; disposable gloves and aprons, were available throughout the home. Observation of staff practice identified that staff adhered to IPC procedures. Discussion with staff established that they were knowledgeable and had understanding of IPC policies and 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 registered manager reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with trust/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 individualised with photographs, memorabilia and personal items. The home was fresh-smelling, clean and appropriately heated throughout.

Inspection of the internal environment identified that the home was 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. No malodours were detected in the home. Redecoration of the main hall was a work in progress. The flooring at reception and hall had been replaced alongside redecoration throughout the home. This reflects the continuous efforts made by the registered provider to maintain a high standard within the environment.

The registered manager advised that the home's policy, procedures and risk assessments relating to safe and healthy working practices continue to be appropriately maintained and reviewed regularly. For example; Control of Substances Hazardous to Health (COSHH); fire safety and moving and handling.

The home had an up to date fire risk assessment which was dated 12 March 2018. No recommendations for improvement were made. Fire safety records identified that fire-fighting equipment, fire alarm systems, emergency lighting and means of escape were checked weekly and/or monthly and were regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEP) in place.

Review of staff training records confirmed that staff completed fire safety training twice annually. Fire drills were completed on a regular basis and records reviewed confirmed these were up to date. The records also included the staff who participated and any learning outcomes.

Residents, staff, visiting professionals and residents' visitors/representatives spoken with during the inspection made the following comments:

- "I feel safe here, staff always about to see to us." (resident)
- "Good home, care is excellent, staff very attentive and professional." (relative)
- "We have adequate staff and really good training to meet the needs of our residents." (staff)

Three completed questionnaires were returned to RQIA from residents' relatives who indicated their level of satisfaction with this aspect of care as "very satisfied".
One relative commented "family and resident very happy with all aspects of care provided within Sunnymead. Also, very happy with the general surroundings and food. Communication with staff also very good – couldn't have a better place for a relative".

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

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

There was a records management policy in place which includes the arrangements for the creation, storage, maintenance and disposal of records. Records were stored safely and securely in line with General Data Protection Regulation (GDPR). Staff training in GDPR had been provided.

A review of three 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. Care needs assessment and risk assessments were reviewed and updated on a regular basis or as changes occurred. The registered manager explained that refresher training for senior staff in care records was scheduled to take place during December 2018. This would include needs assessments, risk assessments, person centred care planning and review alongside recording.

The care records reviewed 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. 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 as appropriate. An individual agreement setting out the terms of residency was in place and appropriately signed.

Discussion with staff confirmed that a person centred approach underpinned practice. Staff were able to describe in detail how the needs, choices and preferences of individual residents were met within the home. For example; residents participated in the development of their care plans to ensure that their views, choices and preferences were reflected.

A varied and nutritious diet was provided which met the individual and recorded dietary needs and preferences of the residents. A very nice ambience was present during the mid-day meal. Tables were nicely set with table cloths, range of condiments, napkins and range of drinks available. Meals, including special diets, were served by staff in a respectful unhurried manner. Residents were supervised and assisted, as required, throughout the meal. Adequate portions of food were served. Staff systems were in place to regularly record residents' weights and any significant changes in weight were responded to appropriately. There were arrangements in place to refer residents to dieticians and speech and language therapists (SALT) as required. Guidance and recommendations provided by dieticians and SALT were reflected within the individual resident's care plans and associated risk assessments.

Discussion with the registered manager and staff confirmed that wound care was managed by community nursing services. Staff advised that they were able to recognise and respond to pressure area damage observed on resident's skin and to make appropriate referrals to the multi-professional team in a timely manner. Resident's wound pain was found to be managed appropriately.

The registered manager advised that monitoring, audit and reviews the effectiveness and quality of care delivered to residents was ongoing. Audits of risk assessments, care plans, care review, accidents and incidents (including falls, outbreaks), complaints, environment were available for inspection and evidenced that any actions identified for improvement were incorporated into practice. Further evidence of audit was contained within the reports of the visits by the registered provider and the annual quality review report.

The registered manager advised 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. Staff reported that they had received training in communication/customer care. Minutes of staff meetings and residents were reviewed during the inspection. Minutes of meetings with ancillary staff were also in place.

Observation of practice evidenced that staff communicated effectively with residents. Discussion with the registered manager and staff confirmed that management operated an "open door" policy to everyone in regard to communication within the home.

There were also systems in place to ensure openness and transparency of communication, for example, the reports of monthly visits undertaken by the registered provider, RQIA inspection reports, annual satisfaction survey report were on display for residents, their representatives any other interested parties to read.

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 registered manager reported that arrangements were in place, in line with the legislation, to support and advocate for residents.

Residents, staff, visiting professionals and residents' representatives spoken with during the inspection made the following comments:

- "Food is very good with variety in choice always available." (resident)
- "Absolutely great care and attention to my mother and indeed all residents, staff are to be commended." (relative)
- "We are very well supported by the manager and the care is provided in keeping with care plans." (staff)

Three completed questionnaires were returned to RQIA from residents' relatives who indicated their level of satisfaction with this aspect of care as "very satisfied".

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 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.

A range of policies and procedures was in place which supported the delivery of compassionate care.

The registered manager advised 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.

The registered manager, residents and their representatives advised that consent was sought in relation to care and treatment. Discussion and observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff described their awareness of promoting residents' rights; independence and dignity for example; staff knock on resident's door before entering, residents and where appropriate their representative is involved in the development of their person centred care plans. Staff confirmed that confidentiality is protected in accordance with the home's policy.

Discussion with staff, residents and their representatives confirmed that residents' spiritual and cultural needs, were met within the home. Action was taken to manage any pain and discomfort in a timely and appropriate manner. This was further evidenced by the review of care records, for example, care plans were in place for the identification and management of pain, falls, infection, nutrition, where appropriate.

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 listened to, valued and communicated with in an appropriate manner and their views and opinions were taken into account in all matters affecting them. For example residents were encouraged and supported to actively participate in the annual reviews of their care. Other systems of communication included, residents' meetings, daily discussion and monthly visits by the registered provider.

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

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. Residents confirmed they had opportunity to participate in a wide range of therapeutic activities including; arts, crafts, musical activities and passive exercise. Arrangements were in place for residents to maintain links with their friends, families and wider

community. For example residents participated in arranged outings to various community events and local shopping. Therapeutic activities were organised and led by the home's activity coordinator who designs and displays the weekly timetable of daily organised events on notice boards throughout the home and, with permission from residents, within their bedrooms. Residents confirmed they looked forward to clergy who visit on a regular basis. One resident explained how pleased she was to have learned to croquet since she was admitted.

Records of activities provided were retained alongside those who participated.

Residents, staff, visiting professionals and residents' visitors/representatives spoken with during the inspection made the following comments:

- "I feel we are treated with dignity and respect by all staff, we are offered choice of what we want to do and I can have a cup of tea at any time day or night." (resident)
- "My mother would not want to move from this home where we believe the care is compassionate and second to none." (relative)
- "Staff work as a team here and strive to provide the best possible care which is great and I would never wish to work anywhere else."

Three completed questionnaires were returned to RQIA from residents' relatives who indicated their level of satisfaction with this aspect of care as "very satisfied".

Areas of good practice

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.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 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

On arrival at the home the key senior care assistant in charge welcomed the inspector to the home. The registered manager, who was off duty, came to the home at 12 midday. The registered manager continues to be supported by a deputy manager, senior care staff, care assistants, activity co-ordinator and cook and team of ancillary staff. The registered manager explained that agency staff are not currently commissioned as permanent or the home's employed bank staff provide cover as and when required.

Review of the staff duty roster evidenced correct number and grade of staff on duty on the day of inspection.

The registered manager outlined the management arrangements and governance systems in place within the home and stated that 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. The registered manager stated that 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 their representatives were made aware of how to make a complaint by way of the Resident's Guide and information displayed. Discussion with staff confirmed they were knowledgeable about how to respond to complaints. RQIA's complaint poster was displayed in the home.

Review of the complaints records confirmed that no complaints had been received since the previous care inspection. Arrangements were in place to share information about complaints and compliments with staff. .

The home retains compliments received, for example, many thank you letters and cards and there are systems in place to share these with staff.

There was an accident, incident and notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of these events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. Monitoring of accidents/incidents was undertaken by the Southern Health and Social Care Trust (SHSCT) who receive notification from the home of all incidents occurring. A regular audit of accidents and incidents was undertaken by the deputy manager home with records retained. The registered manager explained that the analysis of accidents/incidents was discussed at their monthly management meeting with the registered provider. These were not viewed during this inspection. The registered manager advised that learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice when required.

There was a system to ensure safety bulletins; serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

Discussion with the registered manager confirmed that information in regard to current best practice guidelines was made available to staff, for example; Department of Health (DoH) guidelines, Northern Ireland Social Care Council (NISCC) and Guidelines and Audit Implementation Network (GAIN). Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents including diabetes and dementia.

The registered manager explained that the registered provider is in the home every day and that monthly monitoring visits 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, RQIA and any other interested parties to read.

There was a clear organisational structure and staff who met with the inspector were aware of their roles, responsibility and accountability. This was outlined in the home's Statement of Purpose and Residents Guide.

The registered manager stated that the registered provider was kept informed regarding the day to day running of the home including daily discussions, telephone calls, emails and monthly management meetings.

Inspection of the premises confirmed that the current RQIA certificate of registration and employer's liability insurance certificate were displayed.

The home had a whistleblowing policy and procedure in place and discussion with staff confirmed that they were knowledgeable regarding this. The registered manager advised that staff could also access line management to raise concerns and that staff would be offered support.

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents.

Residents, staff, visiting professionals and residents' visitors/representatives spoken with during the inspection made the following comments:

- "We have an excellent team and manager who is always around seeing that residents are satisfied with the care provided and that staff are supported. She is very aware of all the residents needs and provides an open door to everyone." (staff)
- "The manager comes and speaks with me each day." (resident)
- "Absolutely no worries about my mother's care, she is much improved since coming here."

Three completed questionnaires were returned to RQIA from residents' relatives who indicated their level of satisfaction with this aspect of care as "very satisfied".

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

The Regulation and Quality Improvement Authority

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