

Unannounced Care Inspection Report

3 October 2016



Roxborough House

Type of service: Residential Care Home

Address: 2 Dungannon Road, Moy, Dungannon, BT71 7SN

Tel no: 02887784278

Inspector: Priscilla Clayton

www.rgia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Roxborough House took place on 3 October 2016 from 10.00 to 17.00 hours.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Staff were observed providing care in a safe way. For example moving and assisting residents with various activities and during meal times. There was good supporting evidence of prevention of infection through good hygiene practice.

Two recommendations made in this domain related firstly to the updating of staff training matrix to show dates and named staff in attendance and secondly the development of an individualised care plan which reflects the measures in place minimise the identified choking risk of one resident.

Is care effective?

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

One requirement made in this domain related to ensuring that each resident admitted through the intermediate care scheme has a comprehensive care plan in place. Two recommendations made related the undertaking an audit of risk assessments to ensure these are dated and signed. The recommencement of residents meetings is recommended to ensure that they are kept fully informed on the day to day running of the home and that their views, choices and preferences are sought and recorded. Circulation of minutes to residents is recommended.

Is care compassionate?

There were examples of good practice found in relation to the culture and ethos of the home, listening to and valuing residents and taking account of the views of residents as recorded within care records examined and observed staff interactions with residents during the inspection.

No requirements or recommendations were made in this domain.

Is the service well led?

There were examples of good practice found in relation to governance arrangements which included staff meetings, supervision, appraisal, service user involvement, communication through an "open door" approach to all and maintaining good working relationships within the team and other visiting professional staff.

One requirement made in this domain related to review and revision of the statement of purpose to include the name of the current registered provider / chief executive.

One restated requirement related to the availability of monthly monitoring reports made on behalf of the registered provider / chief executive.

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	3	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Marie Gorman and Ann Nesbitt, senior care assistants, 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 on 29/04/16

Other than those actions recorded within the QIP no further action has been taken.

2.0 Service details

Registered organization /registered person: Southern Health and Social Care Trust (SHSCT)	Registered manager: Lucia Donnelly.
Person in charge of the home at the time of inspection: am – Ann Nesbitt, senior care assistant. 2pm – Marie Gorman, senior care assistant.	Date manager registered: 5 October 2010.
Categories of care: I - Old age not falling within any other category DE – Dementia LD - Learning Disability	Number of registered places: 30

3.0 Methods/processes

The following records were examined during the inspection:

- Staff duty rota
- Induction programme for new staff
- Staff supervision and annual appraisal schedule

- Sample of competency and capability assessments
- Staff training schedule/records
- Three resident's care files
- The home's Statement of Purpose and Residents' Guide
- Minutes of recent staff meetings
- Complaints and compliments 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 reports available.
- Programme of activities
- Policies and procedures

A total of 22 questionnaires were provided for distribution to residents, their relatives / representatives and staff for completion and return to RQIA. Eight questionnaires were completed and returned to RQIA within the requested timescale.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 29/04/16

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 29/04/16

Last care inspection statutory requirements		Validation of compliance
Requirement 1 Ref: Regulation 29 (5) Stated: First time To be completed by: 31 May 2016	The registered person shall ensure that monthly monitoring reports are retained in the home and made available on request to – RQIA, the registered manager, the resident or representative; and an officer of the HSS Trust. The reports should reflect any staffing issues, review of accidents/incidents and interviews with relatives/representatives.	Not Met
	Action taken as confirmed during the inspection: Examination of reports retained in the home showed that the last monthly monitoring report available was dated April 2016. Reports examined reflected staffing, accidents / incidents and views of residents and staff. (During the inspection reports dated May, June	

	<p>and July were e-mailed to the home following a request from administrator. No reports for August or September 2016 were included.)</p> <p>This requirement has been stated for a second time.</p>	
Last care inspection recommendations		Validation of compliance
<p>Recommendation 1</p> <p>Ref: Standard 16.1</p> <p>Stated: First time</p> <p>To be completed by: 31 July 2016</p>	<p>The registered manager should undertake a review and revision of the Adult Safeguarding Policy is undertaken to ensure systems and processes are in keeping with the Department of Health, Social Services and Public Safety (DHSSPS) Adult Safeguarding policy; Prevention and Protection in Partnership (July 2015) are in place. The identification of a Safeguarding Champion is required. Staff training is necessary so that staff are informed of best practice including the role and function of the safeguarding champion.</p>	Met
	<p>Action taken as confirmed during the inspection:</p> <p>The home has adapted the new DHSSPS policy and staff training provided.</p> <p>The senior care assistant confirmed that the identification of a named adult safeguarding champion has not yet been identified.</p>	
<p>Recommendation 2</p> <p>Ref: Standard 21.1</p> <p>Stated: First time</p> <p>To be completed by: 30 June 2016</p>	<p>Several policies and procedures held in hard copy format and did not match those held electronically on computer. This was considered to be unsafe due to the potential for confusion among staff. Review of all hard copies of policies and procedures to ensure these match with those held electronically is necessary.</p>	Met
	<p>Action taken as confirmed during the inspection:</p> <p>Discussion with the senior care assistant and review of a random selection of policies and procedures evidenced that review had taken place.</p>	
<p>Recommendation 3</p> <p>Ref: Standard 1.4</p> <p>Stated: First time</p> <p>To be completed by: 30 June 2016</p>	<p>The registered person should review the uniforms worn by all staff who wore the same style and colour of uniform. Confusion arose for some residents in knowing who to speak with if they wanted advice or had any issues or concerns as.</p>	Met
	<p>Action taken as confirmed during the inspection:</p> <p>Observation of staff and discussion with residents and staff confirmed that new uniforms had been provided making the identification of staff easier for residents / relatives / representatives.</p>	

4.3 Is care safe?

The senior care assistant in charge of the home confirmed the staffing levels were satisfactory to meet the assessed needs of residents accommodated and that staffing levels were subject to regular review. On the day of inspection three staff, consisting of one senior and two care workers were on duty to meet the needs of 18 residents. Care staff commented that the home can be very busy at times with two care staff on duty. This was discussed with the senior care staff who assured the inspector that service users' needs were always met and if additional staff was required this would be provided.

No issues or concerns were raised regarding staffing levels during discussion with residents or within returned satisfaction questionnaires from relatives / representatives, staff and residents.

Discussion with staff and a review of returned staff questionnaires confirmed that staffing was satisfactory and that mandatory training and appraisal of staff was provided.

Staff demonstrated knowledgeable and 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 adult safeguarding training was provided for all staff on 22 September 2016 with a second date planned for 26 October 2016. The senior care assistant confirmed that other mandatory training was provided although this was not fully reflected in matrix records provided. One recommendation was made in regard to updating the record of staff training provided in the central matrix.

Discussion with the senior care assistant, review of accident and incidents notifications, care records and complaints records confirmed that these were appropriately recorded and managed in accordance with policies / procedures in place. No complaints or safeguarding allegations had been reported or recorded since the previous inspection.

The senior care assistant confirmed there were risk management procedures in place relating to the safety of individual residents, for example; moving and handling, dysphasia and falls risk. Discussion with the senior care assistant and staff identified that the home did not admit any individuals whose assessed needs could not be met or were not within the registered categories of care.

Review of care records identified that individual care needs assessments and risk assessments were obtained prior to admission. Care needs assessment and risk assessments were being reviewed and updated on a regular basis or as changes occurred.

The recent choking incidents recorded within incident records were discussed with the two senior care assistants. Whilst it was acknowledged that the speech and language therapist had undertaken risk assessment and made recommendations on their assessment template there was no specific care plan in place which reflected the identified choking risk and measures in place to minimise the risk; including recommendations made or level of staff supervision required at meal or snack times. Reference to the speech and language therapist assessment was recorded at the bottom of a care plan dated 31 October 2013. One recommendation was made in regard to the development of an individualised care plan for the identified resident with a choking risk to ensure all measures necessary to minimise the identified choking risk is recorded and known by staff.

The senior care assistant and staff confirmed there were no restrictive practices employed within the home. This was confirmed during observation of care practice and inspection of the environment.

The senior care assistant confirmed there was a risk management policy and procedures in place. Review of the home's policy and procedures relating to safe and healthy working practices confirmed that these were appropriately maintained and reviewed regularly, for example; Control of Substances Hazardous to Health (COSHH) and fire safety.

Staff training records examined confirmed that all staff had received training in Infection Prevention and Control (IPC) in line with their roles and responsibilities. A pre-arranged staff training session on infection prevention and control was held on 23 February 2015. 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 where care was delivered. Observation of staff practice identified that staff adhered to IPC procedures.

Hand hygiene was a priority in regard to prevention of cross contamination of infection with efforts applied to promoting good standards of hand hygiene among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

The senior care assistant confirmed that there had been no outbreaks of infection since the previous inspection and that any outbreak would be managed in accordance with the homes policy and procedures, reported to the Public Health Agency, the commissioning trust and RQIA with appropriate records retained.

A general inspection of the home was undertaken. The residents' bedrooms were found to be personalised with photographs, memorabilia and personal items. All areas within the home were clean, organised, fresh smelling and appropriately heated.

Inspection of the internal and immediate 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.

The home had a current fire risk assessment. Review of staff training records confirmed that staff completed fire safety training twice annually.

The most recent fire drill was completed on 29 July 2016. Fire safety records identified that fire-fighting equipment; fire alarm systems, emergency lighting and means of escape were checked weekly and were regularly maintained.

Eight completed questionnaires were completed and returned to RQIA from residents, resident's representatives and staff. Positive responses were received in the safe care domain.

One representative commented:

- Staff are always at hand and they are very approachable and good at their job
- I am completely satisfied that my mother is safe in their care

Areas for improvement

Two recommendations made for improvement within this domain related firstly to the updating of staff training matrix to show dates and staff attendance at training provided and secondly the development of an individualised care plan which clearly reflects the measures in place to minimise the choking risk of one resident.

Number of requirements	0	Number of recommendations	2
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4.4 Is care effective?

Discussion with the senior care assistant established that staff would always respond appropriately to residents and can meet their assessed needs.

An inspection of three care records of residents admitted under the intermediate care scheme was undertaken. Areas identified for improvement related to ensuring individualised holistic plans are developed for all residents admitted under the trust intermediate care scheme in accordance with regulation 16 (1) (2) of The Residential Care Homes Regulations (Northern Ireland) 2005 and standard 6 of The Residential Care Homes Minimum Standards (2011). One recommendation was also made in regard to the undertaking of an audit of risk assessments in place to ensure these are dated and signed as it was noted that this detail was not recorded in one fall risk assessment examined.

Examination of care records of permanent residents accommodated showed that these contained comprehensive needs assessments, care plans, reviews and progress notes. There was evidence of good multi-professional collaboration in planned care.

The senior care assistant confirmed that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included for example, pre-admission information including distribution of the service user guide, issue of service user agreements, multi-professional team reviews, residents' meetings held during 2015 and staff shift handovers. Staff confirmed that the manager operated an "open door" approach in regard to communication within the home.

One recommendation made related to the recommencement of residents meetings to ensure they were consulted and kept fully informed on the day to day arrangements and their views and preferences sought. Staff confirmed it had been some time since the last meeting was held. Minutes held showed the last meeting was held on 15 November 2015.

Records available in the home showed the staff meetings were held on a three monthly basis or more frequently as required. Minutes were recorded which included staff in attendance.

Residents spoken with and observation of practice evidenced that staff communicated effectively with residents, their representatives and other key stakeholders.

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.

Eight completed questionnaires were returned to RQIA from residents, representatives and staff. Questionnaires reflected positive responses in relation to the domain of effective care. No issues or concerns were indicated.

One resident's representative commented in a questionnaire:

- "Care is effective and staff are quick to inform me and the GP when needed"
- "My relative is thriving in this home"

Areas for improvement

One requirement made in the effective care domain related to ensuring that residents admitted through the intermediate care scheme has a holistic care plan in place. Two recommendations made related firstly to the undertaking an audit of risk assessments to ensure these are dated and signed and secondly to the recommencement of residents' meetings.

Number of requirements	1	Number of recommendations	2
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4.5 Is care compassionate?

The senior care assistant confirmed that there was a culture/ethos within the home that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents. These values were reflected within care records examined, residents guide and statement of purpose.

There were a range of policies and procedures in place which supported the delivery of compassionate care. Discussion with staff and residents confirmed that residents' spiritual and cultural needs were being met.

Staff and residents confirmed that each resident's consent was always sought in relation to care and treatment to be provided. Observation of care practice and staff interactions demonstrated that residents were treated with dignity and respect in this regard. Staff confirmed their awareness of promoting residents' rights, independence and dignity.

The senior care assistant and staff confirmed that residents were listened to, valued and communicated with in an appropriate manner. 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 relatives were sought through daily interactions / discussions, care reviews and monthly monitoring visits. Recommencement of residents' meetings was recommended within section 4.3 of this report as minutes showed last meeting was held on 15 November 2015.

Residents confirmed that their views and opinions were taken into account in all matters affecting them and that they would not hesitate to inform the manager if they were dissatisfied with anything.

Eight completed questionnaires were returned to RQIA from residents, resident's representatives and staff. These reflected positive responses in relation to the domain of compassionate care.

Comments recorded within satisfaction questionnaires by respondents included:

- “Very caring staff, religious support available”
- “Compassionate staff, always happy and pleasant”
- “Exceptional care tailored to all needs”
- “Staff treat all service users with respect and ensure privacy is afforded to them”

Examples of comments made by residents included:

- “Everything is very good, no complaints from me”.
- “I like it here, everybody is friendly”.
- “I have everything I need, couldn’t ask for anymore”.

Areas for improvement

No areas for improvement were identified within this domain.

Number of requirements	0	Number of recommendations	0
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4.6 Is the service well led?

The Lucia Donnelly, registered manager of the home was off duty on the day of inspection. Ann Nesbitt, senior care assistant was in charge of the home during the morning shift and Marie Gorman, senior care assistant was in charge during the afternoon. Both staff had been deemed competent and capable to undertake this role and responsibility by the registered manager as reflected within recorded assessments undertaken.

The home’s current RQIA certificate of registration was displayed in a prominent position.

There was a clear organisational structure and staff on duty, including two care assistants, domestic and kitchen staff demonstrated awareness of their roles, responsibility and accountability.

The home’s statement of purpose and resident guide were available. One requirement made related to review and revision of the statement of purpose to ensure that the name of the current trust registered provider / chief executive is reflected.

The senior care assistants confirmed that the health and social care needs of residents were being met in accordance with the home’s statement of purpose and the categories of care for which the home was registered with RQIA.

A range of policies and procedures were in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff. Policies and procedures had been systematically reviewed recently to ensure that those held in hard copy matched those held electronically.

Residents confirmed they were aware of how to make a complaint by way of the residents guide and information displayed within the home. Discussion with staff confirmed that they were

knowledgeable about how to receive and deal with complaints. The senior care assistant confirmed that no complaints or safeguarding matters were reported since the previous inspection. Records examined confirmed none were received.

A review of accidents/incidents/notifiable events confirmed that these were documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures.

The senior care assistant confirmed that the home had introduced the use of the falls prevention toolkit. Risks and measures in place to minimise fall risks were reflected within care plans examined.

Review of records and discussion with the senior care assistant confirmed that no adult safeguarding issues had arisen since the previous inspection and explained the procedure if any had been alleged.

The home had a whistleblowing policy and procedure. Discussion with staff established that they were knowledgeable regarding the policy and procedure. Discussion with staff also confirmed that there were good team working relationships and that the manager was responsive to suggestions and/or concerns raised. There were also open and transparent methods of working and effective working relationships with internal and external stakeholder.

Audits of accidents were recorded and discussed with the senior care assistant. Trends and patterns were identified and where necessary action taken. For example, falls reflected in accordance with the toolkit with action recorded, monitored and reviewed as reflected within care records.

Eight completed questionnaires were returned to RQIA from residents, resident's representatives and staff. Responses reflected positive views in relation to the domain of well led care.

Comments recorded within returned questionnaires included:

- "Staff are knowledgeable and experienced"
- "Staff work together to provide a friendly, specialised and excellent service for all"
- "As a relative I get any information regarding my (relative)"
- "The manager is approachable at all times"
- "Staff are approachable and caring"

Areas for improvement

One requirement made in this domain related to review and revision of the statement of purpose to include the name of the current registered provider / chief executive.

Number of requirements	1	Number of recommendations	0
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ann Nesbitt and Marie Gorman, senior care assistants, 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 to care.team@rqia.org.uk 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 29 (5)

Stated: First time

To be completed by:
30 October 2016

The registered person shall ensure that monthly monitoring reports are retained in the home and made available on request to – RQIA, the registered manager, the resident or representative; and an officer of the HSS Trust.

The reports should reflect any staffing issues, review of accidents/incidents and interviews with relatives/representatives.

(Restated for a second time)

Response by registered provider detailing the actions taken:

An action plan has been put in place by the Head of Service to ensure that there are no further compliance issues with Regulation 29 (5). The registered manager can confirm that monthly monitoring reports are now up to date and are available in the home. The reports reflect staffing issues, review of accidents and incidents and interviews with residents relatives and representatives.

Requirement 2

Ref: Regulation 16 (1) (2)

Stated: First time

To be completed by:
13 October 2016

The registered provider shall ensure that all residents admitted under the intermediate care scheme has an individualised care plan developed in accordance with the this regulation and standard 6 of The Residential Care Homes Minimum Standards (2011)

Response by registered provider detailing the actions taken:

The Registered Manager can confirm that she has put in place a new individualised Care Plan document for all residents including those admitted under the ICS Scheme and this has been developed in accordance with Regulation 16 (1) (2) and standard 6 of The Residential Care Homes Minimum Standards (2011)

Requirement 3

Ref: Regulation 3 Sch 1 1

Stated: First time

To be completed by:
30 October 2016

The registered provider shall ensure that review and revision of the statement of purpose is undertaken to ensure the name of the current trust registered provider / chief executive is reflected.

A copy of the amended statement of purpose should be forwarded to RQIA with the return of the QIP.

Response by registered provider detailing the actions taken:

The statement of purpose has been amended in October 2016 and in compliance with Regulation 3 has been updated with the name of the interim Chief Executive. A Copy of the updated version will be forwarded to RQIA with this QIP.

Recommendations	
Recommendation 1 Ref: Standard 23.6 Stated: First time To be completed by: 30 October 2016	The registered provider should update the staff training provided in the central staff training matrix.
	Response by registered provider detailing the actions taken: Training attended by staff has been recorded in the training matrix.

Recommendations	
Recommendation 2 Ref: Standard 20.10 Stated: First time To be completed by: 20 November 2016	The registered provider should ensure that an audit of risk assessments is undertaken to ensure these are dated and signed in accordance with good professional practice.
	Response by registered provider detailing the actions taken: Risk assessments are being audited, updated, signed and dated in accordance with Standard 20.10.
Recommendation 3 Ref: Standard 1.2 Stated: First time To be completed by: 30 November 2016	The registered provider should ensure that residents meetings recommence with minutes recorded and circulated to residents.
	Response by registered provider detailing the actions taken: The Registered manager can confirm that Minutes of residents meetings are in place, have been circulated to residents and dates of future meetings have been prepared, circulated and are available in advance for all residents.
Recommendation 4 Ref: Standard 6.6 Stated: First time To be completed by: 4 October 2016	The registered provider should ensure that the care plan of one resident at risk of choking fully reflects the measures in place to minimise the identified risk, including recommendations made by the speech and language therapist and the level of staff supervision required at meal and snack times.
	Response by registered provider detailing the actions taken: The identified residents Care Plan has been reviewed and amended to reflect the measures in place to minimise the risk of choking and includes the recommendations made by the speech and language therapist.

Please ensure this document is completed in full and returned to care.team@rqia.org.uk from the authorised email address



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