Unannounced Care Inspection Report
27 February 2019

Slieve Roe House

Type of Service: Residential Care Home
Address: Manse Road, Kilkeel BT34 4BN
Tel No: 028 4176 3760
Inspector: Alice McTavish

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 with 17 beds that provides care for older people and for people living with dementia.

3.0 Service details

Organisation/Registered Provider: Southern HSC Trust **Responsible Individual:** Shane Devlin	**Registered Manager:** Hylda Patterson
Person in charge at the time of inspection: Hylda Patterson	**Date manager registered:** Hylda Patterson - application received - “registration pending”
Categories of care: **Residential Care (RC)** I - Old age not falling within any other category DE – Dementia	**Number of registered places:** 17 RC-DE for 5 existing residents. RQIA to be notified of any requests for further admissions of residents with dementia.

4.0 Inspection summary

An unannounced care inspection took place on 27 February 2019 from 10.25 to 14.10.

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 sought only to review care records and to examine the home’s environment.

Evidence of good practice was found in relation to care records and the standard of comfort and cleanliness in the home.

No areas requiring improvement were identified.

Residents and their representatives spoke in very positive terms about the quality of the care provided in Slieve Roe House.

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 Hylda Patterson, 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 21 September 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 any written and verbal communication received since the previous care inspection.

During the inspection the inspector met with the manager, two staff, a visiting professional and two residents' representatives.

RQIA involves service users and members of the public as volunteer lay assessors. A lay assessor is a member of the public who will bring their own experience, fresh insight and a public focus to our inspections. A lay assessor was present during this inspection and met with six residents. The comments provided to the lay assessor are included within this report along with a summary of observations made by the lay assessor.

A total of 10 questionnaires was 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. One questionnaire was returned by a resident's representative and three questionnaires were returned by staff within the agreed timescale.

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

- care files of two residents

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 21 September 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 21 September 2018

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

6.3 Inspection findings

Care records

The care files for each resident were stored securely. Any changes or updates to the care records were completed in the staff offices and this ensured confidentiality.

A review of the care records confirmed that these were maintained in line with the legislation and standards. The records were written in a professional manner using language which was respectful to the individual. The files contained pre-admission information which allowed staff to become familiar with the specific needs of each individual and to make preparations to meet these needs in the home.

Staff in the home completed care needs assessments, risk assessments and care plans for each resident. The risk assessments covered such areas as moving and handling, choking, nutrition, falls and skin condition, where necessary. The care plans provided staff with guidance as to how the identified needs should be met and how any risks present could be minimised. The care documentation was completed in detail and with a focus on individualised, person-centred care.

All documents were kept up to date, regularly reviewed and appropriately signed and dated. The care plans noted consent and integrated Human Rights considerations throughout. This represented good practice.

Multi-professional involvement in the residents' health and social care needs was documented where necessary and this was kept up to date to accurately reflect any changes. The care records noted visits from General Practitioners (GPs), community nursing, dieticians, speech and language therapists and other associated professionals.

Residents were weighed regularly and any significant weight loss was appropriately referred to the residents' GPs; care staff reported that there was good communication between care and catering staff to ensure that any residents at risk of losing weight were provided with an enriched diet.

There were regular reviews of the care provided in the home which were attended by all relevant parties. Staff in the home completed a care review preparation report; this was completed in a high level of detail and demonstrated that staff were very familiar with the care needs of individual residents. The individual written agreements were up to date and accurate.

There was a system in place to audit care files regularly to ensure that all documentation was complete, up to date and accurate. This helped to ensure that any changing needs were comprehensively recorded and acted upon.

It was noted that there had been discussion between a resident and the resident's GP in regard to the arrangements for resuscitation. There was a brief note of this in the resident's care file but the signature was not clear and it was not obvious that a signature belonged to a GP. This was discussed with the manager who acknowledged that a more formal record would be useful, especially in an emergency situation. The manager later confirmed that the GP had been asked to record this arrangement on an official form which was clearly signed.

It was evident that there were systems in place to ensure that written and verbal information was accurately and comprehensively recorded. This supported the delivery of safe and effective care whilst also supporting person-centred, compassionate care to the individual residents. It was also evident that the manager ensured that care records were maintained to a good standard and that care in the home was well led.

The home's environment

A general inspection of the home was undertaken. All communal areas, bedrooms and bathrooms were found to be clean, warm, comfortably furnished and well decorated. The residents' bedrooms were individualised with photographs, memorabilia and personal items. There were no malodours. 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.

Residents who spoke with the lay assessor during the inspection made the following comments:

- "I am very happy here and I have no more of the stresses that I had when I was living alone in my own home. I have no worries now. I feel safe, I get the help that I need and the food is excellent. I can watch TV when I want, I get the newspapers and I get to go out for walks or outings. I get visits from my family. I enjoy life now!"
- "If you travelled the whole of the north of Ireland, you wouldn't find a better place!"
- "This place is great, absolutely wonderful. The staff take me out into the town and I love to do things like flower arranging."
- "I need staff to help me to walk and they are there for me. The food is excellent, too."

Residents' representatives spoken with during the inspection made the following comments:

- "The care here is fantastic! My (relative) is very happy and gets on well with all the staff. They treat him very well and keep his spirits up. We visit very regularly and we can see how the staff treat him and all the other residents. It doesn't feel like coming into a care home, it feels like coming into a family home – there's a lovely warmth and a great atmosphere. We are very happy with the care and, most importantly, he is happy – and he would soon let us know if he wasn't happy."
- "My experience of Slieve Roe has been excellent from day one. The care given to my (relative) has been wonderful and I have found all of the staff to have been very supportive towards my (relative). This has been a fantastic experience. We are so lucky to have such a facility on our doorstep. I would recommend this place to anyone, and would even consider it for myself, if I need a care home in future."

A visiting professional spoken with during the inspection made the following comments:

- "The care here is excellent. The staff are well trained and know their jobs. They keep a good line of communication with the community nursing services and they let us know if

they have any concerns about the residents. Because of this we have been able to work with the staff to prevent any deterioration, for example, to residents' skin, and we get all of the correct equipment, if is needed. The staff know the residents very well – they can recognise at an early stage is something isn't right. All the residents seem to be happy here. I also know this as I had a (relative) who lived here and she loved it."

One completed questionnaire was returned to RQIA from a resident' representative and three questionnaires were returned by staff. Respondents described their level of satisfaction with this all aspects of care as satisfied or very satisfied.

A comment received from a resident's representative was as follows:

- "All very satisfactory"

Comments received from staff were as follows:

- "All satisfactory."
- "All residents are treated with respect, dignity and empathy at all times. Slieve Roe is very well managed and both staff and residents are very happy within the home environment."

The lay assessor reported the following:

- "I noted several staff sitting with and giving comfort to residents…the resident felt the staff listened to their problems and sorted them out quickly. One particular member of staff was in demand and residents spoke highly of her and of the manager. Residents reported that, even at night, staff are attentive to the residents, for example, if a resident felt unwell the staff will provide hot milk or hot chocolate to help them sleep; staff sit with them to hear any worries or stresses they might have. The atmosphere in the home is excellent, visitors are treated like one of the family."

Areas of good practice

Good practice was identified in relation to the integration of Human Rights considerations within care records.

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.

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