Unannounced Care Inspection Report
30 December 2019

Glenowen Court

Type of Service: Residential Care Home
Address: 177a Andersonstown Road, Belfast, BT11 9EA
Tel No: 028 9060 2898
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.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for

2.0 Profile of service

This is a registered residential care home which provides care for up to 44 residents. Inspector to adjust/delete as required: The home is divided into four units each containing 11 beds.

3.0 Service details

Organisation/Registered Provider: Radius Housing Association **Responsible Individual:** Fiona McAnespie	**Registered Manager and date registered:** Siobhan Savage 2 November 2015
Person in charge at the time of inspection: Siobhan Savage	**Number of registered places:** 44 A maximum of : RC-DE 10, RC-LD/LD (E) 5, RC-SI 2, RC-MP/MP (E) 3
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia LD - Learning Disability LD (E) – Learning disability – over 65 years SI – Sensory impairment. MP - Mental disorder excluding learning disability or dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years PH (E) - Physical disability other than sensory impairment – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 42

4.0 Inspection summary

An unannounced inspection took place on 30 December 2019 from 09:30 hours to 16.00 hours.

This inspection was undertaken by the care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found throughout the inspection in relation to the home's open culture where staff ensure that residents' human rights are upheld and are treated with dignity and respect. Systems were in place for the delivery of safe care by way of staff training, effective modes of communication with residents, their representatives, staff and other stakeholders.

Areas identified for improvement included; review of one resident's care plan, ensure compliance with GDPR and recording of full details within complaints records.

Residents described living in the home as being a good experience/in positive terms. Residents unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others/ with staff.

Comments received from residents, people who visit them and staff during and after the inspection, are included in the main body of this report.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Siobhan Savage, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent inspection dated 18 October 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 18 October 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included registration information, and any other written or verbal information received, for example serious adverse incidents.

During our inspection we:

- where possible, speak with residents, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

Five completed resident / representative questionnaires were returned to RQIA within the timescale.

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

- staff duty rotas from 23 December to 30 December 2019
- staff training schedule and training records
- three residents' records of care
- complaint records
- compliment records
- governance audits/records
- accident/incident records
- monthly monitoring reports dated October 2019 and November 2019
- RQIA registration certificate

Areas for improvements identified at the last care inspection were reviewed and assessment of compliance recorded as met.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 18 October 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 6.3 **Stated:** First time	The registered person shall ensure that the resident or their representative, where appropriate, sign the care plan along with the member of staff responsible for drawing it up and the registered manager. If the resident or their representative is unable to sign or chooses not to sign, this is recorded.	**Met**
	Action taken as confirmed during the inspection: Review of three care plans evidenced signatures.	

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

6.2 Inspection findings

6.3 Is care safe?

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

On arrival at the home we observed that several residents were up washed and dressed and having breakfast. Residents were appropriately clothed with obvious care and attention given to their personal care needs. Care staff were attending and assisting other residents with their personal care needs. The senior care assistants were in the process of administering medication to residents.

As the morning progressed we observed staff assisting and supervising residents' to have breakfast in the dining room, on each of the three floors, for residents who by choice choose to get up later in the morning.

Call bells were being answered promptly by staff. The atmosphere within the home was considered to be calm, warm and comfortable with staff attending to residents in a friendly, caring manner.

We spoke with several residents who told us they felt safe in the home and that staff were always readily available to assist them day or night when required.

Discussion with the manager and staff on duty confirmed that staffing levels were meeting the needs of residents accommodated and should additional staff ever be required this would be addressed by way of the use of bank or agency staff. Staff explained that at times when staff are needed to replace staff at short notice and bank / agency cannot provide they have to rearrange the scheduled activity plans in discussion with their residents.

The manager explained that staffing levels were determined in accordance with the number of residents accommodated, dependency levels and fire safety arrangements. The staff duty roster reviewed accurately reflected current care staffing levels. Rotas were also in place for ancillary staff on duty each day.

Competency and capability assessments were in place for senior care staff in charge of the home when the manager is off duty. The manager confirmed that staff in charge were deemed competent in taking charge of the home in her absence.

The manager explained that staff recruitment and selection files were retained at the organisations head office and that all appointments made were in accordance with Regulation 21 (1) (b) Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005. The manager advised that AccessNI enhanced disclosures was undertaken for all staff prior to commencing employment.

The manager explained the arrangements were in place to monitor the registration status of staff with the Northern Ireland Social Care Council (NISCC) which includes five yearly registrations alongside recurring annual retention.

A review of staff training records was undertaken and confirmed that mandatory training was being provided as required. Additional professional development training was also provided to support in their roles. Staff told us they were provided with a wide range of training which enabled them to keep up to date and ensure their residents receive good care in accordance with person centred care plans.

The home retains a current policy / procedure on adult safeguarding which was readily available to staff. The manager confirmed that she works closely with the commissioning trust in relation to adult safeguarding and should an allegation be reported or witnessed immediate contact was made with the safeguarding team and records completed. Staff who spoke with us demonstrated good knowledge and understanding of the principles of adult safeguarding and knew what action to if an allegation or actual abuse arose. One reported safeguarding closed incident was discussed with the manager and records reviewed evidenced correct procedure was followed including the development of an action plan.

The manager explained that the organisation's adult safeguarding champion's position statement was a work in progress for 2019.

The manager explained that the management of fall included the use of an adapted "falls toolkit" to enable proactive management including identification of trends and patterns with measures in place to minimise the identified risk. Referrals were made to the commissioning trust falls clinic so that a comprehensive multi- professional assessment can be undertaken and care planned to meet recommendations made.

Restrictive practices within the home was discussed with the manager who explained that these included; locked doors, wheel chair lap straps and management of smoking materials and that these had been agreed with the commissioning trust, resident / representative. Restrictions were reflected within care records and reported to be in the residents' best interest for the safety of their health and safety. The manager advised that care staff training in The Mental Health Capacity Act –Deprivation of Liberty (DoLS) was currently being sourced by senior management.

An inspection of the home was undertaken. All areas were observed to be exceptionally clean, tidy, organised and fresh smelling. Wash rooms including wash hand basins, taps, showers and baths were clean. Seven steps pictorial wash hand notices were displayed in all wash rooms. Staff told us they had received training in infection, prevention and control and that they have all the necessary resources to minimise the risk of infection.

The home was comfortably heated with good lighting and adequate ventilation. All furnishings viewed were of a good standard. Bedrooms were appropriately furnished with items of personal memorabilia displayed. Fire doors were closed and fire exits unobstructed. The home's fire risk assessment was dated November 2019. Various dates were provided for staff training in fire safety to ensure all staff receives twice yearly.

Three relatives who spoke with us during the inspection stated they were very satisfied with the care. Some comments included:

"We can leave here knowing our relative is safe"
"The home is always very clean and tidy"
"I have a really good feeling about here"
"Always staff around seeing to residents"

Comment from residents included:

“I like it here, this is my home now”
“I wouldn’t want to move from here”
“The home is always kept clean and tidy, not just because you are here today”

Five satisfaction questionnaires from residents / representatives were completed and returned to RQIA. Respondents indicated they were very satisfied that the care provided within the home was safe.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, 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 in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.4 Is care effective?

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

Three care records were provided for review and discussion with the senior care assistant and manager. Individual care records were retained within an EpiCare electronic system and also in hard copy format. Records retained included life histories which provided staff with information which helps them to understand the resident; their background, interests, likes, dislikes, hobbies and who and what is important to them. Comprehensive assessments were complemented with a range of risk assessments, person centred care plans were developed and daily progress notes recorded. Annual care reviews reports were retained. Care records reflected multi-professional collaboration into the residents’ health and social care needs. One area discussed with the manager and staff related to the care plan of a resident identified to be at risk of choking and include the level of staff supervision necessary at meal and snack times.

One area discussed with the manager related to the pre-admission template title; Supported Living / Housing with Care which is inappropriate as the home is registered as a residential care home. The manager readily agreed to review and discuss this matter with her line manager.

We saw and staff confirmed that a person centred approach underpinned practice. They were able to describe in detail how residents’ needs, choices and preferences of individual residents were met. For example, what time they liked to retire to bed at night and get up each day, where they choose to sit in the dining room and their choice of clothes they wanted to wear.

Staff told us how the routine of the home commenced each morning with the shift hand over report given by the night staff. The allocation of work for the day was presented by the senior care staff with the allocation of care staff to each unit including the associated care duties to be provided as per care plans and scheduled activities for the day discussed. In addition a safety brief meeting was held each morning at 11.30 hours to provide feedback on the care provided, any issues arising or changes required to ensure the care prescribed in care plans was effective. This practice is to be commended.

Records of accidents / incidents retained were discussed with the manager and cross referenced with notifications submitted to RQIA. Accidents recorded had been appropriately managed with action taken to minimise recurrence. Audits of accidents / incidents were undertaken by the manager to address any trends or patterns identified.

The manager explained that an adapted form of the "Falls Toolkit" was used with post falls management conducted and recorded. Care plans reviewed reflected risk assessments including, falls, moving and handling, nutritional and choking with interventions recorded to minimise risks identified. One area of improvement related to ensuring that the level of staff supervision at meal and snack times is included within care plan interventions of one resident at risk of choking.

Systems were in place for monitoring the frequency of residents health screening; dental, optometry, podiatry and other health or social care services appointments and referrals are made, if necessary to the appropriate service. Records were retained in this regard.

We could see from review of selected records provided, along with accident / incident reports that referral to other health and social care professionals was timely and responsive the needs of residents.

The manager explained that when a resident requires nursing intervention/s, for example; administration of injections, wound care then referral to the district nursing service would be made. The district nurse would also be involved if a resident was waiting for an alternative placement within a nursing home when a comprehensive nursing assessment would be undertaken and nursing care plan developed and agreed with the resident / representative. The district nurse subsequently becomes accountable and responsible for the prescribed care to ensure the needs of the resident were being met with regular monitoring visits undertaken.

Discussion with the manager and staff 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 care reviews, residents meetings, staff meetings and staff hand-over reports presented at each staff shift change.

Throughout the inspection we observed that staff were attentive, listening to residents and respectfully attending to their requests for assistance in a timely manner.

Minutes of staff meetings held during August 2019, May 2019 and February 2019 contained a lengthy agenda of topics including; residents' dietary needs, accidents / incidents, general data protection regulations, complaints management update, dysphasia policy and IPC audit update.

Minutes of residents meetings were also held on a regular basis with minutes recorded. Minutes dated October 2019, July 2019 and April 2019 were reviewed and evidenced discussions including communications, how to complain, and medications, outcome of audits and provision of therapeutic activity.

When we spoke with staff they had a good knowledge of peoples' abilities and level of decision making; staff know how and when to provide comfort to people because they knew residents needs well. They said they had a good team who work well together, were well trained and had the necessary resources to ensure residents receive effective care.

During the inspection we spoke with three visitors, three staff and eight residents individually and with other small groups of residents as they sat socialising in the lounge. Some comments made included;

"I like here and I think the care I get is second to none. Plenty to see and people to talk to" (resident)
"Our relative had no difficulty settling in here, everyone was really friendly" (relative)
" Mum, always taken care of with love and affection" (relative)

Five satisfaction questionnaires from residents / representatives were completed and returned to RQIA. Respondents indicated they were very satisfied that the care provided within the home was effective.

Areas of good practice

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

Areas for improvement

The following areas identified for improvement related to the care plan of a resident identified to be at risk of choking to include the level of staff supervision necessary at meal and snack times and ensure notifications submitted to RQIA and monthly monitoring reports do not include named persons or reference to room numbers in accordance with GDPR.

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The atmosphere throughout the home was calm, encouraging and good humoured. Several residents have varying degrees of dementia and those who were able to comprehend spoke openly and gave positive feedback on the caring support and encouragement that staff provided. Other residents were calm and relaxed with no aimless wandering around the home. The manager explained that staff promoted a culture and ethos that supported the values of dignity and respect. This was evident throughout the inspection

On the morning of the inspection we observed one staff member encouraging a resident to have breakfast in a respectful, unhurried, supportive manner. Other observed respectful practice included staff knock on bedroom doors before entering and the friendly interpersonal communication with residents.

Information was displayed at various areas within the home was presented in pictorial and written format, for example, menus for the week, hand washing, how to complain and outcome of the satisfaction survey.

A wide range of activities were provided each week. The schedule displayed included; Bingo, arts and crafts, hairdressing, passive exercises, church services and shopping trips for residents who were able to go. Review of records and discussion with residents evidenced that residents' spiritual and cultural needs were met. Records of activities provided each day were retained.

We could clearly see that residents' interests, wishes and preferences were reflected within care records, for example, preferred activities, food and daily routines.

Action was taken by staff to manage any reported pain or discomfort in a timely and appropriate manner. Residents told us that staff were very good in this regard and would respond immediately.

Review of residents meetings evidenced discussions about how to raise issues if unsatisfied with anything, preference and planned activities, prevention of falls and good oral hygiene.

We discreetly observed the serving of resident's meals at lunch time. Tables were set with confinements, napkins and drinks provided. Meals were nicely presented with adequate portions of food served. Special diets were served as prescribed. Residents were served their choice of meal. Residents were assisted and supervised by staff during the meal. A pleasant atmosphere prevailed throughout the meal with residents quietly conversing and enjoying their meal. Records of daily meals served were retained.

Visiting relatives express satisfaction with care and life in the home. They indicated that staff always made them feel welcome and kept them fully informed about their relatives care. No issues or concerns were raised or indicated about the care provided.

Comments made by staff, residents and visitors during the inspection included;

"I like having the company and things to do, at home I was on my own most of the time"(resident)
"I don't have any concerns or worries about my care the staff are good girls" (resident)
"All our residents are treated with dignity and respect" (staff)
"Always staff around seeing to residents, we are happy with the care given" (relative)
"Food and mealtimes great" (resident)
"`I love the craic and the chat at the hair dressers" (resident)

The home retained a wide range of complementary letters and cards from families and residents.

Five satisfaction questionnaires from residents / representatives were completed and returned to RQIA. Respondents indicated they were very satisfied that the care provided within the home was effective. No issues or concerns were recorded.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing resident and their representatives and taking account of the views of resident

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 the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The manager explained the organisational structure of the home and support received at operational level from a mixed skill team of care and ancillary staff; good support was also received from senior management with regular monthly governance meetings held, frequent visits to the home and direct contact made by way of the telephone and electronically by emails.

The manager described how the focus of care in the home was to provide a high standard of care for residents and smooth running of the home. The manager maintains oversight of various systems and processes including, for example, staff training, accidents / incidents, complaints, fire safety and risk management with audits, spot checks undertaken and action taken to address any identified shortfalls.

The manager described how complaints were managed; review and discussion on complaints received and recorded within the home's complaints records retained. Improvement was identified as full information was not always recorded. For example, the complainants name / date received were not recorded within some complaints recorded. Review and revision of the general layout of the recording template was suggested. The manager readily agreed to address improvements as discussed.

The manager advised that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. Audits undertaken included for example; care records, falls, accidents / incidents, complaints, infection, prevention and control (hand washing),medication, fire safety and reconciliation of residents finances. Action plans were developed to meet identified shortfalls. A satisfaction survey was conducted during the year with responses from residents / representatives analysed and results displayed on the notice board in the hallway for all to see. Areas of the survey included; care, laundry, activities, meals and environment. Responses ranged 94% - 100%.which is commendable. Some comments from residents / representatives included;

“Staff does a good job”
“Very happy here”
“My family says this is the best place ever and I agree”
“Would like to see more activities”

The manager explained that there were systems in place for the management of risks which included for example; receipt of Northern Ireland Accident Incident Centre (NIAC) and staff alerts. Notices were distributed from the organisations head office, read and retained on file for further reference if required. Other risk assessments required by Health and Safety such as moving and handling, control of substances hazardous to health (COSHH) and fire risk were undertaken and regularly reviewed and updated as required.

The homes annual quality report for 2019 had been completed and was displayed within the reception of the home alongside the analysis of responses received from residents and relatives in the home’s annual satisfaction survey.

The manager confirmed that visits to the home made on behalf of the registered provider were undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; reports were produced and made available to residents, their representatives, and staff, RQIA and the commissioning Health and Social Care Trust (HSCT). Review of the last two reports, October and November 2019 evidenced information was recorded as required. The manager advised that she received feedback on the outcome of the visit and that action plans had been addressed as recorded within the reports reviewed. One area identified for improvement related to reference made to the residents’ room numbers which should not be recorded in compliance with GDPR.

Five satisfaction questionnaires from residents / representatives were completed and returned to RQIA. Respondents indicated they were very satisfied that the care provided within the home was well managed. No issues or concerns were recorded.

Areas of good practice

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

Areas for improvement

The following areas were identified for improvement in relation to complaints records and monthly monitoring reports to cease the use of reference to resident's room numbers.

	Regulations	Standards
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Siobhan Savage, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 6.2 **Stated:** First time **To be completed by:** 1 January 2020	The registered person shall ensure that the care plan intervention of one resident identified to be at risk of choking includes the level of staff supervision necessary at meal and snack times. Ref: 6.4
	Response by registered person detailing the actions taken: The resident's care plan contains all relevant information in respect of risk of choking, including staff supervision requirements.
Area for improvement 2 **Ref**: Standard Ref: 17.10 **Stated:** First time **To be completed by:** 1 January 2020 and ongoing	The registered person shall ensure that notifications submitted to RQIA do not include named persons. Ref: 6.4
	Response by registered person detailing the actions taken: All Senior staff have been reminded to use the unique identifier code.
Area for improvement 3 **Ref**: Standard: 17.10 **Stated:** First time **To be completed by:** 1 January 2020 and ongoing	The registered person shall ensure that the record of complaints includes full details; the complainant's name, date and time when the complaint was received. Ref: 6.6
	Response by registered person detailing the actions taken: All Senior staff have been reminded of the details required for the scheme, complaint/concern book.
Area for improvement 4 **Ref**: Standard: General Data Protection Regulation. **Stated:** First time **To be completed by:** 1 January 2020 and ongoing	The registered person shall ensure that information recorded within the monthly monitoring report does not include reference to the resident's bedroom number. Ref 6.6
	Response by registered person detailing the actions taken: The designated person will avoid use of flatlet number in future MMV reports.

Please ensure this document is completed in full and returned via Web Portal

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