Unannounced Follow-up Care Inspection Report
12 August 2019

Iniscora

Type of Service: Residential Care Home
Address: 29 St Patrick's Drive, Downpatrick BT30 6NE
Tel No: 028 4461 2128
Inspectors: Alice McTavish and Paul Nixon

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 provider 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 nine beds which provides care to adults who have a learning disability.

3.0 Service details

Organisation/Registered Provider: Mainstay DRP **Responsible Individual:** Helen Owen	**Registered Manager:** Laura Torney
Person in charge at the time of inspection: Laura Torney	**Date manager registered:** Acting manager from 18 April 2019
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 9

4.0 Inspection summary

An unannounced inspection took place on 12 August 2019 from 10.00 to 17.45.

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

This inspection was undertaken by the care inspector supported by the pharmacy inspector.

RQIA received information from an anonymous source in relation to the home concerning the following areas:

- the home's environment
- staffing levels and the impact that reduced staffing levels had on the care delivered to residents
- the management of specific incidents by senior staff
- medication errors

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, if RQIA is notified of a potential breach of regulations or minimum standards, it will review the matter and take appropriate action as required; this may include an inspection of the home.

The following areas were examined during the inspection:

- the home's environment
- staffing arrangements including staffing levels and deployment
- records relating to incidents in the home
- the management of medications

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	1	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Laura Torney, manager, 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.

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 13 March 2019.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the findings from the most recent care and pharmacy inspections, registration information and any other written or verbal information received.

During the inspection the inspectors met with four residents, the acting manager and the deputy manager, three members of care staff (one of whom also worked as domestic staff) and the home's maintenance man. No visiting professionals and no residents' relatives were present.

Questionnaires 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. No questionnaires were returned to RQIA from residents, residents' relatives or staff.

The following records were examined during the inspection:

- staff duty rota
- care records relating to individual residents
- notifications of accidents and incidents
- incidents relating to individual residents
- referral to Trust adult safeguarding team
- minutes of residents meeting
- report of the visit by the registered provider, July 2019
- medication records
- medicines management audits

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 13 March 2019

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement identified.

6.3 Inspection findings

The home's environment

The information provided to RQIA was that there was a leak in the first floor bathroom and there was a strong smell of urine despite the leak being fixed; this provided an unpleasant environment for residents to shower in; handles were falling off doors including fire doors and bathroom doors which meant that staff had to hold the door closed in a bathroom to protect residents' privacy.

We completed an inspection of the premises and found no problems with the handle on the door to the upstairs bathroom. The bathroom was clean and tidy and there were no malodours. Staff told us that the leak around the base of the toilet had been repaired and resealed.

We found no issues with the door handles to the residents' bedrooms but we did note that the handle on the door to the upstairs hallway, although still working, was loose. This issue was immediately notified to the organisation's maintenance department.

A maintenance man was present in the home and he reported that he was to repair or replace two door handles. One, leading to the staff cloakroom and toilet, had been broken since the previous week and the other, at the downstairs bathroom used by residents, had broken on the evening before the inspection. Each of these handles were repaired before the end of the inspection.

The maintenance man advised that the waterproof flooring and skirting in the shower in the downstairs bathroom was cracked and there were plans in place to replace the flooring in the bathroom. He also reported that there may be a blockage in the drain at the front of the home and he was scheduled to trim back the climbing shrubbery and clean the drains on the day of the inspection.

We noted that the home was generally clean and tidy but that the internal paintwork on skirting boards and door surrounds was chipped in places. We also saw that there was some build-up of dust on the staircase. We discussed this with the manager who acknowledged that the internal woodwork needed to be repainted. We identified the internal decoration of the home as an area for improvement to comply with the Standards.

In our discussion with staff we established that the hours devoted to providing domestic support had been reduced from 25 per week to between 10 and 15 hours per week. Staff reported that this may account for the lack of attention to detail in respect of cleanliness. We discussed this with the manager who confirmed that the domestic hours had been reduced and explained that the 10 to 15 hours saved from cleaning and laundry were now used to provide care to residents.

The day after the inspection the manager provided written confirmation that the domestic hours would return to 25 per week with effect from 20 August 2019.

This area is partially substantiated and we have identified an area for improvement. We are assured, however, that the organisation had responded appropriately to the issues raised during this inspection.

The management of specific incidents by senior staff

The information provided to RQIA related to an event which may have necessitated a referral to the Trust Adult Safeguarding team; it also raised concern regarding the management of whistleblowing within the organisation.

We looked at records relating to incidents in the home and saw that such an event had occurred. We spoke with the manager and the deputy manager who advised that a timely referral was made to the Adult Safeguarding Team as this was appropriate. We saw documentation to confirm this.

On 14 August 2019 the manager submitted a written account of the organisation's internal investigation into the event. There was evidence that the investigation was thorough and that clear actions had been carried out.

This area has not been substantiated.

Staffing levels and the impact that reduced staffing levels had on the care delivered to residents

The information provided to RQIA related to poor staffing levels in the home, particularly staff supervision of residents during the delivery of personal care and at mealtimes; the management of an incident; the need to employ a cook and the general standard of care being affected.

Staff on duty told us that a resident needed to have a member of staff beside them for safety at each mealtime, two other residents needed direct supervision and some other residents needed staff to be in the near vicinity. Staff told us that the current staffing levels made this particularly difficult, particularly in the mornings when residents needed help with getting showered and dressed and having breakfast.

We examined the staffing arrangements including staffing levels and the deployment of care and ancillary staff. The staff duty rota showed that there was a shift leader and a care assistant on duty each morning to provide personal care and to supervise residents whilst they were taking breakfast.

We discussed this with the manager who advised that since late July 2019 an additional member of staff was rostered to stay in the home for two hours after finishing night shift at 08.00. We found, however, that the duty rota did not always note these additional two hours. We brought this to the attention of the manager and the staff duty rota was immediately reviewed to accurately reflect the planned staffing. There was acknowledgement by the manager that inaccuracies in the staff rota could easily raise a degree of uncertainty and concern among the staff team.

The manager told us that the staffing levels in the home at mealtimes were safe and took account of residents' needs as advised by the Trust's Speech and Language Therapy (SLT) team. The manager also told us that the needs of residents had been shared with the care team at a staff meeting and confirmation was communicated to all staff in relation to SLT guidelines and supervision levels in late July 2019. This was later confirmed to RQIA in writing.

The manager provided written confirmation after this inspection that she had completed spot checks with staff to ensure their knowledge in relation to required supervision levels and consistencies of residents' diets and she was assured that the residents' meals were safely managed; this area would continue to be monitored.

Staff on duty told us that a cook had not been employed in the home for some months. We were told that care staff did the shopping and made all meals and this impacted both on their ability to assist residents at mealtimes and to spend time with residents to provide quality time and activities.

We discussed this with the manager who advised that the number of residents accommodated in the home had reduced several months ago and the cook had been moved to work in another home. The manager also acknowledged that when the number of residents increased, a cook had not been arranged.

The manager submitted written confirmation on 14 August 2019 that the organisation had begun the process of recruiting a cook and that the situation was to be advertised in the local press the following week. Whilst we recognise the organisation's subsequent efforts to employ a cook, we have identified this as an area for improvement to comply with the Regulations.

We looked at records and established that an incident occurred in the home which needed a response from senior staff. We spoke with the manager about this and we were assured that no residents came to harm. We established, however, that the correct process had not been followed for reporting this within the organisation both at the time of the event and with the manager after the event; this had led to inadequate support for the staff on duty in the home.

We asked that the manager conduct a comprehensive post incident review of the actions of the staff in the home and senior staff on call at the time in order to identify deficits and any learning opportunities. This was completed and shared with RQIA.

We spoke with staff who told us that the care provided to residents was good. We did not see any evidence in the care records of residents or in our observations of the presentation of residents that the standard of care had reduced.

In our discussions with staff it was brought to our attention that a new arrangement had been introduced by the organisation regarding residents paying for staff take away meals. We discussed this with the manager who advised that this had been misinterpreted and that all residents had money fully reimbursed. This was later confirmed in writing and the information was shared with a RQIA finance inspector for further examination.

These areas have been partially substantiated and we have identified an area for improvement. We are assured, however, that the organisation has since responded appropriately to issues raised during this inspection.

Management of medicines

The information provided to RQIA related to medication errors. We found that medicines were managed in compliance with legislative requirements, professional standards and guidelines. Medicines were managed by staff who had been trained and deemed competent to do so. Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. There were satisfactory arrangements in place to manage changes to prescribed medicines. The sample of medicines examined had been administered in accordance with the prescriber's instructions.

Audits which cover all areas of medicines management are performed regularly, discrepancies investigated and records maintained. There were robust arrangements in place for the management of medicine related incidents. Medicines records complied with legislative requirements, professional standards and guidelines.

Medicines were safely and securely stored in compliance with legislative requirements, professional standards and guidelines. Medicines were stored in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised.

We found no evidence to substantiate that medication errors had occurred.

Areas of good practice

The management of medications was identified as an area of good practice during this inspection.

Areas for improvement

Two areas for improvement were identified during the inspection. These related to the internal decoration of the home and to the employment of a cook.

	Regulations	Standards
Total number of areas for improvement	1	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Laura Torney, acting manager, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 20 1 a **Stated:** First time **To be completed by:** 30 September 2019	The registered person shall ensure that a cook is employed to work in the home. Ref: 6.3
	Response by registered person detailing the actions taken: Following 4 attempts we managed to recruit a cook who will take up post once all all checks have been completed. Interim arrangements in respect of meal preparation are in place
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 27.1 **Stated:** First time **To be completed by:** 30 September 2019	The registered person shall ensure that the internal woodwork in the home is repainted. Ref: 6.3
	Response by registered person detailing the actions taken: Internally all communla areas have been redecorated.

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

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