Unannounced Care Inspection Report
8 November 2018

Kimberley House

Type of Service: Residential Care Home
Address: 45 Abbey Road, Newtownards, BT23 8JL
Tel No: 028 9181 0003
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 16 beds that provides care for adults who have a learning disability. The home comprises two buildings, Kimberley House and the adjacent premises at 80 Upper Movilla Street. The home had previously operated under two separate registrations which were amalgamated under one registration.

3.0 Service details

Organisation/Registered Provider: Praxis Care Group / Challenge **Responsible Individual:** Andrew Mayhew	**Registered Manager:** Joanne Black
Person in charge at the time of inspection: Sarah Hill, team leader, until 10.00. Kathryn Coey, team leader, from 10.00.	**Date manager registered:** 2 August 2013
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 16

4.0 Inspection summary

An unannounced care inspection took place on 8 November 2018 from 09.50 to 17.15.

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

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

Evidence of good practice was found in relation to staff induction, training, supervision and appraisal, adult safeguarding and infection prevention and control, care records, audits and reviews, listening to and valuing residents, quality improvement and maintaining good working relationships.

An area requiring improvement was identified. This related to the reports of the visits by the registered provider.

Residents said that they enjoyed living in the home and that the staff took good care of them.

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	0

Details of the Quality Improvement Plan (QIP) were discussed with Kathryn Coey, person in charge on the day of the inspection and with Joanne Black, registered manager, by telephone after the inspection. 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

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 28 March 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, the returned QIP, notifiable events and any written and verbal communication received since the previous care inspection.

During the inspection the inspector met with the person in charge, six residents, four team leaders, two support workers and the home's administrator. No visiting professionals and no residents' representatives were present.

A total of ten questionnaires were provided for distribution to residents and/or their representatives to enable them to share their views with RQIA. A poster was provided for staff detailing how they could complete an electronic questionnaire. No questionnaires were returned by residents, residents' representatives or staff within the agreed timescale.

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

- staff duty rota
- induction programme for new staff
- staff supervision and annual appraisal schedules
- staff competency and capability assessments
- staff training schedule
- three residents' care files
- the home's Statement of Purpose and Resident's Guide
- minutes of staff meetings
- complaints and compliments records
- audits of risk assessments, care plans, care reviews, Infection Prevention and Control (IPC)
- equipment maintenance records
- accident, incident, notifiable event records
- minutes of recent residents' meetings
- reports of visits by the registered provider
- legionella risk assessment
- fire safety risk assessment
- fire drill records
- maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- individual written agreements

- programme of activities
- policies and procedures

Areas for improvements identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

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 28 March 2018

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

6.2 Review of areas for improvement from the last care inspection dated 28 March 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 8 **Stated:** First time	The registered person shall ensure progress records are maintained on an accurate and up to date basis at all times. Ref: 6.5	**Met**
	Action taken as confirmed during the inspection: Discussion with the person in charge and inspection of care documentation confirmed that progress records for residents were maintained on an accurate and up to date basis.	

6.3 Inspection findings

6.4 Is care safe?

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

The person in charge advised that the staffing levels for the home were subject to regular review to ensure the assessed needs of the residents were met. Some agency staff were used in the home. The person in charge described how agency staff were block booked, where possible, to ensure continuity of care to residents. All agency staff were provided with a comprehensive induction and were not left alone to provide one to one supervision and care to residents. Any turnover of staff was kept to minimum, where possible, and was monitored by the management of the home.

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

A review of completed induction records and discussion with the person in charge and staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities.

Discussion with staff confirmed that mandatory training, supervision and annual appraisal of staff was regularly provided. Schedules of training, staff appraisals and supervision were reviewed during the inspection. Staff advised that they received monthly supervision throughout their probationary period of employment and had quarterly supervisions thereafter. A review of care documentation also established that bespoke training was provided to staff in the use of Positive Behaviour Support planning.

Discussion with the person in charge confirmed that competency and capability assessments were undertaken for any person who is given the responsibility of being in charge of the home for any period in the absence of the manager. Staff competency and capability assessments were reviewed and found to be satisfactory.

A review of the recruitment and selection policy and procedure during a previous care inspection confirmed that it complied with current legislation and best practice. This policy and procedure was unchanged and was not reviewed on this occasion. The person in charge advised that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005 and that records were retained at the organisation's personnel department. The person in charge advised that AccessNI enhanced disclosures were undertaken for all staff prior to the commencement of employment.

Arrangements were in place to monitor the registration status of staff with their professional body (where applicable). The person on charge advised that records were maintained of the date of registration of staff with the Northern Ireland Social Care Council (NISCC) and the due dates of annual fee payments. Professional registration was also a permanent agenda item on staff supervisions.

The adult safeguarding policy in place was consistent with the current regional policy and procedures. This included the name of the safeguarding champion, definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed

Staff were knowledgeable and had a good understanding of adult safeguarding principles and had an awareness of child protection issues. 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 mandatory adult safeguarding training was provided for all staff.

Discussion with the person in charge, review of accident and incidents notifications and care records confirmed that any suspected, alleged or actual incidents of abuse were fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records were retained. Appropriate action plans, as agreed with the adult safeguarding team, were in place to address any identified safeguarding concerns.

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

The home had a policy and procedure on restrictive practice/behaviours which challenge. This was reviewed during a previous care inspection and was found to be in keeping with DHSSPS Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) and the Human Rights Act (1998). It also reflected current best practice guidance including Deprivation of Liberties Safeguards (DoLS).

The person in charge confirmed there were restrictive practices employed within the home, notably a keypad entry system at the front door and locked doors to the kitchen. Door alarms were used at night. Discussion with the person in charge regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required. A review of the residents guide identified that restrictions were adequately described.

A review of care records identified that a restrictive practices register, describing the nature of and rationale for any restrictions employed, was completed for each resident. This was kept under regular review.

Systems were in place to make referrals to the multi-professional team in relation to behaviour management when required. Behaviour management plans were devised by specialist behaviour management teams from the trust and noted to be regularly updated and reviewed as necessary. The person in charge was aware that when individual restraint was employed, RQIA and appropriate persons/bodies must be informed.

A previous inspection identified that there was an Infection Prevention and Control (IPC) policy and procedure in place which was in line with regional guidelines. A review of staff training records evidenced that all staff had received training in IPC in line with their roles and responsibilities. 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 wherever care was delivered. Personal Protective Equipment (PPE), e.g. disposable gloves and aprons, was available throughout the home. Observation of staff practice identified that staff adhered to IPC procedures.

Good standards of hand hygiene were observed to be promoted within the home among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

The person in charge reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with home policy and procedures, reported to the Public Health Agency, the trust and RQIA with appropriate records retained. IPC compliance audits were undertaken and action plans developed to address any deficits noted.

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

Inspection of the internal and 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. No malodours were detected in the home.

The home had an up to date Legionella risk assessment in place dated 20 September 2017.

The home had an up to date fire risk assessment in place dated 18 June 2018 for the main building and all recommendations had been actioned. A fire risk assessment, dated 16 November 2018, was submitted after the inspection for the building at 80 Upper Movilla Street. One recommendation was made and this had been addressed.

A review of staff training records confirmed that staff completed fire safety training twice annually. Fire drills were completed on a regular basis and the registered manager later advised that an additional fire drill was completed for the home on 29 November 2018. The records of fire drills included the staff who participated and any learning outcomes.

Fire safety records identified that fire alarm systems were tested weekly and that fire-fighting equipment, emergency lighting and means of escape were checked weekly and were regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEP) in place and an easy read, pictorial emergency fire plan was displayed in the reception area of the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff induction, training, supervision and appraisal, adult safeguarding and infection prevention and control.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

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

Records were stored safely and securely in line with General Data Protection Regulation (GDPR). A review of the care records of three residents confirmed that these were maintained in line with the legislation and standards. They included an up to date assessment of needs, life history, risk assessments, care plans and daily statement of health and well-being of the resident. Care needs assessment and risk assessments (e.g. behaviour management plans, where appropriate) were reviewed and updated on a regular basis or as changes occurred. Care plans integrated Human Rights considerations throughout. This represented good practice.

The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were observed to be signed by the resident and/or their representative. An individual agreement setting out the terms of residency was in place and appropriately signed.

It was established that where residents smoked, this was noted within care plans, risk assessments and in restrictive practice registers.

Discussion with staff confirmed that they were familiar with person centred care and that a person centred approach underpinned practice. Staff were able to describe in detail how the needs, choices and preferences of individual residents were met within the home.

A varied and nutritious diet was provided which met the individual and recorded dietary needs and preferences of the residents. Systems were in place to regularly record residents' weights and any significant changes in weight are responded appropriately. There are arrangements in place to refer residents to dieticians and speech and language therapists (SALT) as required. Guidance and recommendations provided by healthcare professionals were reflected within the individual resident's care plans and associated risk assessments.

The person in charge advised that no residents currently accommodated were at risk of developing pressure damage to skin. Staff advised that they were able to recognise any pressure area damage and they were aware of how to make referral to the multi-professional team. Any pressure care would be managed by community nursing services.

The person in charge 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 of risk assessments, care plans, care reviews and Infection Prevention and Control (IPC) were available for inspection and evidenced that any actions identified for improvement were

incorporated into practice. Further evidence of audit was contained within the reports of the visits by the registered provider.

The person in charge advised that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included pre-admission information, multi-professional team reviews, residents' meetings, staff meetings and staff shift handovers. Staff reported that they had received training in communication and customer care. Minutes of staff meetings and resident meetings were reviewed during the inspection.

Observation of practice evidenced that staff were able to communicate effectively with residents. Discussion with the person in charge and staff confirmed that management operated an open door policy in regard to communication within the home.

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.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

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

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

The person in charge advised that staff in the home promoted a culture and ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

The person in charge and staff advised that consent was sought in relation to care and treatment. Discussion and observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff described their awareness of promoting residents' rights, independence, dignity and how confidentiality was protected. A review of care records identified that written consents were in place for the sharing of information with relevant parties and for the use of photography; the consents were provided in an easy read, pictorial format and were signed by the resident. This represented good practice.

Discussion with staff confirmed that residents' spiritual and cultural needs, including preferences for end of life care, were met within the home. Action was taken to manage any pain, discomfort or distress in a timely and appropriate manner. This was further evidenced by the review of care records, for example, care plans were in place for the identification and management of anxiety and behaviours which challenge, where appropriate.

Residents were provided with information, in a format that they could understand, which enabled them to make informed decisions regarding their life, care and treatment. Menus and the activity programme, for example, were written in a pictorial format and there was an easy read guide to Human Rights for adults with a learning disability on display in the reception area of the home.

Discussion with staff and residents and observation of practice confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff; residents were listened to, valued and communicated with in an appropriate manner and their views and opinions were taken into account in all matters affecting them.

The person in charge advised that residents were consulted with, at least annually, about the quality of care and environment. The findings from the consultation were collated into a summary report and action plan was made available for residents and other interested parties to read.

Discussion with staff and residents and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. Arrangements were in place for residents to maintain links with their friends, families and wider community.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing residents and taking account of the views of residents.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

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

The person in charge outlined the management arrangements and governance systems in place within the home and advised that the needs of residents were met in accordance with the home's statement of purpose and the categories of care for which the home was registered with RQIA.

A range of policies and procedures was in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff.

There was a complaints policy and procedure in place which was in accordance with the legislation and Department of Health (DoH) guidance on complaints handling. This was also provided in an easy read version for residents. Residents and/or their representatives were made aware of how to make a complaint by way of the Resident's Guide and information on display in the home. Discussion with staff confirmed that they had received training on complaints management and were knowledgeable about how to respond to complaints. RQIA's complaint poster was available and displayed in the home.

A review of the complaints records confirmed that arrangements were in place to effectively manage complaints from residents, their representatives or any other interested party. Records of complaints included details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction. Arrangements were in place to share information about complaints and compliments with staff and the person in charge described how this would be done through individual staff supervisions and staff team meetings.

There was an accident, incident and notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of these events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. The person in charge advised that learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

Discussion with the person in charge confirmed that staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents, for example, Positive Behaviour Support, administration of emergency epilepsy medication, restrictive practices.

A visit by the registered provider was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, RQIA and any other interested parties to read. An action plan was developed to address any issues identified which include timescales and person responsible for completing the action. It was noted, however, that the reports did not consistently cover both Kimberley House and the adjacent premises at 80 Upper Movilla Street which now operate under one registration. Action was required to ensure compliance with the regulations in this regard.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability. This was outlined in the home's Statement of Purpose and Residents Guide. The person in charge reported that the registered provider was kept informed regarding the day to day running of the home through the line management structure of the organisation, also that senior managers were easily contactable by telephone and email and visited the home.

The returned QIP confirmed that the registered provider responded to regulatory matters in a timely manner. Inspection of the premises confirmed that the RQIA certificate of registration was displayed.

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

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised. There were open and transparent methods of working and effective working relationships with internal and external stakeholders.

The person in charge described the arrangements in place for managing identified lack of competency and poor performance for all staff.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to quality improvement and maintaining good working relationships.

Areas for improvement

One area for improvement was identified during the inspection. This related to the reports of the visits by the registered provider.

	Regulations	Standards
Total number of areas for improvement	1	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Joanne Black, registered manager, by telephone after the inspection. 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 29 **Stated:** First time	The registered person shall ensure that each report of the visit by the registered provider covers both Kimberley House and the adjacent premises at 80 Upper Movilla Street. Ref: 6.7
To be completed by: 30 November 2018	**Response by registered person detailing the actions taken:** The Head of Operations for NDA has confirmed that the required amendments to the completion of the Monthly Monitoring Report will be in place in December 2018.

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

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