Unannounced Care Inspection Report
4 December 2019

Loughview Fold

Type of Service: Residential Care Home
Address: 159a High Street, Holywood, BT18 9HU
Tel No: 02890425117
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 28 residents consisting of five older people and 23 residents with various degrees of dementia.

3.0 Service details

Organisation/Registered Provider: Radius Housing Association **Responsible Individual:** Fiona McAnespie	**Registered Manager and date registered:** Helen Craig – 23 June 2016
Person in charge at the time of inspection: Helen Craig	**Number of registered places:** 28 Maximum of 23 persons in RC-DE category of care.
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia	**Total number of residents in the residential care home on the day of this inspection:** 25 residents.

4.0 Inspection summary

An unannounced inspection took place on 4 December 2019 from 11.00 hours to 17.00 hours.

The inspection assessed progress with one area identified for improvement 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 in relation to how well residents were treated; with dignity respect and fully involved in decisions affecting their treatment, care and support. There was evidence of good leadership and governance arrangements, modes of communication both internally between residents, staff and externally with other key stakeholders. Work to the improvements to the interior of the home is to be commended.

Two areas identified for improvement included; needs assessments and development of an individual activity programme for one resident.

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 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	2

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

4.2 Action taken following the most recent inspection dated 7 January 2019

The most recent inspection of the home was an unannounced medicine management inspection undertaken on 7 January 2019. No areas were identified for improvement.

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.

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. No questionnaires were returned within the timescale.

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

- staff duty rotas from 25 November 2019 to 4 December 2019
- staff training schedule and training records
- three residents' records of care
- complaint records
- compliment records
- governance audits/records
- accident/incident records
- report of visits by the registered provider/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.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 25 October 2018

One area identified for improvement had been addressed as shown below within the QIP issued on 25 October 2019.

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 6.2 **Stated:** First time	The registered person shall ensure that one resident's care plan reflects the interventions necessary to minimise / prevent the risk of fall. Review of other care plans should be undertaken to ensure interventions relating to any fall risk are reflected.	**Met**
	Action taken as confirmed during the inspection: The manager explained that all care plans had been reviewed and where necessary revised to included interventions. Three care plans randomly selected evidenced measures in place to minimise recurrence of fall.	

6.3 Is care safe?

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

On arrival at the home we were welcomed by the manager who remained on duty throughout the inspection. The previous care inspection QIP was discussed with evidence of compliance with the improvement in place.

The manager explained that safe staffing levels, to meet residents' needs were in place. Staffing levels were determined in accordance with the dependency levels and number of residents accommodated, layout of the home and fire safety. Regular review of staffing levels is undertaken by the manager in this regard. Review of the staff duty roster evidenced an accurate reflection of the current staff on duty. The manager advised that cover for staff leave was provided by permanent staff working extra hours, bank staff who work flexi hours or if necessary

agency staff. Staff who spoke with us felt that staffing levels in place were meeting the needs of residents accommodated. Throughout the inspection we could see that there was sufficient staff to attend to residents.

The manager advised that residents accommodated were within the categories of care in which the home was registered with RQIA and that care provided was reviewed to ensure that placement within the residential setting remained appropriate. The manager demonstrated awareness of the procedure to follow should the needs of residents change to require nursing care.

The manager explained that records relating to the selection and recruitment of staff were retained at the organisations head office and that safe systems and process, in accordance with legislation and standards. Access NI clearance checks were received prior to any member of staff commencing employment with appropriate records of same retained. Records on the audit of recruitment of staff was undertaken and held by the manager.

The registration and monitoring of staff registrations with Northern Ireland Social Care Council (NISCC) was discussed with the manager who advised the system in place and monitoring process to ensure staff remain on the register. The manager demonstrated knowledge of the action to take should a staff member fail to re- register within the timescale required. Staff who spoke with us confirmed that they were registered with annual retention fees paid.

Discussion with the manager, staff and review of staff mandatory training records evidenced compliance with legislation. We noted that senior care staff undertook dementia training over two days this year and other additional training for care staff including, GDPR and food hygiene.

The home had a policy on adult safeguarding which was readily available to staff. The manager advised that no safeguarding issues had arisen since the previous inspection. Staff training records evidenced all staff had received training in adult safeguarding. Staff who spoke with us demonstrated good knowledge and understanding of the procedure to follow, in accordance with their role, should any suspected or alleged incidents of abuse arise. The manager explained that all issues arising in this regard would be reported immediately to the trust safeguarding gateway team and that a record would be retained.

The manager explained that the responsible person is the adult safeguarding champion for the home and that the annual position statement for the home was a work in progress.

A review of governance records provided evidence that all notifiable incidents had been submitted to RQIA as required. The manager explained how falls were managed which included the undertaking of fall risk assessments with interventions to minimise recurrence reflected within care plans in keeping with the post falls management plan. Referrals to the trust fall clinic were made as required and regular monthly audits to identify trends and patterns were undertaken with records showing visual colour coded number days / daily totals and action plans. Copies of all accident / incident reports are submitted to the commissioning trust and the organisation’s governance team for monitoring purposes.

During the course of the inspection one resident fell and was subsequently taken to hospital for x-ray and treatment if required. Staff were observed to apply appropriate first aid and ensure the resident was made comfortable, without moving the resident in case of causing further injury until the ambulance arrived. This resident had a fall risk assessment in place with care plan which showed the measures in place to minimise the risk.

Staff supervision schedules and appraisal records were in place. Staff told us they found supervision and appraisal to be helpful and supportive.

Staff told us how the daily routine care was planned and delegated to each day following the night staff handover report. Any changes to residents care needs / care plans are shared with the care team coming on duty so that they are fully informed. Staff who spoke with us knew their residents well and demonstrated good understanding of residents' individual needs and planned interventions as reflected within care plans which were readily available to them. Staff told us they would always report any observed changes in the health and well-being of residents to the senior care assistant or manager. Residents' representatives were kept informed of any changes occurring.

We spoke with residents, some individually and with others in small group format. All residents spoke openly with us and gave positive feedback on the care provided. Everyone agree the care was very good. No issues or concerns were raised or indicated. Some of the residents who were unable to articulate their views were observed to be relaxed and comfortable in their surroundings and in their interactions with others / with staff. Some comments included:

- "We are very well looked after here, no concerns what so ever" (resident)
- ''Staff keep me fully informed about the care of my relative, the care is super" (relative)
- "I have work here for a long time and the care provided has been really good and safe in every way" (staff)

Restrictive practice was discussed with the manager who explained these included management of smoking materials and swipe card entrance and exit doors as well as other locked storage rooms in the home. The manager explained that these restrictions were agreed in the best interests of residents health and safety and were reflected within care records. The manager stated that staff training in the Mental Health Capacity Act – Deprivation of Liberty Safeguards (DoLS) was planned for 16 December 2019.

Inspection of the home evidenced ongoing work to several areas with redecorating and replacement flooring. Residents told us they did not feel inconvenienced in any way by the ongoing work, rather they enjoyed watching the improvements made and how brighter lighting had helped them and improved the general ambience of the home. Completion of the redecoration programmed is planned for March 2010.The home was adequately heated and fresh smelling throughout. Resident bedrooms were nicely furnished and decorated with items of memorabilia displayed.

There was evidence of a plentiful supply of infection, prevention and control resources within the home including disposable aprons and gloves, hand sanitising and liquid soap, pedal operated disposal bins and pictorial hand washing notices displayed at wash hand basins. There was effective management of waste disposal. Staff training in the subject had been provided.

The homes fire risk assessment was dated March 2019. Records showed that fire safety training and drill had been provided on a number of dates, to accommodate all staff, during June 2019. Nominated, named staff were appropriately trained as fire safety resource staff. One notification submitted to RQIA regarding a small toaster fire was discussed with staff who explained immediate action taken and the measures in place to minimise recurrence. Action taken to prevent recurrence included locking of the entrance door to the kitchen when not occupied by staff and the toaster locked within the kitchen cupboard as an added precaution.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment improvements.

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 residents care records were provided for review. These were retained electronically with hard copy back up. Care records reviewed contained records including, life histories showing resident's interests, hobbies, preferences, likes and dislikes. Pre-admission assessments titled "Supported living / Housing with Care" were in place which contained sections not relevant to a residential care home. This was identified as an area for improvement as needs assessment should reflect the appropriate title and contain relevant holistic needs assessments including physical, social, psychological and spiritual areas of need.

Care records reviewed also contained risk assessments; nutritional, moving and handling, falls, pressure sore and dependency scores based on the Barthel dependency model. Daily progress notes were recorded. Records of residents care plans were retained electronically which care staff use to obtain details of person centred care plans and to record daily progress notes. Staff explained the monitoring of residents weights was undertaken by way of monthly weighing and recording. Residents with excessive weight gain or loss is identified and when necessary action taken with referral to the GP and dietician.

Discussion with the manager and review of care record interventions / progress notes evidenced multi-professional input in order to meet the identified actual and potential needs of residents. Professional staff included for example; GP, social worker, optician, speech and language therapist (SALT), community nurse and podiatrist.

Systems in place for monitoring the frequency of residents' health screening, dental, optometry, podiatry and other health or social care service were in place with appointments and referrals made, as necessary to the appropriate service.

The provision of care management reviews was discussed with the manager who explained these were not always undertaken when scheduled with a number overdue. The manager explained the difficulties sometimes arose when trying to make contact with the trust to follow up on overdue reviews due to recurring changes in posts held by care managers' and issues in

not knowing who the named key worker or care manager was. The manager agreed to contact management within one trust regarding the provision of a named person with whom they can liaise to ensure care management review meetings are held. The development of a system to monitor care review dates and reports received was discussed with the manager as a useful way to monitor and report findings / concerns to her line manager and the commissioning trust.

The modes of communication between residents and staff were discussed and observed. Staff told us they work well together with effective team work in all aspects of care and life in the home. Staff advised that residents and/or their representatives were involved in the planning of care and signatures are obtained to show involvement and agreement. Staff demonstrated they had a good knowledge of peoples' abilities and level of decision making and knew how and when to provide comfort to people because they know residents needs well.

Other means of good communication included staff hand over reports at each change of shift and resident / relative meetings which take place on a quarterly basis. The minutes recorded evidenced topics discussed which included; meals and menu service, activities, laundry service, redecoration / modernisation of the home, staff changes and complaints procedure. In addition the home publishes and distributes a newsletter every three months to residents / representatives which contains evidence of good information sharing including; activities and special events / celebrations and newly appointed staff. A copy of the latest news letter was displayed on the notice board.

Staff confirmed that they attended three monthly staff meetings which they found to be beneficial in keeping them up to date with all aspects of care and life in the home including new developments and improvements. Copies of minutes of meetings held were retained.

Residents, staff and one relative told us they were satisfied that the care provided was effective. Some comments made included;

- "We are well looked after, no concerns" (resident group)
- " My mother is very content here and I am kept fully informed of the care provided" (relative)
- "We have all the resources necessary to provide good care" (staff)

Areas of good practice

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

Areas for improvement

One area identified for improvement related to ensuring pre-admission needs assessment templates reflect the correct title and holistic assessment of needs including; physical, social, psychological and spiritual needs.

	Regulations	Standards
Total number of areas for improvement	0	1

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 good humoured and encouraging. The majority of residents accommodated had varying degrees of dementia and those who were able to articulate their views gave positive feedback on the caring support and encouragement that staff gave them. Other residents who were unable to articulate their views were calm and relaxed with no aimless wandering around the home. All residents were observed to be appropriately clothed with obvious care and attention given to their personal care needs.

We could see that residents' wishes, interests and preferences were reflected within care records, for example, there was information about what activities they liked, their preferences and chosen daily routines.

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

Observation of activities provided evidenced of residents relating positively to staff and each other. Staff were observed interacting with residents in a friendly, respectful, unhurried manner.

One small group of residents told us that staff listened and encouraged them to participate in planned activities. Staff told us that residents were very much involved in the development of the programme of activities and that resident life history information obtained on admission was also used to determine an appropriate programme. Residents commented on their enjoyment in the activities provided and advised that they could choose if they wished to participate or not. Resident participation in activities was recorded.

The activities provided for one resident, who chooses to remain within their bedroom each day, was discussed with the manager who readily agreed to review, discuss and agree the development of a suitable individual activity programme with the resident in consultation with their relative. This was identified and agreed as an area for improvement.

The manager advised that a resident / representative and health care professional satisfaction survey was carried out during the year with pleasing responses received to date. The analysis of responses is currently a work in progress. The report of the satisfaction survey dated 2018 was displayed. The summary report responses from residents / relatives / health professional evidenced a high satisfaction score with care and support, staffing, laundry service, meals, activities and the environment.

The provision of meals was reviewed; observation of the serving of mid-day meal and review of the four weekly seasonal menu introduced during October 2019. Dining room tables were observed to be respectfully set with a range of condiments and drinks provided. Staff were observed supervising and assisting residents with their meal. Adequate sized portions of food were served. Menus were observed to be varied and nutritious with choice of main meal reflected. Choice of menu was determined by asking residents what their preference was of the two dishes to be served at each meal. An alternative meal can be provided if desired. Special

diets were provided as required. Records of food taken were recorded. Mid- morning, afternoon and evening snacks including fresh fruit and cakes are served. Positive comments were made by residents who stated that “the food had improved since new providers and cook took over the catering and everything was really good now”.

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

One area identified for improvement related to the provision of a suitable activity programme for a resident who chooses to remain in their bedroom each day.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is the service well led?

Effective leadership, management and governance which create 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 organisation and the support provided to her from senior management. Regular monthly governance meetings were held and monthly quality monitoring visits undertaken. At operational level support is provided by a mixed skill team of care and ancillary staff. Other staff includes clerical administrator, cook / kitchen assistant and domestic staff.

Staff commentated that the manager’s leadership style was supportive and that all staff were expected to take appropriate responsibility for the provision of a quality service. Staff explained that if any issues or concerns arose they would not hesitate to report this to the manager who operated an “open door” to everyone.

The home’s RQIA registration certificate for the home was displayed within a prominent position.

Discussion with the manager and staff alongside review of a range of records, including for example, minutes of staff meetings, staff supervisions/ appraisals, staff training and accident / incidents, audits and monthly monitoring reports provided evidence that effective leadership and management arrangements were in place. Staff who spoke with us were aware of who was in charge of the home in the absence of the manager.

Review of complaints records evidenced that no complaints had been received since the previous inspection. This was confirmed by the manager. Information on “how to complain” was displayed and reflected within the statement of purpose and resident guide. Staff who spoke with us knew the procedure to follow, in accordance with their role, should an issue of dissatisfaction arise.

The manager explained the range of audits undertaken to assure her that the care provided and management of the service was in keeping with written policy and procedures, legislation and department of health (DOH) care standards. Audits conducted included satisfaction surveys, medication management, care records, accident / incidents, fire safe safety, NISCC registrations and staff training. Where shortfall is identified an action plan is developed to address issues.

We reviewed the monthly monitoring reports completed for the months October and November 2019. Reports reflected comprehensive information including a summarised view of residents and staff views about the service and actions taken by the manager to ensure that the home is being managed in accordance with minimum care standards.

The manager advised that the development of the 2019 annual quality report was a work in progress.

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

Areas of good practice

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

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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Helen Craig, 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 DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 5.2 **Stated:** First time **To be completed by:** 31 January 2020	The registered person shall ensure that suitable pre-admission needs assessments of residents are in place which fully reflects the recording of holistic individual needs of residents. The use of supported living / housing with care title should be removed from forms. Ref: 6.4
	Response by registered person detailing the actions taken: The pre admission needs assessment form will be reviewed to ensure that holistic needs, including, physical, social, psycological and spiritual areas of need are fully considered and documented.
Area for improvement 2 **Ref**: Standard 13.3 **Stated:** First time **To be completed by:** 1 January 2020	The registered person shall ensure that, in consultation with the resident and relative, an individual activity programme is developed for one resident who chooses to remain in their bedroom each day. Ref: 6.6
	Response by registered person detailing the actions taken: A consultation has been completed with the resident and their advocate and their needs and wishes have been documented in their plan of care and will continue to be met and kept under review..

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

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