Unannounced Care Inspection Report
16 January 2020

15 Main Street

Type of Service: Residential Care Home
Address: 15 Main Street, Conlig BT23 7PT
Tel no: 028 9146 8039
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.

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 three residents.

3.0 Service details

Organisation/Registered Provider: Praxis Care Group/Challenge **Responsible Individual:** Andrew James Mayhew	**Registered Manager and date registered:** Rebecca Stewart, 19 April 2018
Person in charge at the time of inspection: Rebecca Stewart	**Number of registered places:** 3
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 2

4.0 Inspection summary

An unannounced inspection took place on 16 January 2020 from 13.50 to 15.40 hours.

The inspection focussed on the records of the care for residents in the home.

Evidence of good practice was found in relation to the quality of the care records and to the involvement of residents in directing their own care, where possible.

No areas requiring improvement were identified.

The residents who live in this home chose to speak with the inspector only briefly but were seen to be relaxed and comfortable in their interactions with each other and with staff.

Comments received from staff 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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Rebecca Stewart, registered manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 24 June 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 24 June 2019. No further actions were required to be taken following the most recent inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the findings from the previous care inspection, 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.

One resident completed and returned a questionnaire to RQIA. Twelve questionnaires were completed and returned from staff. Most staff who responded indicated that they were satisfied or very satisfied but others were dissatisfied with aspects of the care provided in the home.

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

- two residents' records of care
- accidents and incidents records between October and December 2019
- RQIA registration certificate

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 last care inspection dated 24 June 2019

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

6.2 Inspection findings

The care files for each resident were stored securely. The manager told us that any changes or updates to the care records were completed in private in order to ensure confidentiality.

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

Staff in the home completed care needs assessments, risk assessments and care plans for each resident. The care needs assessment and care plans covered such areas as physical and mental wellbeing, appearance and hygiene, communication, daily living skills and empowerment, recovery and hope. The care plans provided staff with guidance as to how the identified needs should be met. There was a separate risk assessment and management plan which recorded the nature and indicators of risks, how any risks could be minimised and any restrictions in place required to manage risks. The care documentation was completed in detail and with a focus on individualised, person-centred care.

All documents were kept up to date, regularly reviewed and appropriately signed and dated. The care plans noted consent; Human Rights considerations were integrated throughout and shared with residents in an easy read document. This represented good practice.

Multi-professional involvement in the residents' health and social care needs was documented where necessary and this was kept up to date to accurately reflect any changes.

The effectiveness of care was monitored and evaluated on a monthly basis and there were regular reviews of the care provided in the home which were attended by all relevant parties. Staff in the home completed a care review preparation report; this was completed in a high level of detail and demonstrated that staff were very familiar with the care needs of individual residents.

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

It was evident that there were systems in place to ensure that written and verbal information was accurately and comprehensively recorded. This supported the delivery of safe and effective care whilst also supporting person-centred, compassionate care to the individual

residents. It was also evident that the manager ensured that care records were maintained to a good standard.

One questionnaire was completed and returned to RQIA from a resident. The respondent indicated a high level of satisfaction across all areas of care and services provided in the home.

Twelve questionnaires were completed and returned by staff. Most respondents indicated that they were either satisfied or very satisfied that the care provided in 15 Main Street was safe, effective, compassionate and well led. A small number of responses indicated dissatisfaction across all aspects of care and services in the home. The comments provided by respondents are as follows:

- "I feel that our team strives to make all our service users feel valued, listened to and their needs and wishes are always respected."
- "Within this setting I feel that the staff work as a team in a positive way to promote the holistic well-being of service users and staff. The Management team are extremely easy to approach should any concerns arise and are efficient in finding a solution to create a positive outcome."
- "Service users are treated with respect and their needs are met."

Similar levels of dissatisfaction were apparent in the staff responses after the last care inspection in June 2019. The manager had undertaken to engage with staff in team meetings, shift handovers and individual staff supervisions. Written confirmation was later received that all feedback had been positive, with no areas of dissatisfaction reported.

The manager was advised after the inspection of all responses submitted by staff. The manager confirmed that there were established arrangements for staff to raise issues with management and that all staff were aware of these arrangements. The manager agreed to keep this situation under review.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the quality of the care records and the person centred approach used by staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included as part of this inspection report.

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