Unannounced Care Inspection Report
19 February 2019

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 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 three beds that provides care for adults who have a learning disability.

3.0 Service details

Organisation/Registered Provider: Praxis Care Group / Challenge **Responsible Individual:** Andrew James Mayhew	**Registered Manager:** Rebecca Stewart
Person in charge at the time of inspection: Rebecca Stewart	**Date manager registered:** 19 April 2018
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 3

4.0 Inspection summary

An unannounced inspection took place on 19 February 2019 from 11.00 to 12.35.

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

The following area was examined during the inspection:

- Care records

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	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 care inspection

No further actions were required to be taken following the most recent inspection on 14 August 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 report of the last care inspection and any written or verbal communication received by RQIA since the last inspection.

During the inspection the inspector met with the registered manager. No residents, care staff, visiting professionals or residents' representatives were present.

Two questionnaires were provided for 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. One questionnaire was returned by a resident and nine questionnaires were completed by staff.

The following records were examined during the inspection: the care records of two residents.

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 14 August 2018

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

6.2 Review of areas for improvement from the last care inspection dated 14 August 2018

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

6.3 Inspection findings

Care records

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 care files for each resident contained comprehensive information from the referring trust which was received and considered by Praxis before residents were admitted to the home. The information covered areas such as medical and mental health histories, nursing assessments and communication assessments prepared by a Speech and Language Therapist (SALT). A social work assessment was also present, outlining a social history and family supports, preferred routines, hobbies, interests, goals etc. This information allowed staff to become

familiar with the specific needs of each individual and to make preparations to meet these needs in the home.

Residents and their families were given information in the Residents Guide about what they could expect about life in the home and this was contained in the care files. The Residents Guide was available in a large print, easy read version; further information was provided in the resident agreement. Each document was signed and dated by residents. There was also written information, provided in an easy read format, setting out each resident's right to privacy in the home. This represented good practice.

There was a staff signature sheet to ensure that all staff working in the home had read the care files and were familiar with the needs of the residents and how these should be met. A checklist was also completed so that all necessary information was shared and all steps taken for a smooth move into the home.

On admission to the home, residents received a health and safety induction which included understanding the fire and smoke alarms, the location of the emergency escape routes and exits, the use of the fire blanket and fire extinguishers and emergency contacts. A written record of this was present in the care files and this was signed and dated by the resident.

There was also an information sharing agreement in place where residents gave their written consent for medical information, risk management plans and support plans to be shared with all relevant parties, including RQIA.

Staff in the home completed care needs assessments, risk assessments and care plans and these were completed in a high level of detail, as were the daily records for each resident. All documents were kept up to date, regularly reviewed and appropriately signed and dated. The care plans integrated Human Rights considerations throughout. This represented good practice.

It was noted that a resident who had been recently admitted to the home smoked, however the arrangements for smoking had not yet been fully documented. This was discussed with the registered manager who later forwarded a risk assessment and corresponding care plan.

There was a Restrictive Practice Register completed if any restriction was in place to ensure the safe care of the resident. The restrictions were fully described, assessed and regularly reviewed; the registered manager advised that consideration was given to removing restrictions when they were no longer required.

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. Where there were behaviour management plans in place, there were comprehensive records of this. The records also showed that there was effective communication between staff in the home and in the day care facility, and this ensured that there was good exchange of information and continuity of care was provided for the benefit of the residents.

There were regular reviews of the care provided in the home. These were attended by all relevant parties and the minutes of these reviews were retained in the care files of residents.

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 registered manager ensured that care records were maintained to a high standard and that care in the home was well led.

One completed questionnaire was returned to RQIA from a resident. Nine questionnaires were completed by staff. The resident indicated that they were very satisfied with all aspects of care. The staff described their level of satisfaction with care in the home as satisfied or very satisfied.

Comments received from a member of staff were as follows:

- "The service is managed to a very high standard with extremely competent staff. I feel safe working here and very supported."

Areas of good practice

There were areas of good practice found throughout the inspection in relation to recording the preparations made to receive residents into the home and to recording consent of residents. Good practice was also found in regard to care planning and assessing risk whilst taking into account Human Rights considerations and to documenting any restrictions used in the home.

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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