Unannounced Care Inspection Report
13 March 2019

Orchard Grove

Type of Service: Residential Care Home
Address: 7 The Square, Clough BT30 8RB
Tel No: 028 4481 1672
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 19 beds that provides care for adults who have a learning disability or who experience mental ill health.

3.0 Service details

Organisation/Registered Provider: Orchard Grove **Responsible Individual:** Ian George Emerson	**Registered Manager:** Deirdre Burns
Person in charge at the time of inspection: Deirdre Burns	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) MP - Mental disorder excluding learning disability or dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 19

4.0 Inspection summary

An unannounced inspection took place on 13 March 2019 from 09.50 to 12.10.

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

This was a focused inspection to assess progress with any areas for improvement identified during and since the last care inspection and to examine care records.

Evidence of good practice was found in relation to the detail and quality of care records.

No areas requiring improvement were identified.

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 Deirdre Burns, 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

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 19 July 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 registered manager and one member of care staff. One resident was present in the home. The resident was unable to communicate his views on the care he received in Orchard Grove but was observed to be relaxed and comfortable in his surroundings and in his interactions with staff. No visiting professionals and no residents' visitors/representatives were present.

The following records were examined during the inspection: Northern Ireland Adverse Incident Centre (NIAIC) checks, the home's smoking policy and the care files of four residents.

A total of 10 questionnaires was 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. Nine questionnaires were returned by residents or residents' representatives. No questionnaires were returned by staff within the agreed timescale.

Areas for improvement 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 19 July 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 19 July 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 28.1 **Stated:** First time	The registered person shall ensure that NIAIC checks are completed weekly and a record of such checks is maintained.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and inspection of records confirmed that weekly NIAIC checks were made and a record of checks maintained. Any relevant alerts were shared with staff.	
Area for improvement 2 **Ref**: Standard 21.1 **Stated:** First time	The registered person shall ensure that the smoking policy is reviewed to include current safety guidance for residents who smoke in care settings.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and inspection of the home's smoking policy confirmed that this was reviewed to include current safety guidance for residents who smoke in care settings.	

6.3 Inspection findings

Care records

The care files for each resident were stored securely. Any changes or updates to the care records were completed in the staff offices and this ensured 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 risk assessments covered such areas as moving and handling, nutrition, falls, where necessary. The care plans provided staff with guidance as to how the identified

needs should be met and how any risks present could be minimised. Where any restrictive practices were used, these were fully documented.

The care documentation was completed in detail and with a focus on individualised, person-centred care. Human rights considerations were integrated throughout care plans and there was evidence that all documents were kept up to date, regularly reviewed and appropriately signed and dated by the resident, staff and the registered manager. 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 care records noted visits from General Practitioners (GPs), community nursing, dieticians, speech and language therapists and other associated professionals.

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. The individual written agreements were up to date and accurate.

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 and that care in the home was well led.

Nine questionnaires were returned by residents or residents' representatives. All respondents described their level of satisfaction with the care provided in Orchard Grove as very satisfied.

Some comments included:

- "I am very happy in Orchard Grove."
- "I am very happy in here."
- "Happy living in Orchard Grove, staff and food is good."
- "Happy in Orchard."

Areas of good practice

Good practice was present with regard to integrating human rights considerations into care planning and to regular evaluation and review of the effectiveness of care provided to residents.

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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