Unannounced Follow-up Care Inspection Report
6 March 2019

Redlands

Type of Service: Residential Care Home
Address: 20 Adelaide Park, Belfast BT9 6FX
Tel No: 02890661526
Inspector: Marie-Claire Quinn

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 17 beds that provides care for residents living with dementia and/or aged over 65 years.

3.0 Service details

Organisation/Registered Provider: Whiteabbey Proprietors Ltd **Responsible Individual:** Mark John Uprichard	**Registered Manager:** Irene Best
Person in charge at the time of inspection: Irene Best	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia	**Number of registered places:** 17

4.0 Inspection summary

An unannounced inspection took place on 6 March 2019 from 09.40 to 12.20.

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 areas were examined during the inspection:

- environment
- care records
- accidents and incidents

Residents were positive about their experiences living in the home. Residents were enjoying breakfast in their rooms during the inspection and presented as comfortable, calm and content.

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 Irene Best, 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 21 June 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 care inspection report; the returned QIP; correspondence between the home and RQIA.

During the inspection the inspector met with five residents, three staff and the registered manager. The inspector made a general inspection of the home's environment and observed staffs interactions with residents.

Several questionnaires and 'Sorry We Missed You' cards were provided, to enable residents and relatives to provide feedback following the inspection. Four responses were received and respondents reported they were either satisfied or very satisfied with the care provided in the home.

The inspector also provided a poster for staff detailing how they can provide feedback to RQIA following the inspection; however no staff responses were received within the agreed time frame.

The following records were examined during the inspection:

- The care records of four residents
- Accidents and incidents records
- Accidents and incidents audits

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 21 June 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and further validated by the care inspector at this inspection on 6 March 2019.

6.2 Review of areas for improvement from the last care inspection dated 21 June 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 6.6 **Stated:** First time **To be completed by:** 1 July 18	The registered person shall ensure care plan is kept up to date and accurately reflects residents care needs. Ref: 6.5	**Met**
	Action taken as confirmed during the inspection: See 6.3	
Area for improvement 2 **Ref**: Standard 8.2 **Stated:** First time **To be completed by:** 23 June 18	The registered person shall there is a written entry at least weekly for each resident. Ref: 6.5	**Met**
	Action taken as confirmed during the inspection: See 6.3	

6.3 Inspection findings

Environment

The home was quiet when the inspector arrived; the registered manager advised that there are currently 12 residents living in the home, and many enjoy a lie in in the mornings. Breakfast was being served in the residents' bedrooms, and this is provided throughout the morning, depending on the time requested by the resident.

A notice board in the foyer contained pictorial and written information for residents, such as the date, weather and the names and photographs of the staff on duty throughout the day. The activities schedule was also displayed in written and pictorial format, and updated weekly. This week's arranged activities included nail bar; Devon cream tea; craft day; movie night. The registered manager advised that singers and music are always popular in the home. There is a piano in the main lounge and a cabinet containing a selection of alcoholic drinks. The registered manager advised that some residents enjoy a drink occasionally. The home provides the alcohol, and this is served by staff. The cabinet is not locked; however the registered manager stated this has never caused an issue. The registered manager may consider locking this, to minimise the risk of residents and/or visitors accessing alcohol without staff supervision.

The home was clean, tidy and warm, and cleaning was ongoing throughout the inspection. The inspector spoke with one resident who had just had his room cleaned; he stated the staff clean too much! The inspector noted that one fire door was partially blocked as a wheelchair had been stored behind it. This was highlighted to the registered manager who apologised and addressed this immediately. Discussion with staff confirmed they had received mandatory fire safety training and completed fire drills. This included evacuation techniques. Personal Emergency Evacuation Plans (PEEPs) had also been completed with residents.

All the residents were resting in their rooms and some were still sleeping, therefore the inspector did not disturb them. Other residents were being supported to attend to personal care by staff. Some residents were up, washed and dressed, and were watching television in their rooms, reading the paper or still enjoying their breakfast. Residents' presented with personal care attended to and were dressed in clean and comfortable clothing. Some female residents had recently had their hair blow dried, and the hairdresser visits the home once a week. Residents' appeared calm and relaxed in their surroundings. Any sign of agitation or distress was promptly responded to by staff, and residents' responded well to staff intervention. Residents' were positive about their experiences in the home. Comments included "We're very happy here…If I need something, I get it! (from staff)…It's nice here…There aren't any problems here…The food is very good, but we get too much! Irene (registered manager) is very good, she's here every day."

Staff did not appear rushed or hurried and were observed to be polite, courteous and kind when speaking to residents. Discussion with staff confirmed they felt the care provided in the home was safe and effective. Staff stated that there were adequate staffing levels in the home to meet the current needs' of the residents'. Both staff and the registered manager indicated that additional staff would be arranged depending on the needs and occupancy of residents in the home. Staff also confirmed they were good working relationships in the home, and described the registered manager as good with staff, approachable and responsive.

Care records

The inspector reviewed the care records of four residents'. Care plans were up to date, and correlated with the residents' needs'. Residents' holistic needs assessments were completed at the point of admission and this document was reviewed annually, or as changes occurred. Residents' daily needs were continually reviewed, with staff completing a written record a minimum of twice a day. Discussion with the registered manager and staff confirmed that this was an effective system of communication and ensured residents' needs were met and promptly responded to by staff and other relevant parties such as GPs. For instance, staff record changes in resident's mood and dependency levels, monitor this and make referrals to specialist services as required.

Review of care records confirmed there was close liaison with services such as Speech and Language Therapy (SALT) and dieticians as required. Recommendations were incorporated into care plans, assessments and regularly reviewed. Staff were asked to read the guidance and date and sign to confirm their understanding. Discussion with the registered manager and the home's cook confirmed that the new guidelines have been implemented into practice. Discussion with staff confirmed they had received training and information on dysphagia. Staff presented with knowledge and understanding of the new guidelines and risk management in relation to this. The new guidelines were displayed in the kitchen.

The daily care records were also used to inform the residents' risk assessments. A range of risk assessments were used to identify residents' needs and additional measures required to promote their health and safety. For instance, some residents require bed rails or pressure alarm mats. Care records contained discussion and review of potential Deprivations of Liberty, to ensure the resident's Human Rights were respected and promoted. For example, the home's front door has key pad entry, to minimise the risk to residents' who may be easily lost and confused. This is discussed, agreed and documented in conjunction with relatives and/or multi-agency professionals, to ensure this restriction is proportionate. Residents who are less dependent were provided with the security code, to promote their freedom and independence.

Discussion with staff confirmed the home provided person centred care, and this was confirmed in care records. Care records were individualised and included details on residents' preferences such as rising and retiring times and preferences for personal care, appearance and activities. The home used a 'This is me' tool to contribute to their holistic assessment and promote residents' spiritual, cultural and social needs. This includes end of life care, which was discussed and documented with residents' and/or their relatives.

Residents' and their families were involved and included in discussions regarding treatment and additional safety measures. This was evidenced in care plans and annual quality care reviews, which included their feedback and views. Residents and/or their relatives also signed care plans and care reviews, maintaining written records of their knowledge and consent to the care being provided in the home. The inspector and registered manager discussed ways to further improve this; for example, creating a separate consent form regarding access to records, in line with General Data Protection Regulations (GDPR).

The home's residents' charter of rights was displayed in the hall. The home's ethos is to support residents to maintain independence; safeguard privacy and support genuine and informed choice. This ethos was reflected in care records, for instance regarding nightly bedroom checks. Residents are given the option to have these checks, and to agree on the frequency of same. Residents could opt out if they chose. If a resident lacked capacity, a best interest's discussion was had with relatives and involved professionals, and recorded, including signatures to confirm consent.

Observation of practice identified that staff respected residents' privacy and dignity by knocking bedroom doors before entering; bedroom doors remained closed while residents were receiving personal care; staff advised the inspector if there were residents who were not feeling well and did not wish to speak with her. Discussion with staff confirmed that they ensured the residents' consent and agreement throughout their daily practice; for instance, asking permission before providing support with personal care; continual communication with residents' to ensure their understanding; respecting their choice if care is declined.

Accidents and incidents

Review of the home's accidents and incidents log for 2019 identified that there had been minimal accidents or incidents in the home. One incident had not been notified to RQIA; discussion with the registered manager confirmed her knowledge and understanding of the standards regarding this. She apologised for this single omission and agreed to ensure all notifiable incidents are reported in future.

The most recent falls audit was completed by the registered manager on 1 February 2019; no specific trends or patterns were identified, due to low number of incidents. Discussion with staff confirmed an awareness of how falls prevention techniques are embedded into practice. Staff were able to describe how they respond when a resident has an accident, including falls. Some residents are considered at high risk of falls, and so have a subsequent detailed falls assessment and care plan in place. Of the four care records reviewed, one did not have a falls care plan in place. Discussion with the registered manager identified that this resident's risk of falls had reduced; the registered manager agreed to review the file, and following the inspection, confirmed to the inspector that due to the reduction in the risk, a specific falls management care plan was not required for this resident. The registered manager also advised that she would continue to review this as part of her care plans audits which are completed on a regular basis.

Areas of good practice

There was evidence of good practice in relation to the promotion of privacy, dignity, choice and person centred care provided to residents' 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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