

**Unannounced Care Inspection  
of  
Redlands**

**20 August 2015**

## 1. Summary of inspection

An unannounced care inspection took place on 18 August 2015 from 10.15 to 15.00. On the day of the inspection the home was found to be delivering safe, effective and compassionate care.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005, the DHSSPS Residential Care Homes Minimum Standards (2011), NICE guidelines on the management of urinary incontinence in women (September 2013), NICE guidelines on the management of faecal incontinence (June 2007) and Guidance and Audit Implementation Network (GAIN) guidelines available for palliative care.

### 1.1 Actions/Enforcement taken following the last inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last inspection.

### 1.2 Actions/Enforcement resulting from this inspection

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

### 1.3 Inspection outcome

	Requirements	Recommendations
<b>Total number of requirements and recommendations made at this inspection</b>	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

## 2. Service details

<b>Registered organisation/Registered person:</b> Whiteabbey Proprietors Ltd	<b>Registered manager:</b> Irene Best
<b>Person in charge of the home at the time of inspection:</b> Irene Best	<b>Date manager registered:</b> 1/4/2005
<b>Categories of care:</b> RC-I, RC-DE	<b>Number of registered places:</b> 17
<b>Number of residents accommodated on day of Inspection:</b> 13	<b>Weekly tariff at time of inspection:</b> £535-£570

## 3. Inspection focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standard and theme has been met:

**Standard 14: The death of a resident is respectfully handled as they would wish.**

**Theme: Residents receive individual continence management and support.**

## 4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to the inspection the following records were analysed: returned quality improvement plan from the previous inspection and notifications to RQIA since the last inspection.

We inspected three care records, complaints records, staff training records, fire safety risk assessment, accident and incident records.

We met with eight residents; five members of staff of various grades. No visiting professionals were present during inspection. We spoke with 5 residents' representatives during the inspection.

## 5. Review of requirements and recommendations from previous inspection

The previous inspection of the home was an unannounced care inspection dated 3 March 2015. The completed QIP was returned and approved by the care inspector.

## 5.1 Review of requirements and recommendations from the last care inspection

Previous Inspection Statutory Requirements		Validation of Compliance
<b>Requirement 1</b>  <b>Ref:</b> Regulation 19(2) Schedule 4(7)	The registered person shall maintain in the home the records specified in Schedule 4.	<b>Met</b>
	Schedule 4 (7) a copy of the duty roster of persons working in the home, and a record of whether the roster was actually worked.  Reference to this is made in that the record of hours worked by domestic / ancillary staff must be maintained in detail in the duty rota.	
	<b>Action taken as confirmed during the inspection:</b> We inspected the duty rota. The registered manager confirmed to us it accurately reflects the hours worked by staff.	

## 5.2 Standard 14: The death of a resident is respectfully handled as they would wish

### Is care safe? (Quality of life)

The registered manager confirmed to us that residents can spend their final days in the home unless there are documented health care needs to prevent this.

We inspected three residents' care records and confirmed that care needs assessments; risk assessments and care plans were in place and were kept under continual review. Documentation was amended as changes occurred to residents' medical conditions. The records were kept up to date to accurately reflect at all times the needs and preferences of the resident. The needs assessments and care plans were appropriately signed.

We noted that care plans contained details of residents' wishes regarding any specific arrangements at the time of his or her death. Care records also noted the spiritual and cultural wishes of the residents. Where there had been discussion with the general practitioner relating to medical interventions, this was noted within the care records.

### Is care effective? (Quality of management)

The home had a policy and procedure relating to dying and death. The policy gave guidance on how to manage this area of need.

In our discussions with staff they confirmed that they would be able to recognise the possibility that a resident may die within the next few days or hours. Staff members were knowledgeable about obtaining multi-professional community supports (GP, District Nursing, Occupational

Therapy, Speech and Language Therapy, Dietician). Notification of a death is made to all relevant parties in a timely manner.

Staff confirmed to us that there was a supportive ethos within the management of the home in helping residents, relatives and staff deal with dying and death.

### **Is care compassionate? (Quality of care)**

Staff members who spoke to us indicated that they felt prepared and able to deliver care in a compassionate and sensitive manner. Staff were also able to articulate those values that underpin care within the home as they related to dying and death of a resident.

The staff described how a resident had been cared for in the home at the end of life; whilst the medical needs of the resident had been met by the General Practitioner and the district nursing team, the care needs of the resident were fully met by the staff. The family had been able to be with the resident at the end of life. The staff accommodated the family and made them comfortable within the home. The news of the resident's death had been given to fellow residents in a sensitive manner.

In our discussions with the staff they confirmed that arrangements can be made to provide spiritual care for residents who are dying, if they so wish. Family members, friends, other residents and staff who may wish to offer comfort for a resident who is dying are enabled to do so, if the resident wishes. Following a death, the body of the deceased resident is handled with care and respect and in accordance with his or her expressed social, cultural and religious preferences.

The registered manager confirmed to us that the deceased resident's belongings were handled with care and his or her representative is consulted about the removal of the belongings. The home takes a flexible approach to the removal of belongings from the room of the deceased resident.

### **Areas for improvement**

There were no areas of improvement identified with the standard inspected. Overall, this standard was met.

<b>Number of Requirements:</b>	<b>0</b>	<b>Number of Recommendations:</b>	<b>0</b>
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## **5.3 Theme: Residents receive individual continence management and support**

### **Is care safe? (Quality of life)**

The staff members we interviewed during inspection were able to demonstrate knowledge and understanding of continence care.

We inspected three residents' care records which confirmed that person centred assessments and care plans were in place relating to continence. Staff members were able to describe to us the system of referral to community district nursing services for specialist continence assessment. Care plans were amended as changes occurred to residents' continence needs. Care records were kept up to date to accurately reflect at all times the needs and preferences of the resident in relation to continence management.

There was adequate provision of continence products. Staff confirmed to us that they had unrestricted access to a plentiful supply of laundered bed linen and towels, also that gloves, aprons and hand washing dispensers were present. Staff members were aware of the process for safe disposal of used continence items in line with infection control guidance.

### **Is care effective? (Quality of management)**

The home had a policy and procedure relating to the management of continence. The policy was comprehensive and gave adequate guidance for staff. In our discussions with staff they were able to identify continence issues and the importance of continued review and evaluation.

The registered manager confirmed to us that the trust continence care team can be contacted for advice and direction; they also carry out regular reviews.

### **Is care compassionate? (Quality of care)**

In our discussions with staff they recognised the potential loss of dignity associated with incontinence. They gave examples of how they ensure, as far as possible, the resident's dignity and independence is maintained when assisting with individual continence management. Residents related to us that staff members provide assistance with continence care in a sensitive and caring manner.

### **Areas for improvement**

There were no areas of improvement identified with the theme inspected. Overall, this theme was met.

<b>Number of Requirements:</b>	<b>0</b>	<b>Number of Recommendations:</b>	<b>0</b>
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## **5.4 Additional areas examined**

### **5.4.1 Residents views**

We met with eight residents individually. In accordance with their capabilities they all indicated that they were happy with their life in the home, their relationship with staff and with the provision of care. Some comments included:

“the staff are good and food is nice”

“staff are very helpful”

### **5.4.2 Relatives / representatives' views**

We spoke with four relatives individually. All spoke positively about the home. One relative commented:

“I could not speak highly enough of staff. They are amazing they are approachable, knowledgeable and nothing is a bother.”

### 5.4.3 Staff views

We met with two staff members who spoke positively about their role and duties, staff morale, teamwork and managerial support. Staff indicated to us that they felt well supported by management and are given the necessary resources to fulfil their duties.

Some comments included:

- “I like working here. There is good team work”
- “Staff are all great to work with”

### 5.4.4 Visiting professional's views

There were no visiting professionals on the day of inspection.

### 5.4.5 Care practices

In our discreet observations of care practices we were satisfied that residents were treated with dignity and respect. Care duties were conducted at an unhurried pace with time afforded to interactions with residents in a polite, friendly and supportive manner.

### 5.4.6 Accidents / incidents

The registered manager confirmed accident and incident notifications since the previous inspection had been reported and managed appropriately. The records inspected confirmed this.

### 5.4.7 Complaints

An inspection of the complaints records confirmed that these had been recorded and managed appropriately. Records were retained of investigations, outcomes and of lessons learned.

### 5.4.8 Fire safety

On the day of inspection the home's Fire Safety Risk Assessment was in date. Fire alarms were tested weekly in different zone. We inspected the staff training records which confirmed that staff members had received fire training twice yearly in accordance with regulation.

### 5.4.9 Environment

We found the home was clean and tidy, with good housekeeping arrangements in place. The general décor and furnishings were of good standard. Communal lounges were comfortable and offered choice of seating for residents. Residents' bedrooms were comfortable and personalised.




### Areas for improvement

There were no areas of improvement identified in additional areas inspected.

<b>Number of Requirements:</b>	<b>0</b>	<b>Number of Recommendations:</b>	<b>0</b>
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No requirements or recommendations resulted from this inspection.

I agree with the content of the report.

Registered Manager		Date Completed	29.9.15
Registered Person		Date Approved	29.9.15
RQIA Inspector Assessing Response		Date Approved	13-9-15

Please provide any additional comments or observations you may wish to make below:

*\*Please complete in full and returned to [care.team@rqia.org.uk](mailto:care.team@rqia.org.uk) from the authorised email address\**

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations.