Primary Announced Care Inspection

Name of Establishment:	**Twisel Lodge**
Establishment ID No:	**1662**
Date of Inspection:	**20 May 2014**
Inspector's Name:	**Kylie Connor**
Inspection No:	**16615**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General information

Name of Home:	Twisel Lodge
Address:	19a Church Avenue Holywood BT18 9BJ
Telephone Number:	(028) 9042 8458
E mail Address:	twisellodge@cedar-foundation.org
Registered Organisation/ Registered Provider:	Ms Eileen Marian Thomson The Cedar Foundation
Registered Manager:	Ms Louise Campbell (Acting)
Person in Charge of the home at the time of Inspection:	Ms Louise Campbell
Categories of Care:	RC-LD ,RC-LD(E)
Number of Registered Places:	8
Number of Residents Accommodated on Day of Inspection:	8
Scale of Charges (per week):	£1,128.46
Date and type of previous inspection:	31 May 2013 Primary Announced Inspection
Date and time of inspection:	20 May 2014 9:45am to 6:00pm
Name of Inspector:	Kylie Connor

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect residential care homes. A minimum of two inspections per year are required.

This is a report of an announced primary care inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations and minimum standards and other good practice indicators and to consider whether the service provided to service users was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of residential care homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Residential Care Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Residential Care Homes Minimum Standards (2011)

Other published standards which guide best practice may also be referenced during the inspection process.

4.0 Methods/Process

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the Minimum Standards.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

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

- Analysis of pre-inspection information
- Discussion with the registered manager (acting)
- Examination of records
- Observation of care delivery and care practice
- Discussion with staff
- Consultation with and observation of residents

- Inspection of the premises
- Review of returned staff questionnaires
- Evaluation of findings and feedback

Any other information received by RQIA about this registered provider and/or the service delivery has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

During the course of the inspection, the inspector spoke to the following:

Residents	2 residents and observed others
Staff	3 staff, the registered manager(acting) and the co-head of living options
Relatives	0
Visiting Professionals	0

Questionnaires were provided, during the inspection, to staff seeking their views regarding the service.

Issued To	Number issued	Number returned
Staff	15	4

6.0 Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to establish the level of compliance achieved with respect to the following DHSSPS Residential Care Homes Minimum Standards:

- **STANDARD 10 - RESPONDING TO RESIDENTS' BEHAVIOUR**
  Responses to residents are appropriate and based on an understanding of individual resident's conduct, behaviours and means of communication

- **STANDARD 13 - PROGRAMME OF ACTIVITIES AND EVENTS**
  The home offers a structured programme of varied activities and events, related to the statement of purpose and identified needs of residents

A view of the management of resident's human rights was undertaken to ensure that residents' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

The registered provider and the inspector have rated the home's compliance level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken	In most situations this will result in an area of good practice being identified and comment being made within the inspection report

7.0 Profile of service

Twisel Lodge Residential Care home is situated within the geographical area of the South Eastern Health and Social Care Trust. It is located near the centre of Holywood, in a residential area, close to local amenities.

The residential home is owned and operated by The Cedar Foundation. The current registered manager is Louise Campbell, who is in an acting capacity at present.

The accommodation consists of eight single bedrooms, a lounge / dining area, a multi-sensory / quiet room, kitchen, utility room and two specially equipped bathrooms on the ground floor.

There is also a staff room which has been added to the rear of the building and office space and staff "sleepover room" are located on the first floor. The home also provides for catering and laundry services. Some off street car parking is available at the entrance of the home.

The home provides long term care for seven residents with a learning disability, associated physical difficulties; some of whom may have an acquired brain injury. The home has one respite care place which has been in operation since September 2008.

The home is registered to provide care for a maximum of eight persons under the following categories of care:

Residential care

LD Learning Disability
LD(E) Learning Disability – over 65 years

8.0 Summary of Inspection

This announced primary care inspection of Twisel Lodge was undertaken by Kylie Connor on 20 May 2014 between the hours of 9:45am and 6:00pm. Since the previous inspection, Louise Campbell, Registered Manager (Acting) is in the position in a temporary capacity. Both Ms Campbell and Deborah Stevenson, Co-Head of Living Options were available during the inspection and for feedback at the conclusion of the inspection. A summary of the findings of the standards inspected are outlined below.

The requirements and recommendations made as a result of the previous inspection were also examined. Observations and discussion demonstrated that one requirement and four recommendations were found to be compliant. Improvements were observed in one requirement regarding the annual quality report and this is re-stated as a recommendation. One recommendation obtained the level, moving towards compliance in the area of recruitment and this has been restated. The detail of the actions taken by the home can be viewed in section 9.0 of the report.

Prior to the inspection, a completed self-assessment was submitted to the authority using the standard criteria outlined in the standards inspected. The comments provided in the provider's self- assessment were not altered in any way by RQIA.

During the inspection the inspector met with residents and staff, discussed the day to day arrangements in relation to the conduct of the home and the standard of care provided to

residents, observed care practice, issued staff questionnaires, examined a selection of records and carried out a general inspection of the residential care home environment.

In discussion with residents, they indicated that that they were happy, living in the home, with the food, activities and with their relationship with staff.

A review of the returned questionnaires and discussion with staff indicated that the home has had a number of new staff, that recruitment is on-going and that staff were supported in their respective roles. Staff confirmed that they are provided with the relevant resources and training to undertake their respective duties. Two returned staff questionnaires raised issues in regard to food and a recommendation has been made.

The areas of the environment viewed by the inspector presented as fresh smelling, clean, adequately heated, appropriately decorated and furnished.

A number of additional documentation was returned to the authority prior to the inspection. These were also examined and included, the management of complaints, resident dependency levels, vetting confirmation, care review confirmation and a fire safety audit. No issues where identified and some further detail can be found in section 11.0 of the report.

There were no requirements and nine recommendations made as a result of this inspection. Details can be found in the main body of the report and the attached Quality Improvement Plan (QIP).

The inspector would like to thank the residents, registered manager (acting), Co-Head of Living Options and staff for their assistance and co-operation throughout the inspection process.

Responding to resident's behaviour – Standard 5

The inspector reviewed the arrangements in place for responding to resident's behaviour. The home had policies and procedures in place which reflected best practice guidance in relation to restraint, seclusion and human rights. Through the inspector's observations, a review of documentation and discussion with staff, confirmation was obtained that restraint is not used and that various restrictive practices are in use.

Residents' care records outlined their usual routine, behaviours and some detail in regard to means of communication and how staff should respond to their assessed needs. Staff who met with the inspector demonstrated that they had knowledge and understanding of individual residents assessed needs.

Staff also confirmed that they have received training in behaviours which challenge. Staff were aware of the need to report uncharacteristic behaviour to the person in charge and to ensure that all the relevant information is recorded in the resident's care records. The registered manager is aware of her responsibilities in relation to when to refer residents to the multi-disciplinary team.

A review of a sample of records evidenced that residents representatives and trust staff had been included in decisions affecting their care. The evidence gathered through the inspection process concluded that Twisel Lodge is substantially compliant with this standard. Improvements were identified in the area of reviewing relevant policies and procedures development of a person-centred communication record and ensuring that the registered manager (acting) signs all care plans.

Programme of activities and events – Standard 13

The inspector reviewed the arrangements in place to deliver a programme of activities and events for residents. The home had a policy and procedure relating to the provision of activities. Through the inspector's observations, a review of documentation, returned staff questionnaires and discussion with staff, confirmation was obtained that the programme of activities was based on the assessed needs of the residents.

Two returned staff questionnaires raised the issue of staffing levels impacting upon social activities at times. The inspector was assured by the registered manager (acting) that this remains under review and efforts will be made to facilitate outings when possible. Staff spoke of plans to encourage family to join the residents on planned social outings.

Staff confirmed that residents benefitted from and enjoyed the activities and events provided. The programme of activities was appropriately displayed. The programme identified that activities were provided throughout the course of the week and were age and culturally appropriate. The programme took account of residents' needs and facilitated inclusion in community based events.

Residents were given opportunities to make suggestions regarding the programme of activities. Activities are provided by designated care staff or were contracted in. A selection of materials and resources were available for use during activity sessions. Appropriate systems were in place to ensure that staff who are not employed by the home have the necessary knowledge and skills to deliver the activity. The evidence gathered through the inspection process concluded that Twisel Lodge is compliant with this standard.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous inspection on 31 May 2013

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	3 (Schedule 1)	The statement of purpose should be improved in respect of the items listed in Schedule 1. Particular attention should be made to numbers 3, 14 and 17.	The registered manager (acting) confirmed that this has been reviewed and is dated September 2013. Evidence demonstrated that the areas noted have been inserted. This is not re-stated.	Compliant
2	17 (1) (2) (3)	The annual quality review report should be improved to reflect improvements made/outcomes for residents including as a result from suggestions made by residents or their representatives. The homes annual quality report for 2012 should be submitted to the Authority.	The 2013 annual report evidenced that improvements have been made. The inspector advised to include environmental improvements carried out in the home and a summary of the registered provider visits with comments made/ observations of residents, staff and visitors. This is re-stated as a recommendation.	Substantially compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	11.3	Support provided by the home in relation to residents' finances should be included in the care review report completed by staff prior to the annual review.	One residents care review record evidenced that this is in place. This is not re-stated.	Compliant
2	16.4	Ensure records are made of discussions with Trust re outcome of vulnerable adult referrals made to designated officer.	The registered manager (acting) stated that a recording template is now in place which records outcomes. This is not re-stated.	Compliant
3	20.11	Ensure registered provider reports identify by means of initials or other of residents/staff or visitors spoken to/observed and evidence follow-ups from month to month through the use on an action box.	The report for April 2014 evidenced that this is in place. This is not re-stated.	Compliant
4	19.2	The staff checklist completed by the human resources department should be improved to reflect this criterion and held in the staff file in the home.	The template doesn't state all areas listed including; a birth certificate; photo identification; that one of the two references is from a previous/present employer. The co-head of living options stated that there is a more comprehensive checklist which she signs off for all new staff and will ensure this is copied and held in staff files in the home. This is re-stated.	Moving towards compliance

5	13 23	The registered manager should review and respond to suggestions made by staff in regard to; having more social outreach and provide more training specific to learning disability specifically re communication with individuals with autism or who have no or little speech or facial expressions.	Staff training records evidenced that intensive interaction training was delivered to staff in December 2013. The registered manager (acting) confirmed that residents go out together including bowling and the home has now access to a bigger bus and currently a number of staff are in the process of getting a certificate to enable them to drive it. This is not re-stated.	Compliant

10.0 Inspection Findings

STANDARD 10 - RESPONDING TO RESIDENTS' BEHAVIOUR Responses to residents are appropriate and based on an understanding of individual resident's conduct, behaviours and means of communication.	
Criterion Assessed: 10.1 Staff have knowledge and understanding of each individual resident's usual conduct, behaviours and means of communication. Responses and interventions of staff promote positive outcomes for residents.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Any resident who comes to live at Twisel lodge has a full assessment of care and risk completed "How I prefer to live my daily life". Care and risk assessments are reviewed as and when required but at least annually.The policies and procedures Cedar have in regard to responding to behaviours which challenge are LOG002 Guidance on undertaking a risk assessment, TCF G006 Adverse incidents, TCF G011 Behaviours that challenge. Cedar also has a 'Service user charter of rights'. All staff working in Twisel Lodge have yearly training on Management of Behaviours that Challenge, Restrictive Practice and through this training are made aware of the Human Rights Act (1998). specific training is also given in this area. Care plans and risk assessments are used to identify triggers and also indicate how to appropriately respond evaluate and review to ensure a positive outcome for the resident. Residents, relatives and or representatives are involved in needs and risk assessments and reviews are carried out with their involvement and input. Through training staff respond ensuring the needs and rights of the residents are protected and upheld. Any practices that would impact on the human rights of the resident are undertaken only with prior approval from the Trust, this evidence can be found in the care plan. All incidents/accidents are sent to RQIA on every occasion where required.	Compliant
Inspection Findings:	
The guidance and policies and procedures referred to above are acknowledged. A review of Behaviours that Challenge Policy (February 2014), Guidance on Reducing Restrictive Practices and Promoting Positive Interventions (November 2013) and Procedure regarding reporting and managing incidents of challenging behaviour evidenced that the DHSS Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) and the Human Rights Act (1998) is reflected.	Substantially compliant

The documents state the need for Trust involvement in managing behaviours which challenge. It does not detail that RQIA must be notified on each occasion restraint is used. A recommendation has been made. Observation of staff interactions, with residents and discussions with two staff evidenced knowledge and practice of informed values and the implementation of least restrictive strategies were confirmed. A review of staff training records identified that care staff had received training in behaviours which challenge on 8 or 12 March 2013 and 12 December 2013 which included a human rights approach. A review of residents' care records, chosen at random identified that individual resident's usual routines, behaviours and means of communication were recorded. However, improvements are needed to the care plan to improve specific detail regarding how staff should respond to assessed needs. A recommendation has been made. Risk assessments were appropriately completed. Staff who met with the inspector demonstrated knowledge and understanding of resident's usual routines, behaviours and means of communication. Staff spoken with were knowledgeable in relation to responses and interventions which promote positive outcomes for residents. A review of the four returned staff questionnaires identified that staff indicated that they had received training in behaviours which challenge.	

Criterion Assessed: 10.2 When a resident's behaviour is uncharacteristic and causes concern, staff seek to understand the reason for this behaviour. Staff take necessary action, report the matter to the registered manager or supervisor in charge of the home at the time and monitor the situation. Where necessary, they make contact with any relevant professional or service and, where appropriate, the resident's representative.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Cedar's procedure on Managing Challenging Behaviour is in place and available to all staff. Staff receive annual training in managing behaviours that challenge. There are clear guidelines in place for staff to ensure the reporting and recording procedures are followed. Staff are supported through training and supervision to ensure training needs can be identified and to reduce the re-occurrence of incidents where possible. Cedar has the following policy and procedures in place : TCFF017 Challenging Behaviour Incident report TCFF003 Accident and Incident reporting TCFF004 Adverse incident follow on LOGO10 Guidance on reducing restrictive practice and promoting positive interventions LORSF003 Resident care plan LOFO11 Generic Risk assessment TCFG001 Behaviours that challenge	Compliant

Inspection Findings:	
The guidance and policies and procedures referred to above are acknowledged. The policy and procedures referred to in 10.1 do not, include the following and a recommendation has been made . Identifying uncharacteristic behaviour which causes concern . Recording of this behaviour in residents care records . Action to be taken to identify the possible cause(s) and further action to be taken as necessary . Reporting to senior staff, the trust, relatives and RQIA. . Agreed and recorded response(s) to be made by staff Staff who met with the inspector demonstrated knowledge and understanding in relation to the areas outlined above. Staff are aware of the need to report the uncharacteristic behaviour to the registered manager and or the person in charge. One care record reviewed had identified any uncharacteristic behaviour to date.	Substantially compliant
Criterion Assessed: 10.3 When a resident needs a consistent approach or response from staff, this is detailed in the resident's care plan. Where appropriate and with the resident's consent, the resident's representative is informed of the approach or response to be used.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Within Twisel Lodge any resident who requires a consistent approach or response from staff has this recorded within their care plan and daily notes. Staff are made aware of this through handovers, team meetings and supervision. There are arrangements in place to obtain consent from the resident and/or their representative through yearly reviews and care plan reviews. This is evidenced in care plans. Approaches and responses are not implemented without consent of the care manager, resident and /or their representative.	Compliant
Inspection Findings:	
A review of two care plans identified that when a resident needs a consistent approach or response from staff, this was detailed. Care plans reviewed were signed by the resident or their representative where appropriate, the staff member drawing it up but not the registered manager and a recommendation has been made.	Substantially compliant

Criterion Assessed: 10.4 When a resident has a specific behaviour management programme, this is approved by an appropriately trained professional and forms part of the resident's care plan.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Cedar has the following policy, procedures and guidance in place and work with the multi disciplinary team for support and guidance to develop the best response for the resident. LOGO10 Guidance on reducing restrictive practice and promoting positive interventions. TCFF017 Challenging Behaviour incident report TCFF003 Accident and Incident reporting TCFF004 Adverse incident follow on LORSF003 Resident care plan LOFO11 Generic Risk assessment TCFG001 Behaviours that challenge Each resident has a review of their care at least annually in Twisel lodge, this evidence can be obtained in each residents care file.	Compliant
Inspection Findings:	
The registered manager (acting) informed the inspector that there are currently no residents who have a specific behaviour management programme in place. Therefore, this criterion is not applicable at this time.	Not Applicable

Criterion Assessed: 10.5 When a behaviour management programme is in place for any resident, staff are provided with the necessary training, guidance and support.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Staff receive annually the following training to support and guide them to respond and care for residents: Managing behaviours that challenge Restrictive Practice Reporting and recording Safeguarding Vulnerable adults Human Rights Support and care planning Through supervison and monitoring of daily practice,if staff are identifed to have a learing need, the above training will happen more frequently. Staff training aqnd supervision records are available Regualr staff meetings and daily observation from Practice Leaders ensure that staff are consistently implementing the behaviour management programmes as required.	Compliant
Inspection Findings:	
The registered manager (acting) informed the inspector that there are currently no residents who have a specific behaviour management programme in place. Therefore, this criterion is not applicable at this time.	Not applicable
Criterion Assessed: 10.6 Where any incident is managed outside the scope of a resident's care plan, this is recorded and reported, if appropriate, to the resident's representative and to relevant professionals or services. Where necessary, this is followed by a multi-disciplinary review of the resident's care plan.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Cedar currently have in place guidance and policy around management of incidents, this can be found within Twisel Lodge. The guidance clearly states reporting responsibilities and to whom and within what time frame. All staff are made aware of this during training and development.	Compliant
Inspection Findings:	

A review of random number of accident and incident records from January to March 2014 and discussion with staff identified that no incidents had occurred outside of the scope of a resident's care plan. A review of care plans identified that they had been updated and reviewed and included involvement of the Trust personnel and relevant others.	Compliant
Criterion Assessed: 10.7 Restraint is only used as a last resort by appropriately trained staff to protect the resident or other persons when other less restrictive strategies have been unsuccessful. Records are kept of all instances when restraint is used.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Cedar have a policy and guidance on 'reducing restrictive practice and promoting positive interventions. All staff are trained in human rights and restrictive practice and are therefore aware that they cannot implement anything without prior agreement with the resident and or their representative. If required training would be provided for staff in restraint. Restraint is not currently used at Twisel Lodge. If unauthorised restraint was found to be used, the appropriate forms would be sent to RQIA to notify them of this. Form 1a and follow up form 2. If an incident of restraint were to occur, staff would receive support and guidance following the event.	Compliant
Inspection Findings:	
Discussion with staff and a review of accident and incident records, staff training records and an examination of care records confirmed that restraint is not used when other less restrictive strategies have proved unsuccessful. Residents are not able to discuss details of decisions that affect their care but were able to convey their happiness living in the home. A review of the home's Statement of Purpose evidenced that the types of restraint and restrictive practices used in the home are not described. There was evidence of restrictive practices in place which were detailed on residents care plans include bedrails, use of a baby monitor and lap belts. Consent and / or best interest documentation was in place. Other forms of restrictive practices need to be considered, including for example; pressure mats, locked/alarmed doors**,** night checks, use of medication and this was discussed with the registered manager (acting). A recommendation has been made. The last review of one resident was not available to examine and a second care record examined was due to have a first review.	Substantially compliant

PROVIDER'S OVERALL ASSESSMENT OF THE RESIDENTIAL HOME'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE RESIDENTIAL HOME'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially compliant

STANDARD 13 - PROGRAMME OF ACTIVITIES AND EVENTS The home offers a structured programme of varied activities and events, related to the statement of purpose and identified needs of residents.	
Criterion Assessed: 13.1 The programme of activities and events provides positive outcomes for residents and is based on the identified needs and interests of residents.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Cedar currently have in place the User Involvment policy and a Policy and Guidance document on implementing daily routines. The current programme of activities within Twisel is based on residents wants, likes and dislikes; evidence of this can be found in their individual care plans. The current updated resident guide and statement of purpose provides an overview of the types of activities offered Outcomes of activities are evidenced in resident files Residents provided with transport to Ravara day care services	Compliant
Inspection Findings:	
The home had a Day Activities Policy (May 2014) on the provision of activities. A review of two care records evidenced that individual social interests and activities were included in the needs assessment and the care plan. Discussion with residents and staff and a review of the records of activities and events indicated that residents benefited from and enjoyed the activities and events provided. These activities were based on the assessed needs and interests of the residents. The Statement of Purpose and Residents Guide provide basic information pertaining to activity provision within the home and a recommendation has been made.	Compliant

Criterion Assessed: 13.2 The programme includes activities that are enjoyable, purposeful, age and culturally appropriate and takes into account the residents' spiritual needs. It promotes healthy living, is flexible and responsive to residents' changing needs and facilitates social inclusion in community events.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
All activites are suitable for the resident group and are purposeful, age and culturally appropriate and take in to account spiritual needs if chosen by the resident and or their representative. Documentation on activities planned with residents are available for inspection in Twisel Lodge.	Compliant
Inspection Findings:	
The majority of residents attend a day centre a number of days per week. Examination of the homes programme of activities identified that social activities are organised. Staff stated; "Everybody's needs are totally different." The programme examined included activities which were age and culturally appropriate and reflected residents' needs and preferences. The programme took into account residents' spiritual needs and facilitated residents inclusion in community based events. Care staff confirmed during discussion that residents were provided with enjoyable and meaningful activities on a regular basis. Two returned staff questionnaires indicated that staffing levels are not always available to facilitate outings, however one noted that additional staff were provided to facilitate an outing on 'may day.' Two returned staff questionnaires raised no issues in regard to the provision of activities.	Compliant

Criterion Assessed: 13.3 Residents, including those residents who generally stay in their rooms, are given the opportunity to contribute suggestions and to be involved in the development of the programme of activities.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Evidence of consultation on activities with residents, family and respresentatives can be found in care reviews, questionnaires and 1:1 meetings. Feedback from residents and their relatives/representatives can be found in Twisel Lodge records. Residents always have the choice to participate in activities and decisions are respected.	Compliant
Inspection Findings:	
A review of the record of activities provided, discussion with staff evidenced that there are no residents who generally stay in their rooms. There was evidence that residents were given opportunities to put forward suggestions or their choice for activities.	Compliant
Criterion Assessed: 13.4 The programme of activities is displayed in a suitable format and in an appropriate location so that residents and their representatives know what is scheduled.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The programme of activities is displayed in the communal living areas and in each service user's individual care file. The programme of activities is in a format suitable to the needs of the residents and evidence of individual and group consultation is evidenced in Twisel Lodge. Residents are made aware of activites daily in a verbal and pictorial format suited to their needs.	Compliant
Inspection Findings:	
On the day of the inspection the programme of activities was on display near the front door. This location was considered appropriate as the area was easily accessible to residents and their representatives. It was acknowledged by staff that the programme of activities is more beneficial for visitors as staff use conversation and pictures and symbols individually with residents.	Compliant

Criterion Assessed: 13.5 Residents are enabled to participate in the programme through the provision of equipment, aids and support from staff or others.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
A sensory room is made available for use by all residents at a time of their choosing or where agreed in a review meeting. Resources are made available to staff and residents to facilitate activites in and out of Twisel Lodge. Regular meetings with the manager are in place to ensure the acitivites planned can be sourced. During staff meetings and supervision all staff are updated on activites and invited to give their opinions and ideas for future and current activites within Twisel Lodge. Activites can take place in individual rooms, communal living area and outside, evidence of same can be found in Twisel. Joint participation with other residential facilities in Cedar Lodge have enriched the programme of activites for the residents at Twisel Lodge, evidence of same can be found within the home	Compliant
Inspection Findings:	
Evidence demonstrated that a regional activity coordinator reviewed activity provision in the home in March 2014 and provided feedback to senior staff. Staff confirmed that there was an acceptable supply of activity equipment available. This equipment includes: sensory equipment with a variety of music and lights; lots of arts and craft resources; skittles and comments were made that some residents have their own games and equipment. Staff stated; "There is never a problem with funding trips or getting extra staff or an external music activity. The bigger bus has made a difference." There was confirmation from the registered manager (acting) that activities are financed from within the homes budget. Residents pay 25p per mile and the registered manager (acting) stated that this is detailed in the residents' agreement. The inspector advised to include this information in the care review pre-review report.	Compliant

Criterion Assessed: 13.6 The duration of each activity and the daily timetable takes into account the needs and abilities of the residents participating.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
In order to take into account and fully meet the needs and abilities of the resident, activities are agreed prior to them happening and the resident and relative/representative is asked for their input and ideas. Residents choose their level of involvement. For example hand and feet massages take place in the home however some residents will only have one or the other, or none at all.	Compliant
Inspection Findings:	
Staff confirmed that the duration of each activity was recorded and tailored to meet the individual needs, abilities and preferences of the residents participating. Care staff demonstrated an awareness of individual residents' abilities and the possible impact this could have on their participation in activities.	Compliant
Criterion Assessed: 13.7 Where an activity is provided by a person contracted-in to do so by the home, the registered manager either obtains evidence from the person or monitors the activity to confirm that those delivering or facilitating activities have the necessary skills to do so.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Any person not employed by the Cedar Foundation and who is brought in to provide an activity is first met with by senior staff/ registered manager who endeavour to ensure that the person and their service are suitable for the needs of the service users. Qualifications are evidenced as appropriate. Suitability is monitored on a regular basis. Prior to an external person coming to Twisel, residents and relatives are informed and can oppose if they wish as residents have the option of opting in or out of activities.	Compliant

Inspection Findings:	
The registered manager (acting) confirmed that one person is employed to provide music therapy once per month. The registered manager (acting) confirmed that there were monitoring processes in place to ensure that they had the necessary knowledge and skills to deliver the activity.	Compliant
Criterion Assessed: 13.8 Where an activity is provided by a person contracted-in to do so by the home, staff inform them about any changed needs of residents prior to the activity commencing and there is a system in place to receive timely feedback.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Feedback from and about external services is completed on a regular basis and monitored by the registered manager. Evidence of this can be found in te activity file held at Twisel Lodge. Any feedback received to and from the service in relation to external people providing activities is evidenced within the home.	Compliant
Inspection Findings:	
The registered manager (acting) confirmed that information about changing needs is communicated verbally, prior to activity but no record system is in place to record this or to record feedback, observations or comments from the trainer and a recommendation has been made.	Complaint
Criterion Assessed: 13.9 A record is kept of all activities that take place, the person leading the activity and the names of the residents who participate.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Within Twisel Lodge a comprehensive activity record is kept detailing the activity, who particiapted and what staff member facilitated the activity. Evidence of this can be found in the activity file.	Compliant

Inspection Findings:	
A review of the record of activities identified that records had been maintained of the nature, duration of the activity, the name of the person leading the activity and the residents who had participated in or observed the activity. There was evidence that appropriate consents are in place in regard to photography and other forms of media.	Compliant
Criterion Assessed: 13.10 The programme is reviewed regularly and at least twice yearly to ensure it meets residents' changing needs.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Regular reviews take place on activites; these are expected to happen on a quarterly basis to ensure consistant evaluation and to be reflective of the residents' requirements and seasons of the year. The review takes place during individual care reviews and also group staff meetings and relative/representative meetings.	Compliant
Inspection Findings:	
A review of the programme of activities identified that it is reviewed on an on-going basis and formally every three months. The registered manager (acting) and staff confirmed that planned activities were also changed at any time at the request of residents. Residents who spoke with the inspector confirmed their satisfaction with the activities provided and appeared to be able to make their views and preferences known.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE RESIDENTIAL HOME'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE RESIDENTIAL HOME'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

11.0 Additional Areas Examined

11.1 Resident's consultation

The inspector met with two residents individually and observed others relaxing and watching television in the communal lounge area. In accordance with their capabilities all residents indicated/expressed that they were happy and content with their life in the home, with the facilities, food and services provided and their relationship with staff. No concerns were expressed or indicated.

11.2 Relatives/representative consultation

There were no relatives spoken to during the inspection.

11.3 Staff consultation/Questionnaires

The inspector spoke with three staff with different roles, in addition to the registered manager (acting) and the co-head of living options. A review of the four returned staff questionnaires and discussion with staff during the inspection identified that staff were supported in their respective roles. Staff confirmed that they are provided with the relevant resources to undertake their duties. Staff demonstrated awareness of how to respond to resident's behaviours and indicated that a varied programme of activities is in place. One returned staff questionnaire raised an issue with the quality of the food and another raised an issue regarding variety and choice. A recommendation has been made.

Comments received included:

- "We have a sensory room which is very beneficial. It is so much more relaxing, we can do a one to one in there."
- "Appears to be a happy and very caring home where the residents are at the front of decision making."
- "We are lucky to have the staff we have got."
- "Staff go above and beyond and it is recognised and appreciated by management."
- "I feel it is a great home and enjoy being part of team. My main issues are around lack of social outreach and poor quality of food."
- "Our supervision is quite important. I lead by example."
- "I wish we had a full staff quota."
- "Twisel has seen a change in management and also a change in staff which is still on-going and I feel a change is positive."

A review of the training records identified that staff were provided with a variety of relevant training including mandatory training.

11.4 Visiting professionals' consultation

There were no visiting professionals spoken to during the inspection.

11.5 Observation of Care practices

The atmosphere in the home was relaxed, friendly and welcoming. Staff were observed to be interacting appropriately with residents and were respectful, polite, warm and supportive. Residents were observed to be well dressed, with good attention to personal appearance observed.

11.6 Complaints

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if there is considered to be a breach of regulation as stated in The Residential Care Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion.

A review of the complaints records evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought. Evidence demonstrated that the authority is updated in a timely manner in regard to relevant matters.

The registered manager (acting) confirmed that any lessons learnt from investigations would be acted upon.

11.7 Environment

The inspector viewed the home, accompanied by the registered manager (acting) and inspected a number of residents' bedrooms and communal areas. The areas of the environment viewed by the inspector presented as clean, organised, adequately heated and fresh smelling throughout. Residents' bedrooms were observed to be homely and personalised. The home was found to be appropriately decorated and furnished.

The registered manager (acting) stated that there are plans to re-paint the lounge.

11.8 Resident Dependency/Guardianship Information

A review of the information submitted prior to the inspection was discussed with the registered manager (acting). No issues were identified.

11.9 Fire Safety

The most recent fire safety risk assessment (June 2013) hadn't been completed to show actions taken and a recommendation has been made.

A review of the fire safety records evidenced that fire training, had been provided to staff on 10 December 2013 and scheduled again for June 2014.

The records also identified that an evacuation had been undertaken on 10 December 2013 and that different fire alarms are tested weekly with records retained. There were no obvious fire safety risks observed. All fire exits were unobstructed and fire doors were closed. There was confirmation that fire safety records are reviewed during registered provider monthly visits.

11.10 Vetting

This was returned prior to the inspection. No issues were identified.

11.11 Care Review

This information was reviewed and no issues were identified.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Louise Campbell, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

Kylie Connor
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Quality Improvement Plan

Primary Announced Care Inspection

Twisel Lodge

20 May 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Louise Campbell, Registered Manager (Acting) either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Recommendations

These recommendations are based on The Residential Care Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	10.1	Review relevant policies to ensure they reflect notification to the trust and RQIA of any occasion restraint is used, including the circumstances and nature and making a record on residents care plans.	One	Both Cedar's Residents Guide and Statement of Purpose now include how Cedar respond to residents' unsusal conduct including if any restraint is to be used. This is included in individual care plans and reviewed every 6 months. A policy has been developed by the Co Head of Service ensuring reporting and recording procedures are in place.	1 August 2014
2	10.2	Review relevant policies and procedures to ensure that responding to uncharacteristic behaviours is included, as detailed in the report.	One	Responding to uncharacteristic behaviours is now included in the relevant policies.	1 August 2014
3	10.3	The registered manager should sign and date care plans.	One	A Sign sheet is now at the front of each resident's care plan for the manager to sign. Currently all signed.	By return of QIP

4	10.3	Develop person centred communication records for residents. These should specify the behaviours/non-verbal communication made by residents and an explanation of what is understood of what this can mean and how staff should respond.	One	The Acting Registered Manager +Co Head of Service are currently developing guidelines for staff to complete person centred communication records. These will be ready for review by September 2014.	1 September 2014
5	10.7 13.1	Review and improve the statement of purpose and residents guide regarding the detail of activity provision. The statement of purpose should detail all types of restrictive practices which may be in use to meet the needs of residents with consideration of the human rights act (1998).	One	The Statement of purpose is currently being reviewed detailing any restrictive practice which may be in use, and will be rolled out to residents and staff by 1st August 2014.	1 August 2014
6	12.1	The home should review the menu in place to ensure quality and that residents are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences. Full account is taken of relevant guidance documents or guidance provided by dieticians and other professionals and disciplines. Reference should be made to the nutritional guidelines and menu checklist for residential and nursing homes (2014). (Section 11.3 of the report refers)	One	New menus have been developed using relevant individual guidance from professionals and referencing current RQIA guidelines. Menus have been presented to relatives at our quarterly meeting and will be reviewed seasonly.	1 August 2014

7	29.1	There is a current Risk Assessment and Fire Management Plan that is revised and actioned when necessary or whenever the fire risk has changed. The home should complete action take to respond to recommendations made and forward the information to the estates inspector. (Section 11.9 of the report refers)	One	Fire management plan and risk assessment completed 7th July 2014 is will be sent through to RQIA Estates inspections for review by 16th July 2014 (awaiting it being returned from printers). QIP in place to address recommendations.	By return of QIP
8	20.12	The quality of services provided is evaluated on at least an annual basis and follow-up action taken. Key stakeholders are involved in this process. This pertains to improvements identified in regard to the next annual quality review report. (Section 9 of the report refers)	Two	The Service will be evaluated annually including views of stakeholders and will also include information re activities and social outreach.	31 December 2014
9	19.2	The staff checklist completed by the human resources department should be improved to reflect this criterion and held in the staff file in the home. (Section 9 of the report refers)	Two	All staff files now hold appropriate documentation signed by the registered manager.	1 August 2014

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and returned to care.team@rqia.org.uk

NAME OF REGISTERED MANAGER COMPLETING QIP	Acting Manager Louise Campbell
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Eileen Thomson

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	x	K.Connor	11/7/14
Further information requested from provider			