Unannounced Care Inspection Report
29 May 2018

Karuna Home

Type of Service: Residential Care Home
Address: 3-5 Minorca Drive, Ellis Street, Carrickfergus, BT38 8WP
Tel No: 028 9336 0665
Inspector: Ruth Greer

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 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 ten beds for residents whose needs have been assessed within the categories of care cited in the certificate of registration and outlined in point 3.0 below.

3.0 Service details

Organisation/Registered Provider: The Cedar Foundation **Responsible Individual:** Eileen Thomson	**Registered Manager:** Heather Wright
Person in charge at the time of inspection: Patricia Gordon, team leader Deborah Stevenson, head of service and line manager joined the inspection	**Date manager registered:** Heather Wright - application received - "registration pending".
Categories of care: Residential Care (RC) LD – Learning Disability LD (E) – Learning disability – over 65 years with associated physical disabilities	**Number of registered places:** 10

4.0 Inspection summary

An unannounced care inspection took place on 29 May 2018 from 09.30 to 14.40.

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

The inspection assessed progress with any areas for improvement identified since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to governance at home and provider level, care records, staff training and the environment.

No areas requiring improvement were identified.

Two residents were able to verbalise their views and opinions. Both spoke positively about all aspects of their life in the home.

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 Deborah Stevenson, head of service, 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 medicines management inspection

No further actions were required to be taken following the most recent inspection on 10 May 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, notifiable events, and written and verbal communication received since the previous care inspection.

During the inspection the inspector met with the team leader, the head of service for the organisation in control, six residents and five staff. There were no visiting professionals and no residents' visitors/representatives.

Questionnaires were 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. No questionnaires were returned within the agreed timescale.

During the inspection a sample of records was examined which included:

- Staff duty rota
- Induction programme for new staff
- Staff supervision and annual appraisal schedules
- Staff competency and capability assessments
- Staff training schedule and training records
- Two staff files for the most recently recruited staff members
- Three residents' care files
- The home's Statement of Purpose and Resident's Guide
- Minutes of staff meetings
- Complaints and compliments records
- Audits of risk assessments, care plans, care reviews; accidents and incidents (including falls, outbreaks), complaints, environment, catering, Infection Prevention and Control (IPC), NISCC registration
- Equipment maintenance/cleaning records
- Accident, incident, notifiable event records
- Annual Quality Review report
- Minutes of recent residents' meetings/ representatives' meetings/ other
- Evaluation report from annual quality assurance survey
- Reports of visits by the registered provider

- Legionella risk assessment
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- Individual written agreements
- Input from independent advocacy services
- Programme of activities
- Policies and procedures

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 10 May 2018

The most recent inspection of the home was an unannounced medicines management inspection. No areas of improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 26 October 2017

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

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The head of service advised that the staffing levels for the home were subject to regular review to ensure the assessed needs of the residents were met. The head of service stated that the use of temporary/agency staff, at times, did not prevent residents from receiving continuity of care. There is a low rate of staff turnover but agency staff may be used to cover long term leave. This is kept to a minimum and does not disrupt residents care provision.

No concerns were raised regarding staffing levels during discussion with residents and staff. A review of the duty rota confirmed that it accurately reflected the staff working within the home.

A review of completed induction records and discussion with the head of service and staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities.

Discussion with staff confirmed that mandatory training, supervision and annual appraisal of staff was regularly provided. Schedules and records of training, staff appraisals and supervision were reviewed during the inspection.

Discussion with the confirmed that competency and capability assessments were undertaken for any person who is given the responsibility of being in charge of the home for any period in the absence of the manager. Staff competency and capability assessments were reviewed and found to be satisfactory.

Review of the recruitment and selection policy and procedure confirmed that it complied with current legislation and best practice. Discussion with the head of service and review of staff files confirmed that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005.

The head of service advised that AccessNI enhanced disclosures were undertaken for all staff prior to the commencement of employment. Staff files reviewed confirmed that AccessNI information was recorded and managed in line with best practice.

A register of staff working in the home was available and contained all information as outlined within the legislation.

Arrangements were in place to monitor the registration status of staff with their professional body (where applicable). Care staff spoken with advised that they were registered with the Northern Ireland Social Care Council (NISCC). The organisation in control pays the re registration fees for care staff with NISCC. This is commendable and represents good practice.

The adult safeguarding policy in place was consistent with the current regional policy and procedures. This included the name of the safeguarding champion, definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed. The role and function of the Adult Safeguarding Champion (ASC) and the necessity to complete the annual ASC position report from 1 April 2018 to 31 March 2019 was discussed. Eileen Thompson, responsible person for the Cedar organisation is the named person to complete the annual ASC position report.

Staff were knowledgeable and had a good understanding of adult safeguarding principles and had an awareness of child protection issues. They were also aware of their obligations in relation to raising concerns about poor practice and whistleblowing. A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff.

Discussion with the head of service, review of accident and incidents notifications, care records and complaints records confirmed that there had been no suspected, alleged or actual incidents of abuse. Any allegations would be were fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records would be retained.

The head of service stated there were risk management procedures in place relating to the safety of individual residents and the home did not accommodate any individuals whose assessed needs could not be met. A review of care records identified that residents' care needs and risk assessments were obtained from the trust prior to admission.

The policy and procedure on restrictive practice/behaviours which challenge dated 1 July 2017, was in keeping with DHSSPS Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) and the Human Rights Act (1998*).* It also reflected current best practice guidance including Deprivation of Liberties Safeguards (DoLS).

The head of service advised there were restrictive practices within the home, notably the use of locked doors, keypad entry systems, lap belts for wheelchairs and environment, bed rails. In the care records examined the restrictions were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required. Restrictive practices were described in the statement of purpose and residents' guide.

Systems were in place to make referrals to the multi-professional team in relation to behaviour management when required. Behaviour management plans were devised by specialist behaviour management teams from the trust and noted to be regularly updated and reviewed as necessary. The head of service was aware that when individual restraint was employed, that RQIA and appropriate persons/bodies must be informed.

There was an Infection Prevention and Control (IPC) policy and procedure in place which was in line with regional guidelines. Staff training records evidenced that all staff had received training in IPC in line with their roles and responsibilities. Discussion with staff established that they were knowledgeable and had understanding of IPC policies and procedures.

Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered. Personal Protective Equipment (PPE), e.g. disposable gloves and aprons, was available throughout the home. Observation of staff practice identified that staff adhered to IPC procedures.

Good standards of hand hygiene were observed to be promoted within the home among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

IPC compliance audits were undertaken and action plans developed to address any deficits noted.

The head of service reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with trust and home policy and procedures, reported to the Public Health Agency, the Trust and RQIA with appropriate records retained.

The head of service reported that they were aware of the "Falls Prevention Toolkit" and were using this guidance to improve post falls management within the home. Audits of accidents/falls were undertaken on monthly basis and analysed for themes and trends; an action plan was developed to minimise the risk where possible.

A general inspection of the home was undertaken and the residents' bedrooms were found to be individualised with photographs, memorabilia and personal items. The home was fresh-smelling, clean and appropriately heated.

Inspection of the internal and external environment identified that the home and grounds were kept tidy, safe, suitable for and accessible to residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff. No malodours were detected in the home.

The head of service advised that the home's policy, procedures and risk assessments relating to safe and healthy working practices were appropriately maintained and reviewed regularly e.g. Control of Substances Hazardous to Health (COSHH), fire safety, hot surfaces etc.

The home had an up to date Legionella risk assessment in place dated 20 December 2016 and all recommendations had been actioned.

It was established that no residents smoked.

The head of service advised that equipment and medical devices in use in the home were well maintained and regularly serviced. A system was in place to regularly check the Northern Ireland Adverse Incidence Centre (NIAIC) alerts and action as necessary. A log of visits to the website was maintained.

The home had an up to date fire risk assessment in place dated 26 May 2017 and all recommendations had been actioned.

Review of staff training records confirmed that staff completed fire safety training twice annually most recently on 14 March 2018. Fire drills were completed on a regular basis most recently on 22 May 2018, and records reviewed confirmed these were up to date. The records also included the staff who participated and any learning outcomes. Fire safety records identified that fire-fighting equipment, fire alarm systems, emergency lighting and means of escape were checked weekly and were regularly maintained.

Comments received from residents and staff included:

- "I have to wear a helmet in case I fall and bang my head." (resident)
- "We have to be very vigilant as many of our residents would not have safety awareness." (staff)
- "When X (resident) wants some peace he goes to his room and locks the door he knows that we also hold a key and check him regularly. He understands and agrees to this." (staff)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome

Discussion with the head of service established that staff in the home responded appropriately to and met the assessed needs of the residents.

There was a records management policy in place which includes the arrangements for the creation, storage, maintenance and disposal of records. Records were stored safely and securely in line with data protection/General Data Protection Regulation (GDPR). A review of three care records confirmed that these were maintained in line with the legislation and standards. They included an up to date assessment of needs, life history, risk assessments, care plans and daily/regular statement of health and well-being of the resident. Care needs assessment and risk assessments e.g. manual handling, bedrails, nutrition, falls, where appropriate were reviewed and updated on a regular basis or as changes occurred.

The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were signed by the resident and/or their representative where possible. An individual agreement setting out the terms of residency was in place and appropriately signed.

Discussion with staff confirmed that a person centred approach underpinned practice. Staff were able to describe in detail how the needs, choices and preferences of individual residents were met within the home. This is important as several of the residents have no verbal communication. Staff were able to describe how they interpret and decipher non-verbal cues for example facial expressions and gestures. Staff were able to describe how they recognise non-verbal communications as triggers.

A varied and nutritious diet is provided which meets the individual and recorded dietary needs and preferences of the residents. Systems are in place to regularly record residents' weights and any significant changes in weight are responded appropriately. There are arrangements in place to refer residents to dietitians and speech and language therapists (SALT) as required. Guidance and recommendations provided by dieticians and SALT are reflected within the individual resident's care plans and associated risk assessments. Discussions with the cook evidenced that she is aware of special diets and the consistency of foods required for some residents.

The head of service advised that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals.

The head of service advised that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included pre-admission information, multi-professional team reviews, staff meetings, most recently on 6 March 2018 and 1 May 2018. Time is set aside for staff shift handovers. Minutes of staff meetings were reviewed during the inspection.

Observation of practice evidenced that staff were able to communicate effectively with residents. This included signing, Makaton and verbally. Discussion with staff confirmed that management operated an open door policy in regard to communication within the home.

There were also systems in place to ensure openness and transparency of communication, for example, the Visits by Registered Provider reports/Latest RQIA inspection reports/Annual satisfaction survey report/Annual Quality Review report/Resident meeting minutes/Resident newsletter were on display or available on request for residents, their representatives any other interested parties to read.

A review of care records, along with accident and incident reports, confirmed that referral to other healthcare professionals was timely and responsive to the needs of the residents.

Comments received from residents and staff included:

- "X (resident is in hospital and sometimes we go up to help staff to look after him because he knows us best and always co-operates with us." (staff)
- "I love my room I picked the colours and everything." (resident)
- "I'm going out shopping I like that I love going to the shops." (resident)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records, audits and reviews, communication between residents, staff and other interested parties.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

A range of policies and procedures was in place which supported the delivery of compassionate care.

The head of service advised that staff in the home promoted a culture and ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

Staff advised that consent was sought in relation to care and treatment. Discussion and observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff described their awareness of promoting residents' rights, independence, dignity and confidentiality were protected.

Discussion with staff and residents confirmed that residents' spiritual and cultural needs, were met within the home. Two residents go to their chosen church on Sundays. Some residents attend a social monthly meeting in a local church. Action was taken to manage any pain and discomfort in a timely and appropriate manner. This was further evidenced by the review of care records, for example, care plans were in place for the identification and management of pain, falls, infection, nutrition, where appropriate.

Residents were provided with information, in a format that they could understand, which enabled them to make informed decisions regarding their life, care and treatment.

Discussion with staff, residents and observation of practice confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff; residents' were listened to, valued and communicated with in an appropriate manner and their views and opinions were taken into account in all matters affecting them.

Residents were consulted with, at least annually, about the quality of care and environment. The findings from the consultation were collated into a summary report and action plan was made available for residents and other interested parties to read.

Discussion with staff, residents, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. This is an area of strength in the home. A full time activity coordinator is employed. Discussion with her and observation of the day's activities evidenced that the range of activities is tailored to meet the individual needs of residents. For example one resident had made a 3D model of a volcano. This had been designed to include a shaken carbonated drink as "lava". Other residents were involved in making wall paintings and crafts.

Arrangements were in place for residents to maintain links with their friends, families and wider community.

Comments received from residents and staff included:

- "We have got a wheelchair swing delivered and once fitted outside this will be something residents will enjoy." (staff)
- "I am making paper shapes to put on the picture." (resident)
- "Sometimes I join in (activities) and sometimes I like to stay in bed a while." (resident)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing residents and taking account of the views of residents.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

The head of service outlined the management arrangements and governance systems in place within the home and stated that the needs of residents were met in accordance with the home's statement of purpose and the categories of care for which the home was registered with RQIA.

A range of policies and procedures was in place to guide and inform staff. Policies are held electronically and staff confirmed that they had been provided with an access password. The registered manager stated that policies and procedures were systematically reviewed every three years or more frequently as changes occurred.

There was a complaints policy and procedure in place which was in accordance with the legislation and Department of Health (DoH) guidance on complaints handling. Residents and/or their representatives were made aware of how to make a complaint by way of the Resident's Guide and information on display in the home.

Review of the complaints records confirmed that arrangements were in place to effectively manage complaints from residents, their representatives or any other interested party. Records of complaints included details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction. Arrangements were in place to share information about complaints and compliments with staff. An audit of complaints was used to identify trends, drive quality improvement and to enhance service provision. Staff are given training on how to handle complaints at induction and in supervision.

The home retains compliments received, e.g. thank you letters and cards and there are systems in place to share these with staff. Records showed that a community psychologist had written to commend staff for their implementation of and adherence to a behavioural plan for a resident.

There was an accident, incident and notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of these events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. A regular audit of accidents and incidents was undertaken and was reviewed as part of the inspection process. The head of service advised that learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

There was a system to ensure safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

The head of service advised that there was a system to share learning from a range of sources including complaints, incidents, training; feedback was integrated into practice and contributed to continuous quality improvement.

Discussion with the head of service confirmed that information in regard to current best practice guidelines was made available to staff. Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents. For example – Professional Boundaries on 12 October 2017; Diversity and Equality on 10 December 2017; Record Keeping on 22 November 2017 and Administration of Buccal Midazolam on 12 October 2017.

A visit by the registered provider was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, RQIA and any other interested parties to read. The reports of 18 April 2018 and 17 May 2018 were reviewed and demonstrated that an action plan was developed to address any issues identified which include timescales and person responsible for completing the action.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability. This was outlined in the home's Statement of Purpose and Residents Guide. Discussion with the registered provider identified that she had understanding of her role and responsibilities under the legislation.

The head of service reported that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration and employer's liability insurance certificate were displayed.

The home had a whistleblowing policy and procedure in place and discussion with staff confirmed that they were knowledgeable regarding this. The head of service advised that staff could also access line management to raise concerns and that staff would be offered support.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised. There were open and transparent methods of working and effective working relationships with internal and external stakeholders.

The head of service described the arrangements in place for managing identified lack of competency and poor performance for all staff.

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents.

The equality data collected in relation to residents, for example gender/ religion was managed in line with best practice.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

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.

The Regulation and Quality Improvement Authority

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