Unannounced Care Inspection Report
19 August 2019

Mantlin Court

Type of Service: Residential Care Home
Address: Mantlin Road, Kesh BT93 1TU
Tel no: 028 6863 3149
Inspector: Bronagh Duggan

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.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for

2.0 Profile of service

This is a registered residential care home which provides care for up to 18 residents within the categories of care as outlined in Section 3.0 of this report.

3.0 Service details

Organisation/Registered Provider: Western HSC Trust Responsible Individual: Anne Kilgallen	Registered Manager and date registered: Gillian Ingram 1 April 2005
Person in charge at the time of inspection: Gillian Ingram	**Number of registered places:** 18
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 13

4.0 Inspection summary

An unannounced inspection took place on 19 August 2019 from 10.30 hours to 16.30 hours.

Evidence of good practice was found in relation to staffing, supervision and appraisal, staff training, care reviews, the culture and ethos of the home and maintaining of good relations.

One area requiring improvement was identified in relation to the environment.

Residents described living in the home as being a good experience. Residents unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from residents, one visiting professional and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Gillian Ingram, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 13 January 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 13 January 2019. No further actions were required to be taken following the most recent inspection on 13 January 2019.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with residents, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

Seven completed questionnaires were returned within the identified timescale from residents and or their representatives. All responses received indicated that respondents were very satisfied with the care provided in the home.

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

- staff duty rotas from 16.8.19 to 29.8.19
- staff training records
- one staff personnel file including induction records
- competency and capability assessments
- supervision and appraisal information
- three residents' records of care
- complaint records
- compliment records
- a sample of governance audits/records
- accident/incident records from January 2019 to August 2019
- a sample of reports of visits by the registered provider
- RQIA registration certificate
- fire safety checks

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 last care inspection dated 13 January 2019

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

6.2 Inspection findings

6.3 Is care safe?

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

On arrival we observed the home was comfortably heated and welcoming. The majority of residents were up washed and dressed while others were being assisted by staff with personal care. Residents appeared well cared for and were appropriately dressed with obvious time and attention given to personal care needs. A number of residents sat within the lounge area while others moved freely around the home and some were relaxing in their bedrooms watching television.

The registered manager, who was on duty throughout the inspection, explained that staffing levels for the home were safe and appropriate to meet the number and dependency levels of residents accommodated. The staff duty roster was reviewed; it accurately reflected the number and names of staff on duty over the twenty for hour period and capacity in which they worked. Indicators were made at the names of staff of who were covering night duty or doing sleepover.

Competency and capability assessments were in place for staff in charge of the home when the registered manager was out of the home. A sample of two competency and capability assessments were reviewed, these were found to be satisfactory.

We were assured by staff and management that there was enough staff on duty to provide safe care and should additional staff be required staff would generally work additional hours.

The registered manager explained the system and process in place for the recruitment and selection of staff. The registered manager advised recruitment records were not available in the home for staff, however written confirmation that all relevant checks had been completed was forwarded to the home manager from human resources and was stored in staff personnel files.

The registered manager explained that all care staff were registered with the Northern Ireland Social Care Council (NISCC) and that registrations were tracked by way of discussions with staff during supervision and notifications received from NISCC. The benefit of developing a tracking record/matrix was discussed as this would provide an additional way for monitoring purposes to ensure staff re- register with NISCC within the correct timescale.

The registered manager advised all staff complete a period of induction when they commence work in the home relevant to their job specification. In addition all staff complete mandatory training and any other training relevant to meet the needs of the residents. Staff spoken with confirmed they received good support from the manager and senior staff through the provision of staff meetings, supervision and annual appraisals.

We reviewed staff training records, these evidenced that mandatory training was being provided for staff alongside additional training including for example MAPA training.

The registered manager outlined the adult safeguarding champion arrangements for the home, and advised that any incidents of potential abuse were recorded and reported to relevant bodies which were then handled appropriately. The adult safeguarding position report for 2018 will be reviewed at the next care inspection. Staff training in adult safeguarding was included within mandatory training records and staff were able to correctly describe what action they would take if they suspected or witnessed any form of abuse.

Accident and incident records retained in the home were cross referenced with those notified to RQIA which evidenced compliance with regulations and minimum standards. The measures in place to minimise the risk of falls included for example: fall risk assessments, referral to trust occupational therapist, provision of various aids and appliances to aid mobility. Care reviews were undertaken at regular intervals. Three care records reviewed contained risk assessments and care plans with recorded measures in place to minimise the risk of falls.

An inspection of the home was undertaken. Resident's bedrooms were personalised to reflect the individual likes and interests of residents. Residents spoken with took great pride in showing their bedrooms and sharing stories including competitions they had been involved in and showing medals that they had won through their participation. It was noted from walking around the home parts of the environment were in need of improvement, this included general paintwork which required some touch ups including walls, skirting's, doors and door frames. It was also noted the doors on an identified shower needed refitted. An area for improvement was identified.

Fire doors were closed and exits unobstructed, review of records in the home showed fire safety checks were maintained on an up to date basis and staff had completed fire safety training twice yearly. Records also showed practice fire drills were completed on a regular basis, the most recent drill was completed in May 2019.

All areas within the home were observed to be comfortably heated, odour free and clean. We observed a good supply of disposable gloves, aprons and liquid hand soap throughout the home. Staff were observed washing their hands following practical assistance with residents. Discussions with staff confirmed they were aware of best practice on how to reduce or minimise the risk of infection.

The registered manager described the range of professional staff who visit the home to assess and monitor the health and social care needs of residents referred to them. Visiting professionals included for example; general practitioner, social worker, speech and language therapist and podiatrist. Records of visits were reflected within care records reviewed. Discussion with one professional who would visit the home on a regular basis confirmed that they felt they were kept well informed regarding residents condition.

Comments from the visiting professional included:

- "Staff are very approachable, the care plans are clear. Staff are very visible during visits and know residents really well. The staff and residents are there a long time, they work well together. I am always made feel welcome."

Seven satisfaction questionnaires were completed by residents and or representatives and returned to RQIA following the inspection. All respondents indicated they were very satisfied that the care received was safe. No issues or concerns were recorded.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control.

Areas for improvement

One area was identified for improvement this related to the home's environment.

	Regulations	Standards
Total numb of areas for improvement	0	1

6.4 Is care effective?

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

The care records viewed contained needs assessments which were complemented with risk assessments; care plans in place clearly reflected the individual needs of residents. We observed care staff access care records throughout the day to record interventions for each resident.

The registered manager explained a range of resident risk assessments were completed which included for example MUST regarding nutrition, falls, and choking. There was evidence of recorded review of risk assessments within care records reviewed.

Care records reviewed were found to be detailed and person centred. They reflected the personal preferences of residents including their preferred rising and retiring times and food preferences. It was noted from one of the records reviewed there was a user friendly care plan in place with regards to eating and drinking, in addition all three care records reviewed contained detailed "Hospital Passports" which are a special type of care plan developed for a resident to bring with them to hospital to ensure all relevant information is shared in the event of a hospital admission. This was good practice. The registered manager explained referrals were made to other health care professionals when required, for example; speech and language therapists (SALT) and dieticians when necessary. Records also contained SALT guidance as assessed, kitchen staff confirmed all specialist dietary information was also stored in the kitchen area. Individual placemats as devised by SALT were also in place for identified residents which included detailed guidance regarding specialist dietary information.

The use of restrictive practice was discussed with the registered manager who demonstrated good understanding of ensuring residents' human rights were considered when planning and providing care. The registered manager advised there were restrictive practices within the home, notably the management of smoking materials, use of lap belts and bedrails. Although the entrance door has a locked entry key pad, the registered manager advised keypad access was not required to leave the home, but rather a push button system. The registered manager explained that before any decisions were made about the application of such restrictions best interest care review meetings would take place with trust professionals, resident and /or relatives where applicable and that risk assessments would be discussed and decisions agreed. The registered manager shared an example of a detailed plan of care on what to do in the event of a resident refusing treatment. The registered manager explained there was multi-disciplinary agreement sought to ensure the residents safety and best interest as well as respecting and ensuring the decisions the resident may make are upheld.

Residents spoken with shared that they were happy with the care provided and had no issues or concerns. Residents unable to voice their opinions were seen to be very relaxed and comfortable in their surrounding and in their interactions with staff.

Staff spoken with advised that care reviews were held regularly, records reviewed showed care reviews were maintained on an up to date basis and any changes regarding a residents presentation would be shared accordingly with relevant professionals involved in the residents care.

There was good evidence of effective team work with staff communicating and helping each other to carry out duties. Staff shared there was a good handover at the beginning of each shift and that written handover records were maintained to refer back to if needed. Staff said there was very good team work with few staff changes over the years. Staff demonstrated good knowledge of residents care needs and confirmed that all residents' care needs were being met.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, person centeredness within the care records, reviews and communication between residents, staff and other key stakeholders.

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 compassionate?

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

Throughout the inspection staff interactions with residents were observed to be compassionate with detailed knowledge of residents' choices, likes, dislikes, preferences and assessed needs. There was a pleasant happy atmosphere within the home, with residents conversing with staff and each other in a relaxed manner.

Residents spoke openly with us and appeared relaxed and content. Staff were observed to respond promptly to their requests for assistance. Comments received from residents during the inspection included:

- “I am happy enough, we go to the dancing I like that.”
- “I am getting on great, everyone is nice.”
- “I love it.”
- “Oh aye, I like it here, I am happy enough so I am.”

There was evidence that residents’ human rights were being up held. This was evidenced from observations of staff interactions with residents, responses from residents about the care received and information recorded within needs assessments, risk assessments and care plans.

Residents’ preferences and interests were reflected within care records and staff demonstrated good awareness and understanding of residents likes and dislikes. For example; where they liked to sit each day, how their memorabilia was displayed within their bedrooms, their choice of clothes to wear each day.

Care records reviewed outlined residents preferred activities and daily routines. Staff said that these were flexible and that resident choice was always a priority.

Staff described how they aim to promote residents independence; for example by way of encouragement; being involved in house hold tasks and washing and dressing.

Residents participated in activities such as arts, crafts, spiritual events, visiting local cafes, shops and sporting events. Staff said activities were based on resident’s hobbies and interests and they were consulted about their preferences when activities were being planned. A selection of materials and resources were available for use during activity sessions. Residents and staff confirmed that residents benefitted from and enjoyed the activities and events provided.

The serving of the mid- day meal was discreetly observed. Tables were neatly set with a range of condiments available. Meals were nicely presented with adequate portions of food served. Staff were present throughout the meal supervising and assisting residents as required. Residents were afforded choice at meal times and where required special diets were provided.

Six completed satisfaction questionnaires were returned to RQIA following the inspection. Respondents indicated that they felt staff treated them with compassion; were kind, respectful with privacy and dignity maintained. All respondents indicated they were very satisfied that the staff treated them with compassion.

Comments received from completed and returned questionnaires included:

- “The care is good.”
- “I am happy with everything”.
- “All staff and Gillian and Andy is good and caring.”

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing residents and their representatives 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

6.6 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 certificate of registration issued by RQIA was appropriately displayed in a central part of the home. This certificate identifies the management arrangements for the home and the maximum number of residents allowed to be accommodated in the home. Discussion with the manager and staff, and observations confirmed that the home was operating within its registered categories of care.

Staff confirmed that the home's manager was 'very approachable' and available to provide guidance or advice when necessary. There had been no change in the organisational structure of the home since the previous inspection. Staff we spoke with demonstrated good understanding of their roles and responsibilities.

Review of accident and incident records maintained in the home showed that they were recorded and notified to relevant bodies as required.

The home had a complaints policy and procedure in place. A system was in place to record any complaints received including all actions taken in response to the complaint. Residents consulted during the inspection confirmed that they would have no issues in raising any identified concern with the home's staff or management.

Discussion with the registered manager and review of auditing records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, care records, staff training and the environment. Additional management oversight and quality assurance was undertaken by way of the monthly monitoring visits undertaken by the registered providers representative. Review of reports for January to August 2019 confirmed compliance with regulation 29 of The Residential Care homes Regulations (Northern Ireland) 2005 and minimum care standards.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised. Staff spoken with was aware of the homes whistleblowing procedure. Staff confirmed there were good working relationships with both internal and external stakeholders.

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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Gillian Ingram, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP 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 the residential care home. 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 27.1 **Stated:** First time **To be completed by:** 16 November 2019	The registered person shall ensure improvements are made to the environment including: • paint work on walls, skirting's, doors and door frames • the identified shower door should be refitted Ref: 6.3
	Response by registered person detailing the actions taken: Work has begun on painting the identified areas. New shower gates have been fitted in the identified room.

Please ensure this document is completed in full and returned via Web Portal

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