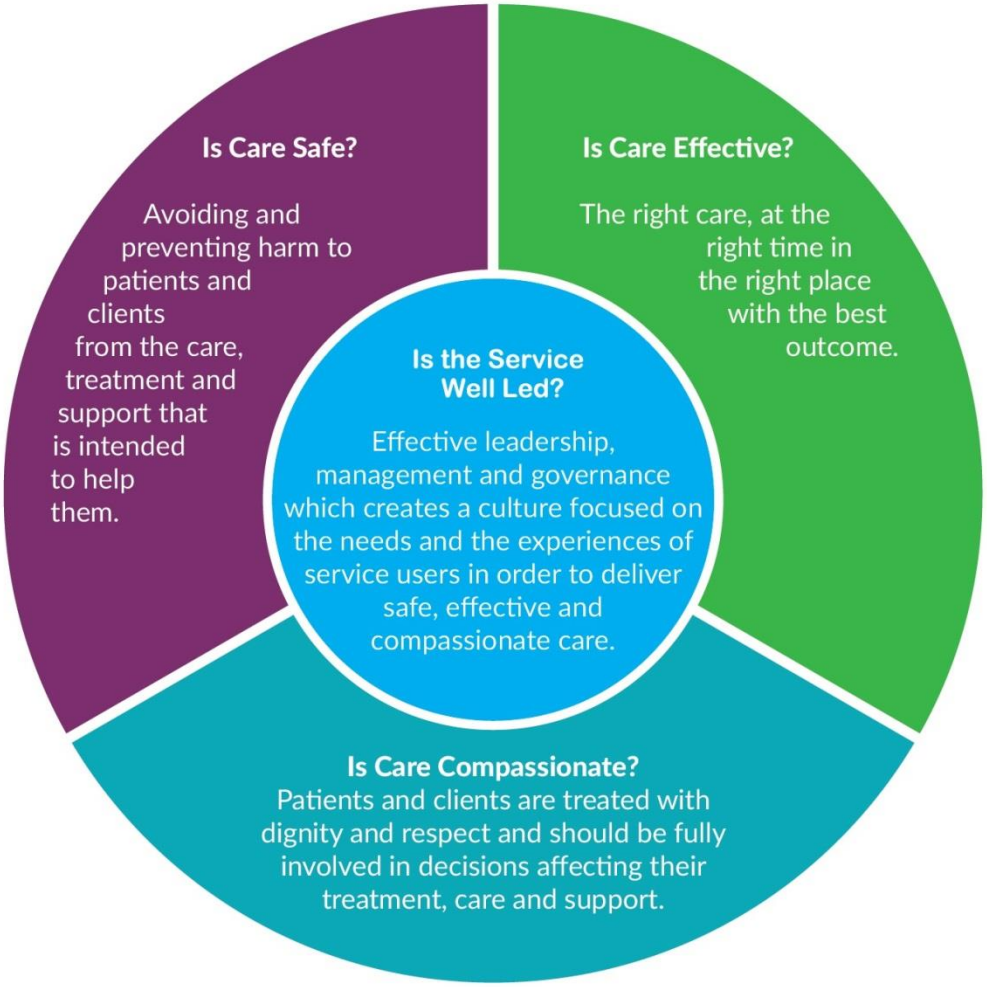
Unannounced Care Inspection Report
14 August 2018

2-1-2 Old Holywood Road

Type of Service: Residential Care Home
Address: 212 Old Holywood Road, Holywood, BT18 9QS
Tel No: 028 9042 5554
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 twelve registered beds for adults assessed as having learning difficulties.

3.0 Service details

Organisation/Registered Provider: Cornerstone Care 212 Limited **Responsible Individual:** Irene McBurney	**Registered Manager:** Irene McBurney
Person in charge at the time of inspection: Alison Bradford – deputy manager	**Date manager registered:** 10 July 2017
Categories of care: Residential Care (RC) LD – Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 12 1 place for day service

4.0 Inspection summary

An unannounced care inspection took place on 14 August 2018 from 09.45 to 14.30.

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 staff recruitment, training and supervision.

Areas requiring improvement were identified in relation to fire alarm tests and regulation 29 visits.

Residents who were able said they were well cared for and that staff treated them well. Residents who did not communicate verbally appeared at ease with staff and in their surroundings.

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	2	0

Details of the Quality Improvement Plan (QIP) were discussed with Alison Bradford, deputy 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 care inspection

No further actions were required to be taken following the most recent inspection on 9 January 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 person in charge, nine residents and three 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
- Four 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, NISCC registration
- Infection control register/associated records
- Equipment maintenance/cleaning records

- Accident, incident, notifiable event records
- Annual Quality Review report
- Reports of visits by the registered provider
- 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 9 January 2018

The most recent inspection of the home was an unannounced care inspection.

6.2 Review of areas for improvement from the last care inspection dated 9 January 2018

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 deputy manager advised that the staffing levels for the home were subject to regular review to ensure the assessed needs of the residents were met. Temporary/agency staff were not used in the home. Any turnover of staff was kept to minimum, where possible, and was monitored by the management of the home.

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. Completion of the duty rota has been delegated to a senior staff member.

A review of completed induction records and discussion with the deputy manager and staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities. New staff receive two days of initial training with an outside training organisation and are then supernumerary in the home until assessed as competent.

Discussion with staff and a review of 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 deputy manager and staff 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 deputy manager 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 deputy manager 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.

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 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.

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 most recently on 22 August 2017.

Discussion with the deputy manager, 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 incidents would be fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records would be retained.

The deputy manager 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 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 deputy manager advised there were restrictive practices within the home, notably the use of locked doors, keypad entry systems bed management of smoking materials etc. In the care records examined the restrictions were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required.

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 deputy manager 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. Hand hygiene audits take place monthly and any issues noted are discussed at supervision.

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

The deputy manager 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 regular basis and analysed for themes and trends; an action plan was developed to minimise the risk where possible. Referral was made to the trust falls team in line with best practice guidance. The deputy manager advised that the trust falls team only accepted referrals for residents who were aged over 65 years.

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. A programme of re decoration has commenced and the areas completed looked well. The lounge was in need of redecoration. The inspector was informed that this was on the planned schedule to be undertaken. Progress will be monitored at the next inspection.

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. There was a slight malodour detected in one part of the home. There was evidence that this was being managed appropriately.

The deputy manager 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 and smoking etc.

The home had an up to date Legionella risk assessment in place dated 29 September 2017 and all recommendations had been actioned.

It was established that one resident smoked. A review of the care records identified that a risk assessment and corresponding care plan had been completed in relation to smoking.

The deputy manager 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.

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

Review of staff training records confirmed that staff completed fire safety training twice annually most recently on 17 April 2018. Fire drills were completed on a regular basis most recently on 6 July 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 was last checked on 10 August 2018, emergency lighting and means of escape were last checked on 19 July 2018. The fire alarm system is checked every three months by an outside professional and records were available for inspection. The internal weekly break glass check had not been undertaken for several months. The deputy manager stated that two residents became distressed when the fire alarm system was activated. This has been identified as an area of improvement. The registered person should access advice as to a means of testing the break glass system which is compatible to the needs of the residents. Individual residents had a completed Personal Emergency Evacuation Plan (PEEP) in place. These were held in a folder at the entrance of the home for ease of access in the event of an emergency.

Residents and staff spoken with during the inspection made the following comments:

- "I like here but I might be getting a bungalow of my own." (resident)
- "I go out with staff to buy CDs." (resident)
- "This is a good home the residents are well looked after." (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, and infection prevention and control.

Areas for improvement

One area of improvement was identified in relation to testing the fire alarm system.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

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

Discussion with the deputy manager 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 four 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 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.

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 dietiticans 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. In discussion with the cook she was able to describe any specific dietary requirements for individual residents.

Discussion with the deputy manager and staff confirmed that wound care is managed by community nursing services. Staff advised that they were able to recognise and respond to pressure area damage. Referrals were made to the multi-professional team to areas any concerns identified in a timely manner. Resident's wound pain was found to be managed

appropriately. Care notes showed that staff recognised any behaviour which indicated a resident may be in pain.

The deputy manager advised that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. Audits of risk assessments, care plans, care review, accidents and incidents (including falls, outbreaks), complaints, environment, catering were available for inspection and evidenced that any actions identified for improvement were incorporated into practice. Further evidence of audit was contained within the reports of the visits by the registered provider and the annual quality review report.

The deputy manager 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, residents' meetings, staff meetings and 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. Discussion with the deputy manager and staff confirmed that management operated an open door policy in regard to communication within the home.

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.

The deputy manager reported that arrangements were in place, in line with the legislation, to support and advocate for residents.

Residents and staff spoken with during the inspection made the following comments:

- "There are only 11residents so we know them all really well and we can tell what they want, even if they can't speak it." (staff)
- "I can make a cup of tea and go out on my own if I want to." (resident)
- "I've settled in and have all my own stuff in my room." (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 deputy manager 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.

The deputy manager 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.

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. Menus and the activity programme, for example, were written in a pictorial format.

Discussion with staff and 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, and residents, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. For example some residents enjoy swimming sessions and the record showed that weekly bus trips are organised. A trip to Dublin zoo had been organised for a few days following the date of the inspection. Arrangements were in place for residents to maintain links with their friends, families and wider community. A barbeque had been held for residents and their families in July.

Residents and staff spoken with during the inspection made the following comments:

- "We like to get the residents out as much as possible, even just to a coffee shop." (staff)
- "If I need anything I just ask the girls (staff) and they get it for me." (resident)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to 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 deputy manager 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 were centrally indexed and retained in a manner which was easily accessible by staff. The deputy manager stated that policies and procedures were systematically reviewed every three years or more frequently as changes occurred. Policies examined had all been reviewed in 2017.

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. Discussion with staff confirmed that they were knowledgeable about how to respond to complaints. RQIA's complaint poster was available and displayed 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.

The home retains compliments received, e.g. thank you letters and cards and there are systems in place to share these with staff.

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 deputy manager 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.

There was evidence of managerial staff being provided with additional training in governance and leadership. The deputy manager is currently undertaking QCF level 5. The deputy manager 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 deputy manager 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.

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 for 25 May 2018 and 28 June 2018 were reviewed and found to be satisfactory. No report of a monitoring visit for July 2018 was available. This has been identified as an area for improvement.

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. The deputy manager stated that the registered provider was kept informed regarding the day to day running of the home including telephone calls, emails and visits to the home.

The deputy manager 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 deputy manager 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.

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

One area for improvement was identified. This was in relation to visits by the registered provider under the requirements of regulation 29.

	Regulations	Standards
Total number of areas for improvement	1	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 Alison Bradford, deputy 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 27 (4) (d) (v) **Stated:** First time **To be completed by:** 27 August 2018	The registered person shall ensure that the internal fire alarm is checked weekly and the outcome is recorded. Ref: 6.4
	Response by registered person detailing the actions taken: A plan is now in place to check a break glass weekly which will set of the fire alarm system and this will be recorded in fire check file.
Area for improvement 2 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** 27 August 2018	The registered person shall ensure that monitoring visits are undertaken in line with the requirements of regulation 29. Ref: 6.7
	Response by registered person detailing the actions taken: Regulation 29 will continue to be recorded on the last week of each month.

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

The Regulation and Quality Improvement Authority

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

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews