The Regulation and Quality Improvement Authority

Inspection Report

20 June 2024

The Gate Lodge

Type of Service: Residential Care Home
Address: 3 Station Road, Castlewellan, BT31 9NF
Tel no: 028 4377 8230

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Corriewood Private Clinic Limited **Responsible Individual:** Mr Ricardo Daniel Goncalves Oliveira	**Registered Manager:** Mr Ricardo Daniel Goncalves Oliveira - Acting
Person in charge at the time of inspection: Ms Dearbhaile McClean – Team Leader	**Number of registered places:** 4 The home is usually registered for a maximum of 4 approved places but on a temporary basis is approved to provide care to two named residents only. Any further admissions are only to take place with the approval of RQIA. The agreed change in the use of rooms in The Gate Lodge will revert back to their original usage when they are no longer required for the named resident and RQIA must be notified.
Categories of care: Residential Care (RC) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of residents accommodated in the residential care home on the day of this inspection:** 2
Brief description of the accommodation/how the service operates: This home is a registered residential care home which provides health and social care for two people who have a learning disability. Each resident has their own bedroom and living spaces. The home has extensive gardens on the grounds. There is a nursing home which occupies the same grounds as the residential care home and the manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 20 June 2024 from 12.00pm to 5.15pm by a care inspector.

The inspection determined if the home was delivering safe, effective and compassionate care and if the service was well led.

Residents were well presented in their appearance and enjoyed meaningful engagements with the staff. Care delivery was very much focused on the social model of care. Records of how each resident spent their day were well recorded.

The inspection resulted in no areas for improvement being identified. RQIA was satisfied that the care in the home was safe, effective and compassionate and that the home was well led.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included registration information and any other written or verbal information received from residents, relatives, staff or the commissioning Trust.

Throughout the inspection RQIA will seek to speak with residents, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the responsible individual (RI) and the team leader at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with residents and staff. Residents were comfortable in their environment and in their engagements with staff. Staff told us that they worked well together and enjoyed engaging with the residents. Staff also confirmed that there were good working relationships between staff and the home's management team.

We received no questionnaire responses or feedback from the online staff survey.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to The Gate Lodge was undertaken on 16 June 2023 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

A comprehensive pre-determined list of pre-employment checks had been completed and verified prior to any new employee commencing work in the home. All staff completed an induction to become more familiar with the homes' policies and procedures. A booklet was completed to record the topics on induction completed. A list of training was identified for completion as part of the induction process.

Staff had a suite of mandatory training topics to complete annually to maintain their knowledge and skills in order to provide safe and effective care. Training was completed face to face and electronically. Training topics included adult safeguarding, deprivation of liberty, positive behaviour support, autism awareness, infection control, food hygiene and fire safety. Staff also confirmed that they had the opportunity to complete National Vocational Qualifications in Health and Social Care. A system was in place to ensure staff completed their training and evidenced 100 percent compliance on last check.

An additional reference file had been created for staff containing information on, for example, communication, duty of candour, human rights, record keeping, meaningful activities, managing medicines and complex behaviours. Staff would read the information and then sign and date when they had completed this.

Staff confirmed that they received an annual appraisal to review their performance and, where appropriate, identify any training needs. Staff also confirmed that they received recorded supervisions on a range of topics.

Checks were made to ensure that care staff applied for and maintained their registrations with the Northern Ireland Social Care Council (NISCC).

Staff were content that the staffing levels in the home met the needs of the residents accommodated in the home at any given time. The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked.

Staff were complimentary of the teamwork in the home. One told us, “It’s perfect; the best team you could work with”. Another commented, “We understand and complement each other”. Staff were observed to work well and communicate well with one another during the inspection.

Minutes from the most recent staff meeting were available for review by all staff and especially those unable to attend the meeting. A folder was accessible to staff containing the meeting minutes. Staff would read the minutes then sign to confirm that they have read and understood them.

5.2.2 Care Delivery and Record Keeping

Residents’ needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents’ needs and included any advice or recommendations made by other healthcare professionals. Care plans were personalised for each resident and reviewed monthly to ensure that they remained relevant to the residents.

Daily evaluations were completed of each resident’s activity during the day. The evaluations included details of their whereabouts, how they were feeling, what they had to eat and drink, medication administered, assistance with personal care, continence needs met, family contacts and any social activities that they engaged in.

Staff confirmed that they received a detailed handover at the commencement of each shift to ensure that residents were getting the right care; especially if care needs had changed. A handover book was completed at each shift to record the detail of the handover. Additional details could be found within the daily evaluation of care recorded in the residents’ care records online. In addition, a 24-hour shift report was completed by the person in charge and shared with the team leader. The team leader provided a weekly report to the responsible individual.

Detailed care plans were in place to assist staff in identifying and managing behaviours which can challenge. These included the triggers for the behaviours, strategies to keep calm, redirection techniques and any additional support required. Any behavioural incidents were recorded and next of kin informed as well as notifications to the Trust and RQIA.

An emphasis was put on what the residents liked and disliked. Care plans were in place to identify the residents’ abilities, listed what they personally liked to do and their preferred daily routines. Staff were all knowledgeable of the residents’ holistic needs and were seen to support the residents in meeting their needs and wishes throughout the day.

Staff were fully aware of residents' nutritional requirements. Each resident had their own food and drink preferences. Access to food and fluids was available throughout the day. Breakfast and supper was prepared in the kitchen in the home. The main meals came from the main kitchen within the nursing home on the same site. A system was in place to ensure that the temperature of the meals was maintained during transit. Residents could also enjoy food from one of the local cafes or restaurants.

A diary was maintained to ensure that important appointments were not missed. The diary was also an aid to staff to ensure arrangements were not missed, such as, planned taxi bookings, school attendances, staff training or contact with families and used to identify which managers were on-call should they require assistance or guidance.

Incident forms were completed following any accident or incident which occurred in the home. Accidents and incidents were reviewed monthly for any patterns or trends to see if any future accident/incident could be prevented in the future.

It was observed that staff provided care in a caring and compassionate manner. It was clear through resident and staff interactions that they knew one another well and were comfortable in each other's company.

5.2.3 Management of the Environment and Infection Prevention and Control

During the inspection we reviewed the home's environment including a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. Residents' bedrooms contained the personal items important to them and were suitably furnished and decorated. Doors leading to rooms which contained hazards to residents had been locked. The home was warm, clean and comfortable. Room temperatures were checked daily to ensure comfort. There were no malodours detected in the home.

It was evident that fire safety was important in the home. Staff had received training in fire safety and fire safety checks, including fire door checks and fire alarm checks, were conducted regularly. Corridors in the home were free from clutter and obstruction as were the fire exits should residents have to be evacuated. Fire extinguishers were easily accessible. A review of the most recent fire risk assessment evidenced that the one area for action had been completed.

There was evidence of daily checks on the physical environment to ensure cleanliness and infection prevention and control. A night check list had also been developed and recorded to ensure that electrical items had been switched off, doors; windows and gates locked and a list of cleaning duties had been completed. In addition, day duty staff had their own list of nominated tasks to complete to ensure cleanliness.

Monthly environmental, housekeeping and bathroom and bin audits were completed to monitor the environment. Individual hand hygiene audits were conducted with each staff member to ensure safe practices in this area.

5.2.4 Quality of Life for Residents

Residents' lives were focused around their daily routines and their interests. They could decide if they wanted to go into their room or stay in the living area in the home. Residents left the home regularly, with staff, to go for walks around the grounds of Corriewood or into the local towns for a walk. Staff had access to vehicular transport and could take the residents out when they wished. They went out for lunches, amusements, shopping and to different events. In addition, residents had access to a private back garden area.

Residents could communicate their needs to staff in various forms and staff were adept at understanding what the resident wanted. Interactions and engagements from staff were caring and compassionate. Residents appeared settled and content in their environment.

Relatives were contacted monthly by management to seek their views on the residents' placement and service given to them. Residents were free to leave the home with family members or stay overnight for planned visits. The home was open to visiting.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been a change to the management arrangements. The Responsible Individual, Daniel Oliveira, was also temporarily covering the management role. Dearbhaile McClean remained as Team Leader in the home. Discussion with the manager and staff confirmed that there were good working relationships between staff and the management team. Staff told us that they found the management team to be 'approachable' and 'always available to give advice or guidance'.

There was a nominated person in charge (PIC) of the home in the absence of the team leader or manager. The PIC completed a competency and capability assessment on taking charge of the home prior to doing so. A PIC folder had been created to support them in this role and contained details, such as, staff contact numbers, duty rotas, important contact numbers and guidance on what to do when certain events occurred, for example, an outbreak of infectious disease or a power cut.

Staff told us that they would have no issue in raising any concerns regarding residents' safety, care practices or the environment. Staff had a good understanding of the home's organisational structure should they need to escalate their concern and were aware of the departmental authorities that they could contact should they need to escalate further.

The manager confirmed their own internal governance practices in order to monitor the quality of care and other services provided to residents. A range of audits were completed to monitor the quality of care. Audits were conducted on, for example, residents' care records, medicines management, staff registrations, staff training and the environment.

A Deprivation of Liberty register was maintained to ensure that the residents were not unlawfully deprived of their liberty.

The home was visited each month by the RI to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed and completed reports were available for review by residents, their representatives, the Trust and RQIA. Where improvement actions were required, an action plan was included within the report. The action plan would be reviewed at the subsequent monthly monitoring visit to ensure completion.

The number of complaints made to the home was low and a system was in place to manage and record any complaints received. All compliments received were recorded and shared with staff.

7.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Daniel Oliveira, Responsible Individual and Dearbhaile McClean, Team Leader.

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