Inspection Report

Name of Service: The Grouse Care Home

Provider: Ann's Care Homes Limited

Date of Inspection: 14 November 2024

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

1.0 Service information

Organisation/Registered Provider:	Ann's Care Homes Limited
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Mr Paul Gildernew **Date registered:** 12 August 2020
Service Profile – This home is a registered nursing home which provides nursing care for up to 28 patients, in two units each within a separate building, who have mental health or physical disability needs. Patients have access to communal dining and lounge areas. Communal rooms and bedrooms are located over a single floor within the Annahugh Unit and the Redlion Unit. Patients have access to a garden area.	

2.0 Inspection summary

An unannounced inspection took place on 14 November 2024 from 9.45am to 4.45pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

The inspection resulted in no areas for improvement being identified. It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe, effective and compassionate care. In addition, the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the 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 the previous areas for improvement issued, registration information and any other written or verbal information received from patients, relatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "I am happy here" and "There's great chat here".

Patients made their own choices throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options and where and how they wished to spend their time.

We did not receive any questionnaire responses from patients or their visitors or any responses from the staff online survey.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Patients said that there was enough staff on duty to help them. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the

staffing levels. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

Staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles. Handover sheets were shared with staff containing the pertinent patient details.

Patients may require special attention to their skin care. For example, some patients may need assistance to change their position in bed or get pressure relief when sitting for long periods of time. These patients were assisted by staff to change their position regularly and records maintained.

Falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented. All incidents occurring in the home were reviewed by management at the time of the incident and on a monthly basis.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Patients confirmed that activities took place in the home. Activities incorporated individual patient's interests and promoted social outings. An occupational therapist was based in the home and engaged daily with patients. A new role of occupational therapist assistant had recently been recruited, and they assisted in promoting one to one social activities. One patient told us that they were looking forward to going shopping later in the day. Some patients shopped for and prepared their own meals, with assistance, if required. The Redlion Unit had a propose built activity room which patients could utilise for their own personal cooking or laundry. Records of activities that each patient was engaging in were well recorded.

Patients spoken with told us they enjoyed living in the home and that staff were friendly. One patient told us, “I am happy here. I enjoy watching TV and listening to my music when I want”.

Relatives spoke positively on the care delivery. One told us, “They take very good care of xxx. It couldn’t be better. We are always kept up to date very well on how they are”.

3.3.3 Management of Care Records

Patients’ needs were assessed by a nurse at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients’ needs and included any advice or recommendations made by other healthcare professionals. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients’ relatives, if this was appropriate.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients’ needs. Patients care records were held confidentially.

Supplementary care records, such as, bowel management, food and fluid intake, repositioning and activity provision had been recorded well. Nursing staff recorded daily evaluations about the delivery of care.

3.3.4 Quality and Management of Patients’ Environment

The home was clean and tidy and patients’ bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Fire safety measures were in place to protect patients, visitors and staff in the home. Actions required from the most recent fire risk assessment had been completed in a timely manner.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mr Paul Gildernew has been the Registered Manager in this home since 12 August 2020. The manager was supported by a deputy manager. Staff commented positively about the management team and described them as supportive, approachable and always available to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place.

There was a system in place to manage any complaints received. A compliments log was maintained and any compliments received were shared with staff.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further. Patients and their relatives spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Paul Gildernew, Registered Manager, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority

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