

Unannounced Care Inspection Report 5 June 2018



Abbeylands-Seapark Unit

Type of Service: Residential Care Home
Address: 441 Shore Road, Whiteabbey, Belfast, BT37 9SE
Tel No: 028 9086 4552
Inspector: Ruth Greer

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 registered with RQIA to provide care for thirty seven persons whose needs have been assessed within the categories of care cited on the registration certificate and outlined in section 3.0 below.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care Responsible Individual: Claire Royston	Registered Manager: Eleanor Dodson
Person in charge at the time of inspection: Linda Moore, deputy manager.	Date manager registered: 23 February 2018
Categories of care: Residential Care (RC) I – Old age not falling within any other category A – Past or present alcohol dependence (for one named resident) MP – Mental disorder excluding learning disability or dementia MP (E) – Mental disorder excluding learning disability or dementia – over 65 years	Number of registered places: 37

4.0 Inspection summary

An unannounced care inspection took place on 5 June 2018 from 10.00 to 15 50.

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 during and 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. It should be noted that this was the first inspection of the home since it was registered as residential home in December 2017.

Evidence of good practice was found in relation to maintaining residents' independence, care files, staff training and the provision of activities.

One area requiring improvement was identified in relation to IPC practice.

Residents stated that they were happy in the home and that staff were kind and attentive.

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	1	0

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

4.2 Action/enforcement taken following the most recent medicines management inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 25 April 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, the returned QIP, notifiable events, and written and verbal communication received since the previous care inspection.

During the inspection the inspector met with the person in charge, fifteen 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 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
- 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
- Accident, incident, notifiable event records
- 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
- Programme of activities
- Policies and procedures

Areas for improvements identified at the last care inspection were reviewed and assessment of compliance recorded as met.

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 25 April 2018

The most recent inspection of the home was an unannounced medicines management inspection.

This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 11 December 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		Validation of compliance
Area for improvement 1 Ref: Standard E 26 Stated: First time	The registered person shall ensure that all residents have been provided with a personal lockable space within their bedroom.	Met
	Action taken as confirmed during the inspection: There is now a lockable space in each bedroom.	

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, residents' representatives 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 deputy manager 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 of training, staff appraisals and supervision were reviewed during the inspection.

Discussion with the deputy manager 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. The competency and capability assessments were audited by the line manager at her monthly monitoring visits.

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 was 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.

Discussion with the deputy manager, review of accident and incidents notifications, care records and complaints records confirmed that all suspected, alleged or actual incidents of abuse were fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records were retained. Appropriate action plans, as agreed with the adult safeguarding team, were in place to address any identified safeguarding concerns.

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 bed rails for one resident and a pressure alarm mat for one resident. 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. Observation of staff practice identified that staff, in the main, adhered to IPC procedures. One member of staff was observed transporting unclean laundry which was not in a laundry bag. The staff member was not wearing appropriate PPE. This was brought to the attention of the deputy manager and has been highlighted as an area of improvement.

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.

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 most recently on 13 November 2017 and action plans developed to address any deficits noted.

The deputy manager reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with the 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 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 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 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.

The home had an up to date Legionella risk assessment in place dated 4 October 2017 and all recommendations had been actioned or were being addressed.

It was established that five residents smoked. A review of the care records of these residents identified that 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 deputy manager and review of Lifting Operations and Lifting Equipment Regulations (LOLER) records confirmed that safety maintenance records were up to date.

The home had an up to date fire risk assessment in place dated 12 April 2018 and all recommendations had been actioned or were being addressed. It was noted that the fire risk assessment had reviewed the arrangements for residents who smoke.

Review of staff training records confirmed that staff completed fire safety training twice annually. Fire drills were completed on a regular basis 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. Individual residents had a completed Personal Emergency Evacuation Plan (PEEP) in place.

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

- “This is a great wee place it’s a lovely spot. I can come and go as I please.” (resident)
- “Care is safe here but the residents aren’t smothered. I think the residents have a good quality of life care because they can be independent but have the security that we are here if they need anything.” (staff)
- “We encourage residents to remain as independent as possible.” (staff)
- “They always tell me to ring the bell if I need to walk but sometimes I forget.” (resident)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, adult safeguarding, risk management and the home’s environment.

Areas for improvement

One area was highlighted for improvement. This was in relation to infection prevention and control precautions.

	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 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.

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 assessment.

Discussion with the deputy manager and staff confirmed that wound care is managed by community nursing services. 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.

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), 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.

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 and resident and/or their representative 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.

In discussion with one resident he raised two areas of concern in relation to food choices and that staff were noisy during the night. The concerns were shared with the deputy manager who undertook to deal with the issues.

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

- "I wouldn't hesitate to go to management if there was anything I was concerned about or just to talk things through. They always make time for you." (staff)
- "I wouldn't be here today if it wasn't for these people looking after me." (resident)
- "I've been here for years and would not consider going anywhere else." (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 and residents 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. Staff were observed knocking on bedroom doors before entering and conversations about personal care were undertaken in the privacy of residents' bedrooms.

Discussion with staff and residents and their representatives confirmed that residents' spiritual and cultural needs were met within the home. 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.

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.

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. A hairdresser was in the home and the activity coordinator was undertaking a pamper session with some residents. Records showed that a visiting pet therapy group was planned to come to the home on the day after the inspection. Arrangements were in place for residents to maintain links with their friends, families and wider community.

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

- “There isn’t one girl who is anything but helpful and patient.” (resident)
- “I wouldn’t have any problem in letting a relative of my own live here.” (staff)
- “Some people have no families and the staff are like their family.” (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 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 would be 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.

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 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. Reports from the visits of 26 April 2018 and 11 May 2018 were reviewed and showed that a plan was produced which highlighted any areas which required further 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. 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. The returned QIP confirmed that the registered provider responded to regulatory matters in a timely manner. 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.

The deputy manager 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, for example in relation to gender, religion and marital status, 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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Linda Moore, 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

<p>Area for improvement 1</p> <p>Ref: Regulation 14 (2) (c)</p> <p>Stated: First time</p> <p>To be completed by: 10 June 2018</p>	<p>The registered person shall ensure that staff adhere to IPC guidance at all times.</p> <p>Ref: 6.4</p>
	<p>Response by registered person detailing the actions taken:</p> <p>The Home Manager has reviewed this QIP. All staff have received ICP supervisions. ICP guidance is given to staff at each handover. The Home Manager ensures that this subject is discussed with staff when she is walking around the Home. The Home Manager observes the environment and includes this in the daily walk around.</p>

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



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