

# **REGISTRATION AND INSPECTION**

**OF**

**PRIVATE NURSING AND RESIDENTIAL HOMES**

ROYAL CONNAUGHT

CARE HOME

ALDERNEY

**INSPECTION REPORT**

**DATE: 13th December 2022**

**This report may only be quoted in its entirety and may not be quoted in part or in any abridged form for any public or statutory purpose**

**HEALTH & SOCIAL CARE REGISTRATION AND INSPECTION OF PRIVATE NURSING AND RESIDENTIAL HOMES**

**INTRODUCTION**

The Registration and Inspection unit of Health & Social Care (HSC) has a statutory responsibility to inspect private nursing and residential homes within the Bailiwick of Guernsey at least twice per year. The Registration and Inspection Officer undertakes a minimum of one announced and one unannounced inspection per year.

The inspections are undertaken in order to establish whether the care home is meeting the legal requirements i.e. The Nursing and Residential Homes (Guernsey) Law 1976 and its associated Ordinances, together with the agreed standards.

In reading the report the following factors should be borne in mind:

* The report is only accurate for the period when the home was inspected.
* Alterations to physical facilities or care practices may subsequently have occurred in the home.
* Feedback will have been given orally to the senior person on duty at the time of the visit.
* Both the Inspector and the Registered Home Owner/Care Manager of the home to which it refers will agree the report as an accurate report.
* The report will show the compliance with the Regulations and Standards and the required actions on behalf of the provider.

Name of Establishment: **Royal Connaught Care Home**

Address: **Le Val, Alderney, GY9 3UL**

Name of Registered Provider: **The Royal Connaught Residential Home Limited**

Name of Registered Manager: **Ms Elizabeth Bowskill (RGN)**

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| **CATEGORY** | **NUMBER OF REGISTERED BEDS** |
| **Residential** | **27** |

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| **Date of most recent inspection: 09/06/22 – Announced** |
| **Date of inspection upon which this report is based – 13/12/22** |
| **Category of inspection – Announced** |
| **Vanessa Penney - Registration and Inspection Officer (Quality & Patient Safety Team) Health & Social Care**  **Elizabeth Lees-Thackery – Children & Adult Safeguarding Named Nurse (Quality & Patient Safety Team) Health & Social Care** |

**SUMMARY OF FINDINGS**

Royal Connaught is a purpose-built care home which can accommodate 27 people who require residential care. On the day of inspection, the home had full occupancy. An extension for a further 14 ensuite rooms is currently in progress with the addition of a passenger lift.

On the day of inspection, the home was clean and tidy throughout and resident’s rooms have been personalised with their personal possessions, which reflects their personality and interests. There is a garden to the back of the home with areas to undertake activities, seating and level pathways that can accommodate a wheelchair. Currently the area to the side of the home has been cordoned off due to the building work taking place.

On entering the home, there was a warm atmosphere and staff appeared friendly and welcoming.

All people who move in to the Connaught have an assessment to ensure the team can plan care and organise any equipment that will be needed. Information is collected from the person, their NOK where relevant and other healthcare professionals who have been involved in the person’s care.

Care plans examined were person-centred and although it took time to navigate information, it was felt this would improve as staff became familiar with using the newly installed electronic care package (Fusion). It was clear in discussion with individual residents that they are supported to manage and be involved in their care whenever possible and some good examples were provided. Residents who were spoken to liked living at the Connaught and said they are happy living there. People said they have choices at meal times and are supported with their nutritional intake as needed and care records reflect this.

There is a safe system in place for the storage, administration and disposal of medication and all carers who undertake the administration of medication have completed training, which is overseen by the care manager and the RNs working within the team.

Staff are clear on policies and procedures for infection control and prevention in the home and have adequate supplies of PPE, which were noted to be worn appropriately when undertaking certain tasks. While there were no concerns identified during the inspection regarding cleanliness, the care manager, needs to organise for an infection control audit to be undertaken by the IPACT as part of auditing for quality assurance.

Staff are aware of safeguarding policies and procedures. To ensure this is maintained, the safeguard lead for the home is in the process of organising for all staff to undertaking refresher training. Residents spoken to said they feel safe living at the Connaught.

There is a complaints policy in place. Residents spoken to said they know how to make a complaint; however, when asked, no resident had any issues to raise and said they feel comfortable to speak to the care manager directly if needed and felt they would be listened to and their issue would be managed sympathetically and appropriately.

The staffing level is satisfactory to meet the care needs of the current residents. The care manager said this is continuously kept under review and there is flexibility when care needs increase e.g. person receiving end of life care.

All staff have an induction when they commence employment at the home. This is followed on by a programme of training throughout the person’s employment at the home. Supervisions are undertaken regularly to further develop people both personally and professionally within the team. Carers are supported to undertake the Care Certificate and the VQ awards.

Accidents/incidents are recorded and reported to the relevant department as needed. The care manager monitors this for trends so that measures can be put in place to minimise further risk.

A number of quality assurance systems are in place, for example audits undertaken both internally and by external healthcare professionals. The care manager said these are also used in their KPIs to further develop the performance of staff and for the ongoing development of the service.

**Royal Connaught – Audit**

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| **CARE PLAN** | **YES** | **NO** | **In part** | **COMMENTS** |
| Care plan is in place and is based on assessment | **√** |  |  | Evidence – Care plans, risk assessments, discussion with carers.  Care planning and risk assessments are now on Fusion (electronic recordkeeping system). The carers and nurses have tablets so that they can record information as they are working. Discussed the system with carers who demonstrated clear understanding of their use of the tablets.  Senior carers and nurses are responsible for implementing and updating care plans following assessment or any changes. There are named key workers for residents but it is everyone’s responsibility to ensure care plans are updated.  Additional care plans were observed for personal care, Vascular Dementia, Parkinson’s and activities.  A RAG rating system is in place to flag up when care plans are out of date.  Residents who are able to participate in their own planning do so; otherwise this is undertaken with the person’s NOK.  All resident records are on Fusion, handover was observed on the day of audit.  **Standard Met** |
| **Risk assessments in place for:** |  |  |  |
| * Moving & handling, mobility & risk of falls | **√** |  |  |
| * Nutrition | **√** |  |  |
| * Skin condition & Pressure sore prevention | **√** |  |  |
| * Other | **√** |  |  |
| Minimum of 3-monthly review of care plan, or as needs change if before review date | **√** |  |  |
| Evidence of user/relative involvement | **√** |  |  |
| Restrictions on choice & freedom are agreed and documented (Mental Health, Dementia) | **√** |  |  |
| Format of care plan is acceptable | **√** |  |  |
| Handover discussions: verbal, written on changeover of each shift | **√** |  |  |
| All entries on documentation are legible, dated and signed | **√** |  |  |

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| **HEALTHCARE NEEDS** | **YES** | **NO** | **In part** | **COMMENTS** |
| Service users are supported and facilitated to take control and manage own healthcare wherever possible; staff assist where needed | **√** |  |  | Evidence – discussion with new resident, senior staff and some other individual residents.  Talked with a resident who had quite recently moved into the Connaught.  The lady understood her own health needs and continued to do her own liaison with the dietician and Oncologist for her health as she had when living independently. She valued being able to do this.  The registered nurses communicate with health professional as needed, make referrals and update care plans.  Training is undertaken in pressure area care by all carers as part of the End of Life training.  Senior nurse has been training the staff about Pressure Ulcers and care, the TVN will attend when needed and provide telephone advice. There are positioning charts in place – observed. Staff are much more aware about pressure area prevention and care.  Potentially 3 people at present have fragile areas that require intervention by staff, all being treated with creams.  Airflow mattresses are purchased and are in place as needed.  OAMH consultant visits from Guernsey and is available for guidance.  Activities are available throughout the day.  Resident shared that she will go out for a short walk, she feels safer to do this now she is living at the Connaught. Previously she was fearful of falling and felt very isolated.  GP Dr Gallagher QRMP is doing the health reviews for all of the residents at the Connaught.  **Standard Met** |
| Access is provided to specialist health services e.g. medical, nursing, dental, pharmaceutical chiropody and therapeutic services and care from hospitals and community services according to need | **√** |  |  |
| Care staff maintain the personal and oral care of each person and wherever possible support the person’s independence | **√** |  |  |
| People are assessed by a person who is trained to do so, to identify those people who have developed, or are risk of developing a pressure injury. Appropriate intervention and outcome are recorded in the plan of care | **√** |  |  |
| People are free of pressure injuries | **√** |  |  |
| There are preventative strategies for health care: link nurses, equipment etc | **√** |  |  |
| Repositioning charts in place where needed | **√** |  |  |
| The registered person ensures that professional advice about the promotion of continence is sought and acted upon and the necessary aids and equipment are provided | **√** |  |  |
| A person’s psychological health is monitored regularly and preventative and restorative care is sought as deemed necessary | **√** |  |  |
| Opportunities are given for appropriate exercise and physical activity; appropriate interventions are carried out for individuals identified as at risk of falling | **√** |  |  |
| Results from appointments, treatments and problems and from health care professionals are recorded in care plan and are acted upon | **√** |  |  |
| Regular night checks are in place | **√** |  |  |
| Service users, relatives and/or advocates have the opportunity to discuss service users’ wishes on their care with an informed member of staff | **√** |  |  |
| The support service needs of each resident are assessed and access provided – choice of own GP, advocacy services; alternative therapy; social worker; bereavement councillor; specialist nurses; dentist; audiologist; spiritual advisor; optician etc | **√** |  |  |
| Residents are referred for reassessment at appropriate time if this becomes necessary e.g. residential to nursing care needs or EMI | **√** |  |  |
| The registered person ensures that peoples’ entitlements to Health & Social Care services are upheld by providing information about entitlements and ensuring access to advice | **√** |  |  |

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| **MEDICATION MANAGEMENT** | **YES** | **NO** | **In part** | **COMMENTS** |
| There are policies for the receipt, recording, storage, handling, administration, disposal, self-medication, errors, re-ordering, homely remedies and for administration during a pandemic | **√** |  |  | Evidence – MARs, discussion with senior carer, medication policy.  Medication is administered by either a registered nurse (RN); or when not on duty, a senior carer who has undertaken relevant training using an e-learning course advised by the island’s pharmacist. Competency is overseen by the home’s RNs. Annual reviews are completed and documented by the RN or the care manager who is also a RN.  The date was not displayed on each policy with the reviewer; however, this was later located on the policies, which are generated and held electronically. The date the policy was introduced/reviewed should be on the copies in the files so that staff know the guidance is current.  An additional pain chart is in place for those that need it with the reasons the pain relief was given.  No residents in Connaught currently self-medicate. One person who was recently self-medicating had been reviewed and a decision was made with the resident that staff would take over this procedure due to concerns identified and this is documented.  No residents are currently receiving their medication covertly; however, when questioned carer was aware of correct consent and procedure required.  The care manager said a monthly multi-disciplinary meeting is due to commence involving RN, senior carer and a GP to review residents’ health and medication as a new surgery has taken over the GP cover for the home (QRMP).  Daily temperature recordings of the medication fridge had lapsed; it is important that this is maintained to ensure medication does not deteriorate if appliance temperature fails.  A medication inspection has not been undertaken by the pharmacist, which is outside of the care manager’s control; however, a monthly in-house audit is undertaken on the changeover of each medication cycle.  **Standard requires some action** |
| Keys for access to medication to be kept with the person in charge of the shift | **√** |  |  |
| NMC guidance and BNF (within 6-month date) available or accessible online | **√** |  |  |
| There is a self-medication assessment completed for each resident if person wanting to continue with this process and this is reviewed regularly | **√** |  |  |
| There is safe storage within a person’s room to store the medication to which suitable trained staff have access with the person’s permission | **N/A** |  |  |
| **Records for:** |  |  |  |
| * Meds received | **√** |  |  |
| * Meds administered – check for overuse of pain control meds and sedatives | **√** |  |  |
| * Meds leaving the home | **√** |  |  |
| * Meds disposed | **√** |  |  |
| * Medication Administration Record (MAR) in place | **√** |  |  |
| * Photo of service user (consent) | **√** |  |  |
| If medication is required to be administered covertly, this is in the care plan, consent from GP and from resident’s next of kin | **N/A** |  |  |
| Controlled drugs (CDs) are stored in line with current regulations | **√** |  |  |
| Register in place to monitor CD usage and stocks – regular checks documented. | **√** |  |  |
| Signature list of all staff who administer medication | **√** |  |  |
| The 2 people administering and witnessing the administration of a CD attend the person and see process until complete | **√** |  |  |
| Compliance with current law and codes of practice | **√** |  |  |
| Medicines, including controlled drugs, (except those for self-administration) for people receiving nursing care, are administered by a medical practitioner or registered nurse | **N/A** |  |  |
| Medication including CDs are returned to pharmacy as soon as no longer in use | **√** |  |  |
| Daily check of medication fridge, which is documented, to ensure remains within advised range (between 2-8˚C) |  |  | **√** |
| Staff training programme in place for residential homes where Carer administering medication e.g. VQ standalone unit for the administration of medication or other accredited training at level 3 | **√** |  |  |
| Competency assessment in place for Carers (residential home) for the administration of medication and this is reviewed at least annually, which is recorded | **√** |  |  |
| Pharmacist advice used regarding medicines policies within the home and medicines dispensed for individuals in the home | **√** |  |  |
| People receive their medication at correct prescribed times | **√** |  |  |
| Each person’s medication is reviewed regularly by a GP. Any concern in a person’s condition as a result of a change in medication must be reported to the GP immediately | **√** |  |  |
| Has a Medication Inspection been undertaken by HSC’s Pharmacist? |  | **√** |  |
| Are flu vaccinations offered to residents, staff annually? | **√** |  |  |
| Medications are kept in the home for a minimum of 7 days or after burial or cremation following a death | **√** |  |  |
| Audit of MARs in place | **√** |  |  |

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| **PEOPLE ARE TREATED WITH RESPECT** | **YES** | **NO** | **In part** | **COMMENTS** |
| Privacy and dignity are provided when assisting a resident with washing, bathing, dressing etc | **√** |  |  | Evidence – Conversations with residents, observation of staff and resident interactions during the day and response to call bells.  All rooms in the home are single occupancy.  Discussed with resident, very complimentary about staff’s approach caring and kindness. Also, that they present as “Happy”.  Resident talked about how she particularly appreciates that staff are willing to have a conversation and make hot drinks during the night and to spend time talking patiently.  Call bells were observed to be answered promptly when people called for assistance and staff did not appear to rush people when they were assisting them.  Signs on doors – Please knock  Residents said they have a fairly flexible routine for getting up, going to bed, being assisted to wash and dress and with mobilising around the home and staff were observed to check they were ok or if they needed any assistance.  Information regarding residents is stored in a locked office for which only authorised staff have access.  **Standard Met** |
| Bedrooms are shared only by the choice of service users e.g. married couples, siblings | **N/A** |  |  |
| Screens are available in shared rooms | **N/A** |  |  |
| Examinations, consultations legal/financial advisors, visits from relatives are provided with privacy | **√** |  |  |
| Entering bedrooms/toilets - staff knock and wait for a reply before entering | **√** |  |  |
| Wear own clothing | **√** |  |  |
| Mail is only opened by staff when instructed to do so | **√** |  |  |
| Preferred term of address in consultation with resident & this is documented in person’s care plan | **√** |  |  |
| Wishes respected and views considered | **√** |  |  |
| Treated with respect – verbally | **√** |  |  |
| Flexibility of daily routine e.g. getting up, going to bed, outings, taking part in activity events, open visiting etc | **√** |  |  |
| Information regarding residents is treated confidentially and in line with data protection | **√** |  |  |

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| **NUTRITION & HYDRATION** | **YES** | **NO** | **In part** | **COMMENTS** |
| People have a nutritional assessment on admission using MUST or equivalent | **√** |  |  | Evidence – care plans  Care plans are now on an electronic system.  MUST assessment was discussed with senior staff.  Going through the care records with the care manager, she has recognised that some information is documented in the care plans and some recorded in the daily records. Therefore, some information could be difficult to evaluate when not all staff are doing the same. This should improve when staff get used to the new electronic recordkeeping system.  Monthly weights were checked and are recorded in care records.  IDDSI observed and talked through support with staff.  A resident shared how she meets with the Chef and her key worker weekly to plan her meals for the following week. The resident doesn’t have much appetite and can feel overwhelmed if there is too much food, so this planning has helped with dietary intake.  The meals at lunch time looked appetising. Conversations with residents suggested residents have a choice at meal times and regular snacks and beverages are offered regularly throughout the day in between meals and also during the night if a person wakes and is hungry or thirsty.  People were observed to receive the appropriate support/supervision with their meal and staff were patient and helpful.  Some residents are prescribed supplements e.g. Fortisip if there are concerns with their appetite; however, the carer said they try people’s favourite foods and drinks and milkshakes before requesting supplements from the person’s GP.  The dining areas were observed to be clean, pleasant and comfortable.  **Standard Met** |
| Concerns as a result of MUST assessment referred to dietician or thereafter during ongoing monitoring | **√** |  |  |
| People’s nutrition is monitored monthly and is documented – weight recorded | **√** |  |  |
| Food & Fluid chart in place where necessary | **√** |  |  |
| Care plan should include the following:   * Food allergies and intolerances * Special dietary requirement due to cultural, religious or ethical choices * Special dietary requirements due to health conditions such as diabetes, kidney failure, heart failure etc * Awareness of IDDSI for modified diets * Relevant support at meal time such as special cutlery or plates, feeding assistance, seating arrangements * Likes and dislikes | **√** |  |  |
| If reduced oral intake, are first line measures in place to promote oral intake e.g. nourishing drinks, extra snacks etc before requesting supplements – dietician will advise if contacted | **√** |  |  |
| Prescribed enteral nutrition and dietary supplements should be given at the specified times e.g. Fortisip | **√** |  |  |
| Supplements prescribed need to be signed for or correct code documented on MAR if not needed / refused etc | **√** |  |  |
| Supplements to be reviewed regularly by GP, dietician |  |  |  |
| PEG care to be carried out to avoid infection and buried bumper syndrome. Training to be kept up to date | **N/A** |  |  |
| People are offered choices at meal times | **√** |  |  |
| The food is nutritious | **√** |  |  |
| Fresh fruit and vegetables are served/offered regularly | **√** |  |  |
| Hot and cold drinks and snacks are available at all times and are offered regularly | **√** |  |  |
| A snack available in the evening/night – e.g. may be necessary for diabetic | **√** |  |  |
| Food covers are used to transport food to rooms | **√** |  |  |
| Eating areas are suitable, clean and pleasant | **√** |  |  |

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| **COMPLAINTS** | **YES** | **NO** | **In part** | **COMMENTS** |
| There is a complaints procedure which is clear and simple, stating how complaints can be made | **√** |  |  | Evidence – Resident’s guide, conversations with residents, discussion with care manager.  Complaints procedure is located in the resident’s guide. Residents spoken to with capacity were able to feedback the process, which they said had been provided to them when they came in.  The care manager said as well as the process for complaint in the residents’ guide, people are also provided with this information on admission. For some residents without capacity or with limited capacity the person’s NOK would receive this information.  Of the residents spoken to, no person had a complaint to raise at this time and the care manager had not received any recent complaints. Residents said they would feel comfortable to raise a concern with the care manager directly if needed and felt it would be addressed sympathetically and appropriately.  When a formal complaint is made, the care manager has previously informed the registration & inspection officer, or a referral made to the safeguard team if needed and records are kept.  **Standard Met** |
| The procedure is accessible e.g. reception notice board, resident’s handbook | **√** |  |  |
| Are there timescales for the process? | **√** |  |  |
| The procedure states who will deal with them | **√** |  |  |
| Records are kept of all formal complaints | **√** |  |  |
| There is a duty of Candour – transparent and honest | **√** |  |  |
| Details of investigations and any action taken is recorded | **√** |  |  |
| There is written information available, clearly displayed, in an accessible place, for referring a complaint to the HSC | **√** |  |  |

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| **PROTECTION** | **YES** | **NO** | **In part** | **COMMENTS** |
| **Polices & procedures are in place for Safeguarding Vulnerable Adults against:** |  |  |  | Evidence – discussed with care manager and senior staff.  Following discussion, staff aware of how to seek advice and support from the Named Nurse within HSC for arising issues and understand how to raise an enquiry with Adult Safeguarding.  Senior registered nurse is delivering the Safeguarding training for the staff team – nurse is trained to level 4.  **Standard requires some action** |
| * Physical abuse | **√** |  |  |
| * Sexual abuse | **√** |  |  |
| * Inappropriate restraint | **√** |  |  |
| * Psychological abuse | **√** |  |  |
| * Financial or material abuse | **√** |  |  |
| * Neglect | **√** |  |  |
| * Discrimination | **√** |  |  |
| * Whistle-blowing | **√** |  |  |
| * Safe storage of money & valuables | **√** |  |  |
| * Staff non-involvement in resident’s financial affairs or receiving of gifts | **√** |  |  |
| Safeguard allegations are reported to the Safeguard Lead & Inspection Officer (HSC) | **√** |  |  |
| Allegations/incidents are recorded, followed up and actioned appropriately | **√** |  |  |
| Staff undertake regular training for safeguarding |  |  | **√** |

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| **PREMISES** | **YES** | **NO** | **In part** | **COMMENTS** |
| Safe – no trip hazards | **√** |  |  | Evidence – Walkthrough the home, discussion with care manager and deputy manager.  The home appears to be kept well-maintained and is clean and comfortable.  There is a variety of furniture and equipment to suit individual people’s needs.  People’s rooms contain their personal possessions, which reflect people’s personality and interests. They were pleasantly decorated and were clean. Some rooms have views out towards the sea and others have a view over the garden.  As well as ensuite rooms, the home also has assisted bathing equipment and communal toilet areas on both floors.  The garden is secure for people to walk around when the weather is fine; however, some areas are currently out of bounds and are secured off due to the extension currently being built.  **Standard Met** |
| Restricted entry/exit to the home is appropriate | **√** |  |  |
| Environment clean and comfortable – resident’s rooms & communal areas | **√** |  |  |
| Appropriate furnishings and furniture | **√** |  |  |
| Adequate bathing and toilet facilities | **√** |  |  |
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| **INFECTION CONTROL** | **YES** | **NO** | **In part** | **COMMENTS** |
| Policies and procedures for the control of infection include: safe handling and disposal of clinical waste, dealing with spillages, provision of protective equipment, hand washing | **√** |  |  | Evidence – Discussion with care manager, housekeeping supervisor and residents, policies for infection control.  Home was clean and tidy throughout. Corridor in the home where carpet has been replaced with hard flooring is proving a good decision for infection control within the care home environment as spills can be cleared away more efficiently.  There are good supplies of PPE for staff use when needed and all staff complete training with a regular refresher, which is monitored by the deputy manager. Care manager has plans in place for infection outbreaks. |
| Staff undertake regular training for infection control | **√** |  |  |
| Infection control audit undertaken by the Infection Control Nurse from within HSC |  | **√** |  |
| Infection Control Nurse and Inspection Officer from within HSC to be informed when outbreak of infection (2 cases) | **√** |  |  |
| Preparedness plan in place in the case of a pandemic (recent Cocid-19 outbreak | **√** |  |  |
| Adequate stocks of PPE available and staff know correct way to put on and take off to minimis risk of spreading infection. | **√** |  |  | An infection control audit has not been undertaken by HSC’s IPAC nurse; however, the housekeeping supervisor undertakes regular audits to ensure high standards of cleanliness are maintained.  **Standard requires some action** |

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| **STAFFING** | **YES** | **NO** | **In part** | **COMMENTS** |
| Satisfactory level for dependency of current residents. | **√** |  |  | Evidence – discussion with care manager and deputy manager, staff duty rota.  The staffing levels are satisfactory to meet the care needs of the current residents. The care manager said this is continually monitored and adjusted accordingly e.g. person receiving end of life care.  Although the care home is currently registered as residential, there are some RNs within the team to provide guidance and support to the carers.  **Standard Met** |

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| **TRAINING & SUPERVISION** | **YES** | **NO** | **In part** | **COMMENTS** |
| Supervised induction on employment – documented programme. | **√** |  |  | Evidence – discussion with care manager, deputy manager, individual staff and 2 induction programmes. |
| Mandatory   * Fire Safety * Moving & handling * Basic first aid and life support * Food hygiene awareness * Infection Control * Safeguarding * Dementia care | **√** |  |  | All staff have an induction where they work through a supervised programme to cover mandatory training. They are initially supernumerary for 4 half shifts and are paired with a more senior colleague during this period. Following induction, regular refresher sessions are provided throughout the person’s employment at the home. |
| Ongoing supervision as needed | **√** |  |  | Supervisions are provided informally when the RNs are working with carers and formally every 3-4 months, for which records are kept. |
| Access to training relevant to meet clients care needs and for team role | **√** |  |  | The care manager said annual appraisals have lapsed due to staff shortages; however, information is covered in supervisions that would be covered in appraisal. |
| Supported to access the VQ or equivalent award | **√** |  |  | Six carers have completed the care certificate and another 2 carers are currently undertaking this course. |
| Annual appraisal | **√** |  |  | 1 carer has a VQ level 3 and another is currently undertaking this award.  There is also a variety of training provided through e-learning, which the deputy manager said is in place and is matched with the person’s job role within the team.  **Standard Met** |

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| **LEADERSHIP** | **YES** | **NO** | **In part** | **COMMENTS** |
| Relevant qualifications and experience for role | **√** |  |  | Evidence – discussion with care manager, deputy care manager, individual staff and residents.  Care manager is a Registered General Nurse (RGN) and has a Level 7 Diploma in Strategic Management and Leadership. She is also a VQ assessor, and has a degree in Health Sciences.  The care manager has an open-door policy and people are able to speak to her at any time. Although her office is not currently easily accessible for residents and relatives, staff on duty inform her if a resident or relative wish to speak to her and she will go to see them. She is also visible around the home as she goes about her work and frequently stops to have conversations with people.  Residents spoken to said the care manager often stops to have a chat with them when she is about the home. They said they are consulted about their ideas for menus, activities and the quality of care they receive and are happy living at the Connaught. No resident had any ideas they felt could improve the home, they said they are happy as things are.  Care Manager has a monthly meeting with the board of directors where she provides a report for the home’s KPI’s, recruitment issues and quality measurements e.g. audits. She said this helps with staff and service development.  **Standard Met** |
| Open and transparent | **√** |  |  |
| Approachable to all stakeholders | **√** |  |  |
| Does manager monitor own performance? | **√** |  |  |
| Feedback received is acted on | **√** |  |  |
| Policies and procedures updated as practice changes, legislation direct (at least 3-yearly) | **√** |  |  |
| Views of service users are sought e.g. with their care, changes within the home, food choices and social engagement provision etc | **√** |  |  |
| Auditing takes place e.g. to improve care, service, environment etc | **√** |  |  |
| Action progressed on agreed implementation of statutory/good practice requirements (progress from last inspection) | **√** |  |  |

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| **ACCIDENTS / INCIDENTS** | **YES** | **NO** | **In part** | **COMMENTS** |
| Accidents, injuries and incidents of illness are documented and are reported to the relevant person (HSE RIDDOR) as appropriate | **√** |  |  | Evidence – discussion with care manager and senior staff.  Incidents are reported to inspector of care homes and is recorded on a running record.  Equipment in place as needed. No issues identified.  The team have access to HSC and MSG consultants for guidance and support. |
| Care plan reviewed and risk assessment updated |  |  | **√** |
| Equipment put in place if needed | **√** |  |  |
| Support sought from external healthcare professionals as needed | **√** |  |  | The care manager and relevant team members have participated in a SWARM / AAR for further learning following an incident. |
| Incidents / accidents are seen as an opportunity for learning e.g. discussed within the team to resolve | **√** |  |  | Manager monitors accidents/incidents for trends regularly, which was discussed with the care manager. |
| Training need identified and acted on | **√** |  |  | Care plans and risk assessments are not always fully reviewed and amended when an incident occurs. |
| Monitor incidents / accidents for trends e.g. happening to same person, same area of home, same time of da e.g. handover | **√** |  |  | **Standard requires some action** |

| **Improvement Plan -** Completion of the actions in the improvement plan are the overall responsibility of the Home’s care manager. | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Action No.** | **Standard** | **Action** | **Date action to be achieved** | **Person/s Responsible for completion of the action** | **Compliance check date:** | **Through addressing the actions, has this raised any issues that require further action** |
| 1. | Medication | * Ensure temperature of the fridge holding medication is recorded daily so that any failure of the equipment can be acted on promptly | Immediate | Care manager | Next visit to Alderney. Date TBC |  |
| 2. | Protection | * Ensure all staff complete refresher training for safeguarding – frequency to be advised by the named nurse for adult safeguarding | Provide time for the in-house trainer for safeguarding to complete training with all staff as soon as possible | Care Manager | Next visit to Alderney. Date TBC |  |
| 3. | Infection Control | * Contact the IPACT within HSC so that an infection prevention and control audit can be undertaken | As soon as a date can be arranged | Care Manager | Next visit to Alderney. Date TBC |  |
| 4. | Accidents / incidents | * When an accident/incident occurs in the home, ensure the person’s risk assessment and care plan are reviewed and updated to include further observation/equipment or support required to minimise further risk | Immediate | Care Manager | Next visit to Alderney. Date TBC |  |

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| **HOME MANAGER/PROVIDERS RESPONSE** |

Please provide the Inspection department of Health & Social Care with an action plan, which indicates how requirements and recommendations are to be addressed and a completion date within the stated timetable.

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| **No** | **Recommended works** | **Action being taken to address requirements** | **Estimated completion date** |
| 1 | Ensure temperature of the fridge holding medication is recorded daily so that any failure of the equipment can be acted on promptly | Regular Audits of fridge checks to be carried out by Nursing and senior staff. | On-going bi-monthly |
| 2 | Ensure all staff complete refresher training for safeguarding – frequency to be advised by the named nurse for adult safeguarding | Lead Training Nurse and Human Resources to source on line Safeguarding and cascade to staff. | Three months for all staff. |
| 3 | Contact the IPACT within HSC so that an infection prevention and control audit can be undertaken | Contacted IPACT and annual inspection due in July August 2023 | Immediate- Completed |
| 4 | When an accident/incident occurs in the home, ensure the person’s risk assessment and care plan are reviewed and updated to include further observation/equipment or support required to minimise further risk | Monthly audits of incident forms to ensure that the current care plan reflects the risk. |  |

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| **No** | **Recommended practice developments** | **Action being taken to address recommendations** | **Estimated completion date** |
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**REGISTERED PERSON’S AGREEMENT**

**Registered person(s) comments/confirmation relating to the content and accuracy of the report for the above inspection.**

We would welcome comments on the content of this report relating to the inspection conducted on **13/12/22** and any factual inaccuracies:

Registered Person’s statement of agreement/comments: Please complete the relevant section that applies.

I Elizabeth Bowskill of The Connaught confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s) and that I agree with the requirements made and will seek to comply with these.

Or

I of am unable to confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s) for the following reasons:

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|  |

##### **Signature:** *Liz Bowskill*

**Position: Manager of Operations**

**Date: 14/04/23**

**Note:**

**In instances where there is a profound difference of view between the inspector and the registered person both views will be reported. Please attach any extra pages, as applicable.**

**December 2022**