Unannounced Care Inspection Report
2 October 2017

Ballyowen House

Type of Service: Residential care home
Address: 179 Andersonstown Road, Belfast, BT11 9EA
Tel No: 028 9063 3103
Inspector: Alice McTavish

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home with 31 beds that provides care for residents living with dementia. There are plans in place for the eventual closure of the home and only three residents were accommodated at the time of the inspection.

3.0 Service details

Organisation/Registered Provider: Belfast HSC Trust Mr Martin Joseph Dillon	**Registered Manager:** Ms Fionnuala Breslin
Person in charge at the time of inspection: Patricia O'Kane, senior care assistant	**Date manager registered:** 20 February 2013
Categories of care: Residential Care (RC) DE – Dementia	**Number of registered places:** 31

4.0 Inspection summary

An unannounced care inspection took place on 2 October 2017 from 09:20 to 13:50.

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 since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staff training, supervision and appraisal, adult safeguarding, risk management, the home's environment, care records, listening to and valuing residents, quality improvement and maintaining good working relationships.

An area requiring improvement was identified in relation to the reporting to RQIA of accidents and incidents.

The residents accommodated were unable to verbalise their views on the care provided to them; they were, however, well presented and appeared to be relaxed and contented in the home.

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 Patricia O'Kane, Senior Care Assistant and Fionnuala Breslin, Registered Manager, by telephone after the inspection. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the most recent inspection on 14 February 2017.

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 and notifiable events received since the previous care inspection.

During the inspection the inspector met with two residents, one member of care staff, the registered manager who was present during part of the inspection and the assistant service manager. No visiting professionals and no residents' visitors/representatives were present.

A total of eight questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA. Two questionnaires were returned within the requested timescale.

The following records were examined during the inspection:

- Staff duty rota
- Staff supervision and annual appraisal schedules
- Sample of competency and capability assessments
- Staff training records
- Care files of three residents
- Minutes of recent staff meetings
- Complaints and compliments records
- Equipment maintenance records
- Accident/incident/notifiable events register
- Minutes of recent residents' meetings
- Monthly monitoring reports
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- Individual written agreement
- Programme of activities
- Policies and procedures manual

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 14 February 2017

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

6.2 Review of areas for improvement from the last care inspection dated 14 February 2017

There were no areas for improvements made as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The person in charge advised that the staffing levels for the home were subject to regular review to ensure the assessed needs of the residents were met. No concerns were raised regarding staffing levels during discussion with staff. A review of the duty roster confirmed that it accurately reflected the staff working within the home.

A review of completed induction records and discussion with the person in charge and staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities.

Discussion with staff and a review of a returned staff views questionnaire confirmed that mandatory training, supervision and appraisal of staff were regularly provided. A schedule for mandatory training, annual staff appraisals and staff supervision was maintained and was reviewed during the inspection.

The person in charge 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; records of competency and capability assessments were retained. Samples of completed staff competency and capability assessments were reviewed and found to be satisfactory.

Discussion with the person in charge confirmed that no staff had been recruited since the previous inspection, therefore staff personnel files were not reviewed on this occasion.

Arrangements were in place to monitor the registration status of staff with their professional body (where applicable).

The adult safeguarding policy and procedure in place was consistent with the current regional guidance and 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.

Staff advised that they were aware of the new regional guidance (Adult Safeguarding Prevention and Protection in Partnership, July 2015) and a copy was available for staff within the home. Staff were knowledgeable and had a good understanding of adult safeguarding principles and of the arrangements in place for the protection of children and young people. 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 assistant service 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.

The person in charge advised that there were risk management procedures in place relating to the safety of individual residents. Discussion with the person in charge identified that the home did not accommodate any individuals whose assessed needs could not be met. Review of care records identified that individual care needs assessments and risk assessments had been obtained prior to admission.

The person in charge confirmed there were restrictive practices employed within the home, notably locked doors with keypad entry systems. Discussion with the person in charge regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required.

Inspection of care records confirmed there was a system of referral to the multi-professional team 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 person in charge confirmed there were risk management policy and procedures in place in relation to safety in the home. Discussion with the person in charge and review of the home's policy and procedures relating to safe and healthy working practices confirmed that these were appropriately maintained and reviewed regularly e.g. Control of Substances Hazardous to Health (COSHH), fire safety etc. The trust also operated a corporate risk register which was kept up to date by the registered manager.

The person in charge confirmed that equipment and medical devices in use in the home were well maintained and regularly serviced.

A review of the infection prevention and control (IPC) policy and procedure confirmed that this this was in line with regional guidelines. Staff training records confirmed that all staff had received training in IPC in line with their roles and responsibilities. Discussion with staff established that they were knowledgeable and had understanding of IPC policies and procedures. Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered. Observation of staff practice identified that staff adhered to IPC procedures.

Good standards of hand hygiene were observed to be promoted within the home among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

The person in charge reported that any outbreaks of infection within the last year had been managed in accordance with the trust policy and procedures. The outbreak had been reported to the Public Health Agency, trust and RQIA with appropriate records retained.

A general inspection of the home was undertaken and the residents' bedrooms were found to be personalised 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 and grounds were kept tidy, safe, suitable for and accessible to residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff.

The home had an up to date fire risk assessment in place dated 14 August 2017; all recommendations were noted to be appropriately addressed or in the process of being so.

A review of staff training records confirmed that staff completed fire safety training twice annually. Fire drills were completed, most recently on 31 July 2017. Records were retained of 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 (PEEPs) in place.

Two completed questionnaires were returned to RQIA from a resident's representative and a member of staff. Respondents described their level of satisfaction with this aspect of care as dissatisfied and very satisfied respectively. The comments received from the resident's representative were discussed with the person in charge by telephone after the inspection; the person in charge agreed to share these with the registered manager.

A comment received from staff was as follows:

- "Mandatory and additional training is always encouraged"

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Discussion with the person in charge established that staff in the home responded appropriately to and met the assessed needs of the residents.

A review of the care records of three residents 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 statement of health and well-being of the resident. Care needs assessment and risk assessments (e.g. manual handling, nutrition, falls, where appropriate) were reviewed and updated on a regular basis or as changes occurred.

The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were observed to be signed by the resident and/or their representative. Discussion with staff confirmed that a person centred approach underpinned practice.

An individual agreement setting out the terms of residency was in place and appropriately signed. Records were stored safely and securely in line with data protection.

The person in charge advised that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. This area may be examined in detail during future care inspections.

The person in charge confirmed 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. The person in charge confirmed that management operated an open door policy in regard to communication within the home.

Observation of practice evidenced that staff were able to communicate effectively with residents, their representatives and other key stakeholders. Minutes of resident meetings were reviewed during the inspection. The assistant service manager advised that a separate representative meeting was to be held on the evening of the inspection.

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.

Two completed questionnaires were returned to RQIA from a resident's representative and a member of staff. Respondents described their level of satisfaction with this aspect of care as very satisfied.

A comment received from a resident's representative was as follows:

- "The residents are always treated with the best care and their needs are always met"

A comment received from a member of staff was as follows:

- "As number of residents has diminished, care is very person centred and meets the needs of the residents very well"

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records and communication between residents, staff and other key stakeholders.

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.

The person in charge confirmed 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.

A range of policies and procedures was in place which supported the delivery of compassionate care. Discussion with staff confirmed that residents' spiritual and cultural needs, including preferences for end of life care, were met within the home. Staff advised that action was taken to manage any pain and discomfort in a timely and appropriate manner; a review of care records identified that care plans were in place for the management of pain or uncharacteristic behaviours which might indicate the presence of pain.

The person in charge confirmed that consent was sought in relation to care and treatment. Discussion with staff and observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff confirmed their awareness of promoting residents' rights, independence and dignity and were able to describe how the confidentiality of residents was protected.

The person in charge and staff advised that residents were listened to, valued and communicated with in an appropriate manner. Discussion with staff and observation of practice confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff.

There were systems in place to ensure that the views and opinions of residents, and or their representatives, were sought and taken into account in all matters affecting them, for example, there were monthly residents' meetings, representatives' meetings and residents were supported and encouraged to participate in annual reviews of their care in the home.

Residents are consulted with, at least annually, about the quality of care and environment. The findings from the consultation were collated into a summary report which was made available for residents and other interested parties to read. An action plan was developed and implemented to address any issues identified.

Discussion with staff, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. There were arrangements in place for residents to maintain links with their friends, families and wider community.

Two completed questionnaires were returned to RQIA from a resident's representative and a member of staff. Respondents described their level of satisfaction with this aspect of care as very satisfied.

A comment received from a member of staff was as follows:

- "Staff respond in a timely manner when residents are in pain or anxious"

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 person in charge outlined the management arrangements and governance systems in place within the home. These were found to be in line with good practice. 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. Policies and procedures were 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 Residents Guide and posters displayed in the home. Discussion with staff confirmed that they had received training on complaints management and were knowledgeable about how to receive and deal with complaints.

A 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. The assistant service manager advised that, if complaints were to be frequently received, an audit of complaints would be used to identify trends and to enhance service provision.

There was an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of accidents/incidents/notifiable events identified, however, that a small number of these had not been reported to RQIA in accordance with the legislation and procedures. The registered manager agreed to submit these in retrospect. Action was required to ensure compliance with the regulations in relation to notifications.

There were quality assurance systems in place to drive quality improvement which included regular audits and satisfaction surveys. There was a system to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

Discussion with the person in charge confirmed that staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents, for example, skin care, continence management, eating and swallowing, end of life care.

A monthly monitoring visit 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, trust representatives and RQIA to read.

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 person in charge advised that the registered provider was kept informed regarding the day to day running of the home through the trust's line management system and the monthly monitoring visits.

The assistant service manager advised that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration was displayed.

Review of governance arrangements within the home and the evidence provided within the returned QIP confirmed that the registered provider responded to regulatory matters in a timely manner.

Review of records and discussion with the person in charge and staff confirmed that any adult safeguarding issues were managed appropriately and that reflective learning had taken place.

The home had a whistleblowing policy and procedure in place and discussion with staff established that they were knowledgeable regarding this. The person in charge advised that

staff could also access line management to raise concerns and that management would offer support to staff.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised.

Two completed questionnaires were returned to RQIA from a resident's representative and a member of staff. Respondents described their level of satisfaction with this aspect of the service as very satisfied.

Comments received from a member of staff were as follows:

- "Manager is very approachable and supportive. Always has time to listen and take on board staff views"

Areas of good practice

There were examples of good practice found throughout the inspection in relation to quality improvement and maintaining good working relationships.

Areas for improvement

One area for improvement was identified during the inspection. This related to:

	Regulations	Standards
Total number of areas for improvement	1	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Patricia O'Kane, senior care assistant and Fionnuala Breslin, registered manager, by telephone after the inspection. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 30.- (1) (d) **Stated:** First time **To be completed by:** 3 October 2017	The registered person shall ensure that RQIA is notified of any event in the home which adversely affects the care, health, welfare or safety of any resident. Ref: 6.7
	Response by registered person detailing the actions taken: During inspection it was noted that RQIA had not been informed of two incidents One incident related to a false fire alarm and the second incident related to an abrasion on a residents shin. The manager will ensure that all future adverse incidents which adversely affects the care, health, welfare or safety of any resident in future will lead to notification being sent to RQIA .The importance and expectation that RQIA must be noified in relation to notifiable incidents has been communicated and reinforced to Senior Care Assistants .

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

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