Day Care Inspection Report
16 January 2017

Wilson House Resource Centre

Type of service: Day Care Service
Address: 17 Raceview Road, Broughshane, Ballymena, BT42 4JL
Tel no: 02825863820
Inspector: Priscilla Clayton

1.0 Summary

An unannounced inspection of Wilson House Resource Centre took place on 16 January 2017 from 10.00 to 16.30 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the day care setting was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence to confirm that the centre was providing safe care. This was gained from service users and staff who spoke with the inspector; records examined, availability of associated policies/procedures, accident/incident records and staff training.

Two areas were identified for improvement. Firstly, the availability of the NHSCT revised policy on adult safeguarding and staff refresher training. Secondly, repair of one damaged bathroom door was restated for a second time from the previous inspection.

Is care effective?

Evidence of the provision of effective care was gained from discussion with staff, service users, care records, minutes of service users meetings, minutes of staff meetings, audits conducted and monthly monitoring reports.

One recommendation made for improvement included obtaining the staff member's signature within the competency and capability assessment document when competency is achieved.

Is care compassionate?

There was strong evidence that the care provided was compassionate from observation of staff interactions with service users, discussions with staff and service users who met with the inspector. Staff explained that there was a culture/ethos within the centre which supported core values as reflected within the service user guide and statement of purpose.

There was a range of policies and procedures in place which supported the delivery of compassionate care.

No requirements or recommendations were made in this domain.

Is the service well led?

There was evidence that the service was well led. This was obtained within records examined including; internal quality audits undertaken, provision of staff supervision/appraisal, staff meetings, staff mandatory training and professional development and positive feedback received from staff and service users.

No requirements or recommendations were made in the "Is the service well led" domain.

This inspection was underpinned by The Day Care Setting Regulations (Northern Ireland) 2007, the Day Care Settings Minimum Standards 2012.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Louanna Bakker, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent care inspection

One requirement was restated for a second time from review of the inspection QIP dated 24 July 2015.

2.0 Service details

Registered organisation/registered person: Northern HSC Trust/Dr Anthony Baxter Stevens	**Registered manager:** Registration pending
Person in charge of the service at the time of inspection: Louanne Bakker	**Date manager registered:** Registration pending

3.0 Methods/processes

Prior to inspection we analysed the following records:

- Previous inspection report and quality improvement plan
- Accident/incident notifications
- Correspondence.

During the inspection the inspector met with the manager, most residents and seven care staff.

The following records were examined during the inspection:

- RQIA registration certificate
- Statement of purpose

- Service user guide
- Selection of policies and procedures including those in respect of adult safeguarding, whistleblowing, staff recruitment, complaints and infection prevention and control
- Staff training
- Staff meetings
- Staff supervision and appraisal
- Service user meetings
- Monthly monitoring visits
- Staff duty roster
- Care records x 3
- Complaints
- Accidents/incident.
- Fire risk assessment
- Annual quality review report.

Fifteen satisfaction questionnaires were given to the manager for distribution to service users (5), staff (5) and relatives (5). Four were completed and returned to RQIA within the timescale; relative (1) staff (1) service user (2).

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 July 2015.

The most recent inspection of the day care centre was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 24 July 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 26(2)(b) **Stated:** First time	The registered persons must ensure the identified bathroom door (room 33) is replaced. Consideration should be given to fitting an appropriate protective sheeting along the bottom third of the door to help prevent future damage from service user's electric wheelchairs, manual wheelchairs or walking aids.	**Not Met**
	Action taken as confirmed during the inspection: The manager confirmed that since her recent appointment she had raised this requirement with the Northern Health and Social Care Trust (NHSCT) estates department who have undertaken an assessment. A decision has to be	

	agreed with regard to the current lay out of the bathroom and associated costing.	
Requirement 2 **Ref:** Regulation 29 **Stated:** First time	The registered manager must ensure accidents and untoward incidents are reported to RQIA as per regulation 29.	**Met**
	Action taken as confirmed during the inspection: The manager demonstrated awareness of notifications to be submitted to RQIA. Random selection of those received since the previous inspection were submitted as required.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 5.2 **Stated:** First time	With regards to continence promotion, the registered manager should ensure the care plans are reviewed of those service users who need staff support or assistance. Where relevant, the revised care plans should reflect: • How the service user is approached • The language used by staff • If a preferred bathroom is used • The name and size of continence product used and where this is stored • The name and type of equipment used and the type and size of sling • The number of staff needed to provide assistance • The level of staff support and assistance needed • If a change of clothes is available and where these are located.	**Met**
	Action taken as confirmed during the inspection: Two care plans discussed and reviewed were considered to be satisfactory in meeting the needs of service users.	
Recommendation 2 **Ref**: Standard 14.10 **Stated:** First time	With regards to the identified Trust's 2014 annual service user's quality assurance questionnaire; the registered manager should ensure: (a) Where possible; there is follow up action taken regarding service users who said they had made verbal complaints to staff regarding Wilson House Resource Centre	**Met**

	(b) If the follow up action concludes complaints had been made; these should be retrospectively recorded in the service's complaints record. A summary of the investigation, the outcome/s of same and if the complainant is satisfied with these should also be recorded in the centre's complaints record.	
	Action taken as confirmed during the inspection: This recommendation was discussed with the manager and complaints records reviewed. Evidenced gained confirmed that appropriate action included NHSCT review of care when additional attendance days are requested.	
Recommendation 3 **Ref**: Standard 17.10 **Stated:** First time	The designated person undertaking the monthly monitoring reports of Wilson House Resource Centre should record: (a) Whether the visit was announced or unannounced (b) The qualitative views and opinions of at least four service users interviewed (c) The time and duration of the visit (d) If actions are needed to ensure that the service is being managed in accordance with minimum standards. (e) The subsequent report should state the outcomes of the actions identified in the previous report.	**Met**
	Action taken as confirmed during the inspection: Reports for December, November and October 2016 were discussed with the manager. Review of records evidenced that amendment was made and issues identified were addressed.	
Recommendation 4 **Ref**: Standard 13.5 **Stated:** First time	With regards to the safeguarding of vulnerable adults; effective communication and joint working; the registered person must ensure the registered manager of Wilson House is informed in a timely manner on a needs to know basis of vulnerable adult issues concerning service users attending the centre.	**Met**
	Action taken as confirmed during the inspection: The manager confirmed that a meeting was held with the social work team regarding effective communication and joint working in respect of	

	safeguarding issues.	

4.3 Is care safe?

Discussion with the manager confirmed that staff employed were sufficiently qualified, competent and experienced to meet the assessed needs of service users in attendance. Staff who met with the inspector demonstrated good understanding of their roles and responsibilities in meeting the needs of service users and associated policies and procedures in the running of the centre.

Staff working in the centre each day alongside hours worked was recorded within the duty roster retained in the general office.

Staff employment records were held within the NHSCT human resource department. The manager confirmed that all appointments made were in keeping with the trust policy/procedures and that all necessary documentation checked and in place before a new employee would commence work. The recruitment aspect of procedures was confirmed by staff members who met with the inspector.

Induction records reviewed contained a comprehensive account of the standard to be achieved. Induction programmes were noted to be signed and dated by the staff member and mentor on the achievement of each activity. Electronic corporate policies and procedures on staff recruitment, selection and induction of were available.

Mandatory staff training was discussed with the manager and staff. Training provided included adult safeguarding and whistleblowing. Staff confirmed that mandatory training was ongoing alongside other professional development opportunities. A staff training day is planned to take place during February 2017.

The manager confirmed that no safeguarding allegations were currently active and should any arise the correct procedure would be followed in accordance with NHSCT policy and procedure. Staff training in the safeguarding was provided on a two yearly basis. The manager explained that staff refresher training in adult safeguarding and the new Department of Health (DOH) regional policy “Prevention, Protection in Partnership” (April 2015) was planned to take place within the near future. The named safeguarding “champion” is to be confirmed and the trust safeguarding policy reviewed and revised to reflect the DOH regional policy/procedure.

The manager and staff confirmed that no restrictive practice takes place in the centre. Electronic policies and procedures on restrictive practice were in place and available to all staff.

Necessary infection protection and control measures were in place with a good standard of hygiene observed throughout the centre. Measures included, for example; “seven step” hand hygiene notices positioned at all wash hand basins, availability of disposable gloves and aprons; provision of staff training in infection, prevention and control, and availability of electronic trust policies/procedures on infection prevention and control.

An inspection of the centre was undertaken. All areas were observed to be clean, tidy, organised and appropriately heated. COSHH substances were noted to be securely stored. All fire doors were closed and exits unobstructed. One recommendation relating to a damaged bathroom door was restated for a second time from the previous care inspection as this has not

been addressed. The centre's fire risk assessment, dated 18 March 2016, was reviewed. No recommendations for action were necessary as no changes had occurred since the previous assessment.

Seven care staff who met with the inspector gave positive feedback in regard to the provision of safe care and confirmed that staff training, supervision, appraisal and staff meetings were provided and ongoing. Staff also explained that there was very good multi-professional working in the planning and monitoring of care.

Service users who met with the inspector indicated that attending the centre was essential to them and how effective the activities, support provided and meeting up with others was in important in meeting their health needs. One service user explained that coming to the centre was a "life line" and that attendance was something he looked forward to each week.

Four of the 15 satisfaction questionnaires were completed and returned to RQIA within the time scale. All respondents indicated they were very satisfied that the care provided was safe.

Areas for improvement:

One recommendation made related to ensuring the revised NHSCT policy on safeguarding was available to staff and that refresher training was provided.
One requirement was restated for a second time as the damaged door had not been made good.

Number of requirements	1	**Number of recommendations**	1

4.4 Is care effective?

Three service users care records were provided by the manager for review. These were found to be in line with legislation and minimum care standards including, for example; holistic health and social care needs assessments which were complemented with risk assessments; person centred care plans and regular records of the health and wellbeing of the service user. Records of reviews held were in place which included participation of the service user and where appropriate their representative. There was recorded evidence of multi-professional collaboration in planned care.

The manager explained the systems in place to promote effective communication between service users, staff and other stakeholders. This was evidenced within a number of sources including: discussions with staff and service users, care records examined; minutes of service users' meetings, minutes of staff meetings, information notices displayed on health and social care and photographs of various activities and social events.

Competency and capability assessment of staff in charge of the centre when the manager is not in the centre was discussed and assessments reviewed. One recommendation was made in regard to ensuring that the staff member signs the assessment alongside the manager when competency is achieved.

Staff confirmed that the modes of communication in use between the staff team, service users/representatives and other stakeholders were effective and that communication was enhanced through the "open door" arrangements operated by the manager and senior staff.

Service users who met with the inspector confirmed they were aware of whom to contact if they had any issues or concerns about the service and that staff were approachable and always willing to help and provided assistance when required.

The manager explained that the annual quality service user satisfaction survey was undertaken and a report developed which reflected responses and action planned to meet identified areas for improvement. Review of the report showed that a wide range of indicators were used to seek the views of service users. Areas included, for example; core values, staffing, infection control, environment, food provided, complaints, care parking and travel/transport arrangements. Overall responses were noted to be positive ranging 80% - 97%. Areas on how the centre could improve the experience of service users were included.

The outcome of the survey is to be shared with service users and staff at their next meeting.

Four of the 15 satisfaction questionnaires were completed and returned to RQIA within the time scale. All respondents indicated they were satisfied that the care provided was effective.

Areas for improvement

One recommendation was made in regard to ensuring that the staff member's signature is recorded in the competency and capability assessment alongside the manager's signature when competency is achieved.

Number of requirements	0	**Number of recommendations**	1

4.5 Is care compassionate?

The manager, who is a qualified social worker, confirmed that there was a culture/ethos within the centre that supported the values of dignity and respect; independence; rights; equality and diversity; choice and consent of service users. This was reflected within the statement of purpose, service user guide, care records and minutes of service user meetings examined.

There was a range of policies and procedures available to staff which supported the delivery of compassionate care.

Observation of staff interactions with service users demonstrated that they were treated with dignity and respect. Staff confirmed their awareness of promoting service user rights, independence and dignity.

Discussions with staff, service users, review of care records and observation of staff practice and interactions confirmed that service users' needs were acknowledged and recorded.

There was evidence that service users were enabled and supported to engage and participate in a range of meaningful activities noted within care records, service user meetings and reviews of care.

Service users confirmed that they were consulted and felt very much involved about arrangements within their centre. Comments from staff and service users were very positive in regard to the service provided. No issues or concerns were raised or indicated in this regard.

Four of the 15 satisfaction questionnaires were completed and returned to RQIA within the time scale. All respondents indicated they were satisfied that the care provided was compassionate.

Areas for improvement

No areas for improvement were identified within the "Is care compassionate" domain.

Number of requirements	0	Number of recommendations	0

4.6 "Is the service well led"?

Louanne Bakker, the manager was appointed in October 2016 has settled very well into her new post and is currently reviewing all systems and processes for the management of the centre. The manager explained that she felt very well supported in her role by her line manager and at operational level by a mixed skill team of care staff, domestic, kitchen staff and clerical staff member. Support is also provided by the locality manager and area manager who both visit the centre on a regular basis. The manager receives good support and supervision on a monthly basis by the locality manager. One the day of inspection the area manager visited the centre, met with the inspector and provided an overview on the quality of care provided.

The manager explained that she had submitted her RQIA application to become registered manager of Wilson House to management for countersigning and that this would be forwarded to RQIA.

There was a defined organisational and management structure that identifies the lines of responsibility and accountability within the centre.

The centre's current RQIA registration certificate was displayed in a prominent position within the centre.

The manager confirmed that the centre operated in accordance with the regulatory framework and that the health and social care needs of service users were met in accordance with the centre's statement of purpose.

There was a range of electronic corporate policies and procedures to guide and inform staff. Several policies were also held in hard copy format. Staff demonstrated awareness of policies including the policy and procedure relating to whistle blowing and adult safeguarding and how to access same.

The manager explained that she had obtained the report on the outcome of the service user satisfaction survey for 2015/16 from the governance team. Reference to the report is made within section 4.4 of this report. Examples of other quality improvement methods included several audits relating to care records, environment, staffing and fire safety. Where necessary action plans are developed to address issues arising. In addition monthly audits of accidents/ incidents and complaints are undertaken by the manager to establish trends/patterns and identify learning outcomes which when necessary are disseminated throughout the wider organisation by the area manager.

Records of accidents/incidents were discussed with the manager who was aware of procedure in regard to notification to RQIA. The manager explained that any issues arising from the

investigation of accidents or incidents would be addressed, and where necessary risk assessments undertaken with measures to minimise the risk reflected within support plans. Where necessary any lessons to be learned would be identified and disseminated throughout the trust.

Records on complaints received were reviewed and discussed with the manager. One complaint was received since the previous inspection. This was noted to be appropriately recorded and managed with resolution achieved. Complaints received during the period 01 April 2015 and 31 March 2016 was discussed and records reviewed. These were recorded as being resolved with the complainants being satisfied with the outcome.

Leaflets entitled "Your views matter and "Tell us what you think" were displayed in a prominent position for ease of access to service users, representatives and others who visit the centre. Corporate policy/procedures on complaints management were available and known by staff who spoke with the inspector.

The manager and staff confirmed that annual appraisal was provided. Individual staff supervision and appraisal was provided with records retained.

Review of monthly staff meeting minutes included the names of staff in attendance and discussions held.

Staff confirmed that there was very good working relationships within the team and that the manager was responsive to suggestions/comments raised during staff meetings.

Monthly monitoring report visits made on behalf of the registered provider were available. These were observed to be in keeping with Regulation 28 of The Day Care Setting Regulations (Northern Ireland) 2007. Reports were available for service users, their representatives, staff, trust representatives and RQIA.

Four of the 15 satisfaction questionnaires were completed and returned to RQIA within the time scale. All respondents indicated they were satisfied that the care provided was well led.

Areas for improvement

No areas for improvement were identified within the "Is the service well led?" domain.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Louanne Bakker, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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 day care setting. 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Day Care Setting Regulations (Northern Ireland) 2007.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Day Care Settings Minimum Standards 2012. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 26 (2) (b) **Stated:** Second time **To be completed by:** 30 April 2017	The registered persons must ensure the identified bathroom door (room 33) is replaced. Consideration should be given to fitting an appropriate protective sheeting along the bottom third of the door to help prevent future damage from service user's electric wheelchairs, manual wheelchairs or walking aids.
	Response by registered provider detailing the actions taken: This work is now completed as of the 2/3/2017
Recommendations	
Recommendation 1 **Ref**: Standard 23.3 **Stated:** First time **To be completed by:** 31 January 2017	The registered provider should that the signature of the staff member is recorded within the competency and capability assessment alongside the manager when competency is achieved.
	Response by registered provider detailing the actions taken: This requirement will be implemented when completing identified documentation.
Recommendation 2 **Ref**: Standard 18.1 **Stated:** First time **To be completed by:** 30 February 2017.	The registered provider should ensure that the reviewed and revised adult safeguarding policy is available to staff within the centre.
	Response by registered provider detailing the actions taken: Copy of the Safeguarding Guidance is available both in paper copy & the Trust's Intranet facility.

Please ensure this document is completed in full and returned to day.care@rqia.org.uk from the authorised email address

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