Unannounced Care Inspection Report
10 & 12 August 2016

Mica Drive Day Services
(Incorporating Fallswater Day Centre)

Type of service: Day Care Services
Address: 1a Mica Street, Belfast, BT12 7BQ
Tel No: 02895 042800
Inspector: Priscilla Clayton

1.0 Summary

An unannounced inspection of Mica Drive Day Services incorporating Fallswater centre took place over two days on 10th and 12 August 2016.

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

Is care safe?

There was good supporting evidence that the centre was providing was safe care which included appropriate staffing, staff induction, staff training, supervision and appraisal, infection and prevention, competency and capability assessments, risk management systems and processes and positive feedback from staff and service users.

No requirements or recommendations were made in this domain.

Is care effective?

There was supporting evidence that the care provided was effective with positive feedback from service users and staff. Needs assessments were complemented with risk assessments and care plans reflected measures to minimise identified risks.

No areas identified for improvement in this domain.

Is care compassionate?

There were several examples of good practice in relation to the culture and ethos of the day care centre, listening to and valuing service users and taking account of the views of service users and their relatives.

No requirements or recommendations were made in this domain.

Is the service well led?

There were examples of a well led service found throughout the inspection with systems and process in place for the effective day to day management of the centre. Staff gave positive feedback in respect of leadership and good team work with good support and encouragement provided by the manager though effective communication, supervision, staff meetings and the open door approach provided by the manager.

No requirements or recommendations were made in this 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	0	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Maria O'Hagan, registered 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

There were no further actions required to be taken following the most recent care inspection undertaken on 4 April 2015.

2.0 Service details

Registered organization / registered person: Belfast HSC Trust	**Registered manager:** Maria O'Hagan
Person in charge of the home at the time of inspection: Maria O'Hagan	**Date manager registered:** 22 June 2012
Categories of care: DCS-LD, DCS-LD(E)	**Number of registered places:** 81

3.0 Methods/processes

Prior to inspection the following records were inspected:

- RQIA Certificate of registration
- Staff duty rota
- Induction programme for new staff
- Staff supervision and annual appraisal schedules
- Sample of competency and capability assessments
- Staff training records
- Four service user's care files
- Statement of purpose and service users guide
- Minutes of recent staff meetings
- Complaint records
- Audits
- Equipment maintenance
- Accident/incident/notifiable events records(7)

- Annual summary Review report
- Minutes of recent service user'/representatives' meetings
- Monthly monitoring reports
- Fire safety risk assessment
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc
- Policies and procedures.

During the inspection the inspector met with five staff including the manager and 9 service users individually and with others in small group format.

A total of 30 satisfaction questionnaires were provided for distribution to service users, relatives/representatives and staff for completion and return to RQIA. No questionnaires were returned to RQIA within the timescale.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 27 April 2016

The most recent inspection of the establishment was an announced estates inspection conducted on 27 April 2016. No requirements or recommendations were made at this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 04 February 2015

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

The manager confirmed that staffing levels were satisfactory and explained that two staff were on long term leave one of whom would be returning to work soon. Cover for staff on leave is provided by experienced consistent agency staff. The manager confirmed that staffing levels are subject to regular review to ensure the assessed needs of the service users were met.

The manager confirmed that all newly appointed staff undertakes a period of induction. Induction programmes for each staff member were completed, dated and signed by both parties.

Discussion with the manager also confirmed that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Day Care Setting Care Homes Regulations (Northern Ireland) 2007 and that all new staff recruitment records were held off site at the Trust's Human Resources department. The registered manager has responsibility to check directly with the Human Resource department that all necessary checks have been completed prior to the staff member commencing service. Review of the NHSC Trust recruitment and selection policy and procedure confirmed compliance with current legislation and best practice.

Discussion with staff and a review of confirmed that mandatory training, supervision (three monthly) and annual appraisal was provided. A schedule for mandatory training, annual staff appraisals and staff supervision was maintained and was available for inspection.

The manager and staff 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. A review of a sample of staff competency and capability assessments were found to satisfactory.

Discussion with staff confirmed that they were aware of the new regional policy entitled, Adult Safeguarding Prevention and Protection in Partnership (July 2015) and the NHSC Trust had the Trust had adopted this policy. A copy of the policy was available in the centre. Staff demonstrated knowledge and understanding of adult safeguarding principles and were also aware of their obligations in relation to raising concerns about poor practice and whistleblowing.

A review of staff training records confirmed that staff receives mandatory training relevant to their roles and responsibilities. Additional recorded training included; dysphasia, dementia awareness and epilepsy management. Adult safeguarding training was provided for all staff. The manager confirmed that the Trust has planned to identify “champions” for adult safeguarding.

The manager confirmed that risk management procedures were in place relating to the safety of individual service users. Risk assessments were observed within care records examined, for example, moving and handling, swallowing and falls risk assessments. Measures in place to minimise identified risks were reflected within care plans. Care needs assessments and risk assessments reviewed were updated on a regular basis or as changes occurred.

Discussion with the manager identified that the centre did not accommodate any service users whose assessed needs could not be met.

A review of policy and procedure on restrictive practice/behaviours which challenge confirmed that this was in keeping with DHSSPS Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) and the Human Rights Act (1998). It also reflected current best practice guidance including Deprivation of Liberties Safeguards (DoLS).

The manager confirmed that there are no measures of restraint currently in use within the centres. Appropriate documented assessment and review involving specialist multi-professional Trust personnel would be sought and records retained if restriction was to be used for the safety of the service user. Staff training in managing challenging behaviour was provided and recorded.

Inspection of four care records confirmed there was a system of timely referral to the multi-disciplinary team when required. Trust specialist behaviour management teams were available if referral was necessary.

Review of the policy and procedures relating to safe and healthy working practices confirmed that these were reviewed. Policies included, for example; COSHH, fire safety and manual handling.

Notifications of accidents / incidents were submitted to RQIA as required. Notifications received were discussed with the manager. Appropriate action was taken to minimise risks identified.

The manager confirmed that equipment and medical devices in use were well maintained and regularly serviced. Observation of manual mechanical hoists and recorded maintenance/service dates evidenced these as fit for purpose.

Review of the infection prevention and control (IPC) policy and procedure confirmed that the policy was in line with regional guidelines. Staff training records confirmed that all staff had received training in IPC; which was in line with their roles and responsibilities. Inspection of the centre confirmed availability of clean 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.

Hand hygiene was a priority in both centres and efforts were applied to promoting good standards of hand hygiene among service users, staff and visitors. Notices displaying the seven steps of good hand hygiene were displayed throughout the centre in both written and pictorial formats.

Inspection of the internal and external environments identified that both centres and grounds were kept tidy, safe, suitable for and accessible to service users, staff and visitors. There were no visible hazards observed which may impact on health and safety. A new self-opening front door has been installed in Mica which automatically opens during service hours and this enables independent direct access for all service users especially those who have physical disabilities.

The centres' fire risk assessments were dated15 January 2016. Recommendations for action had been addressed by the manager. Fire doors were closed and exits unobstructed. Records of weekly and monthly fire equipment were completed as required to ensure all equipment was in good working order. Training records showed that all staff had received fire safety training during March 2016 with fire drill held during July 2016. Personal emergency evacuation plans (PEEPS) have been developed for service users who require additional support needs during an evacuation. These records were held within the fire safety file with a copy in individual service user's file.

Five care staff spoken with during the inspection gave positive feedback in regard to care provided. Comments included;

"The centre provides safe care which is regularly audited".
"Our staffing levels are satisfactory as we do have cover when staff are off".
"Staff meetings are held and we are kept up to date on all matters".
"We receive good support and encouragement from the manager who operates an "open door" approach".
"Any safeguarding issues would be immediately reported".

No issues or concerns were raised or indicated.

Service users who spoke with the inspector indicated they were very satisfied with the care provided. Comments included;

"Staff is excellent, they see that we have plenty of things to do and always ask if we are enjoying the activities arranged".
"We don't have to do anything we do not want to do".
"I like attending as I don't see too many people at home".

No issues or concerns were expressed or indicated.

Areas for improvement

No areas were identified for improvement from this domain.

4.4 Is care effective?

Discussion with the manager established that staff in both centres responded appropriately to and met the assessed needs of the service users.

A review of four care records confirmed that these were being maintained in line with legislation and standards. Care records examined contained an up to date assessment of needs, life history, risk assessments, associated care plans and daily/regular statements of health and well-being of the service user. Care records also reflected the multi-professional input into the service users' health and social care needs and were found to be updated regularly to reflect the changing needs of the service user.

There was recorded evidence that service users and/or their representatives were encouraged and enabled to be involved in the needs assessments, care planning and review process. Discussion with staff confirmed that a person centred approach underpinned practice. For example; care records showed that service users were consulted with choice, views and preference reflected within their person centred care plans. Regular notes were recorded within five days of attendance or more frequently if required. Care records were stored safely and securely in line with data protection.

Review of care records confirmed that initial review of care was held following commencement of each service user's placement to ensure their needs were being met and that the placement was appropriate. Annual reviews are also undertaken with service users/representatives in attendance.

Service user agreements on the terms and conditions of the service had been issued to each service user/representative and signed by both parties with copies retained.

The manager confirmed the arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to service users at appropriate intervals. Audits undertaken included a range of areas as reflected within the Belfast Risk Audit and Assessment Tool (BRATT). This tool is one of the methods by which the current level of compliance to manage health and safety and other risks associated with the delivery of services. Areas audited included; care plans; accidents/incidents; infection prevention and control; COSHH risk assessment; medications, environmental cleanliness, finance and monthly monitoring visit which covers areas including service user/representative and staff views on the service provided. A service user satisfaction survey was also conducted during 2015/16.
Areas identified for improvement from audits conducted included for example; additional electronic access to records, new activities for service users, college based activities for service users, external sports activities and transport issues. The registered manager reported that action to address these areas was work in progress.

The manager explained the systems in place to ensure effective communication with service users, their representatives and other key stakeholders. These included for example; pre-admission information gathering, multi-professional collaboration and team reviews, service user meetings, staff meetings and staff group briefing each morning prior to service users' arrival. Service users and staff confirmed that an "open door" approach to the manager was in place so that anyone can speak directly with her or to the person in charge.

Service users meetings were held on a monthly basis with minutes recorded. Minutes reflected a wide range of topics including discussion on the provision of preferred activities, menu choice and transport issues. The manager reported that action taken to address matters raised was addressed.

Service users who spoke with the inspector provided the following comments:

"There is always staff available to see to us, they are friendly and very kind".
"We have meetings and can raise any issues or talk about the things we like to do".
"I noticed that staff always wash their hands and there is notices to remind us".
"If I wanted to complain about anything I would speak to the manager, but we never have to".

Areas for improvement

There were no areas identified for improvement from this domain.

4.5 Is care compassionate?

The manager 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.

There were a range of policies and procedures in place which supported the delivery of compassionate care. Discussion with staff, service users and one representative confirmed that service users' needs were being met.

The manager, staff and service users, who were able to communicate, confirmed that consent was sought in relation to care and treatment. Discussion with service users and staff along with observation of practice and interactions demonstrated that service users were treated with dignity and respect. Staff confirmed their awareness of promoting residents' rights, independence and dignity. Staff were also able to demonstrate how service' confidentiality was protected. For example any discussions held with service users regarding personal matters would be undertaken in private; care records are only shared with consent and those who need to know.

The manager and staff confirmed that service users were always listened to, valued and communicated with in an appropriate manner. Discussion with staff, service users, one representative and observation of practice confirmed that service users' needs were recognised and responded to in a prompt and courteous manner by staff.

Service users were provided with information, in a format that they could understand. For example, pictorial timetables, service user guide, displayed information leaflets/signage and annual reports which enabled them to make informed decisions regarding their life, care and treatment.

Areas for improvement

No areas for improvement were identified during the inspection.

4.6 Is the service well led?

There was a clear organisational structure and staff demonstrated awareness of their roles, responsibility and accountability. This information was outlined in the centre's Statement of purpose and service user guide. Discussion with the manager identified that she had good understanding of her role and responsibilities under the legislation. The manager confirmed that the registered provider was kept informed regarding the day to day running of the centre through line management and frequent contact with her line manager.

The centre's certificate of registration with RQIA was displayed in a prominent position.

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.

A range of policies and procedures were 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 examined were systematically reviewed every three years or more frequently as changes occurred.

The centre had a complaints policy and procedure which was in accordance with the legislation and DHSPPS guidance on complaints handling. Service users and their representatives were made aware of how to make a complaint by way of the Service User Guide and NHSC Trust leaflets. Discussion with staff confirmed that they were knowledgeable about how to receive and deal with complaints.

Review of the complaints records confirmed that arrangements were in place to effectively manage complaints from service users, their representatives or any other interested party.

Arrangements were in place to share information about complaints and compliments with staff during supervision of staff meetings. Many complimentary letters and cards had been received from relatives/representatives.

A review of a selection of accidents/incidents/notifiable events confirmed that these were recorded and when required notification submitted to RQIA. Audits of accidents and incidents were undertaken with outcome and actions recorded. These included for example; reassessment of speech and language services.

The centre had an annual quality review report (April 2015 to March 2016). This comprehensive report included many areas of improvement including further development of person centred care plans with service users, review report accuracy check with service users, development of service user training, survey conducted with service user group on improving communication, greater interagency working, new automatic self- opening internal doors and self- opening front door at Mica which enables independent direct access to service users. Reference is also made in respect of the BRATT assessment and audit tool (referred to in section 4.4) which was set up to review and revise all risk assessments.

Areas for improvement

There were no areas identified for improvement in this domain.

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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