Unannounced Care Inspection Report
20 June 2016

Benbradagh Resource Centre incorporating The Willow Group

Type of Service: Day Care Setting
Address: Scroggy Road, Limavady BT49 0NA
Tel No: 02877761103
Inspector: Louise McCabe

1.0 Summary

An unannounced inspection of Benbradagh Resource Centre incorporating The Willow Group took place on 20 June 2016 from 11.15 to 16.30 hours.

The focus of the unannounced inspection was to respond to a number of concerns raised by a whistleblower. The term whistleblowing is used to describe a situation where a worker makes a protected disclosure about a wrongdoing or failure in their workplace. This can be reported as a protected disclosure to a prescribed body and their employment rights will be protected. RQIA and the Northern Ireland Social Care Council (NISCC) are the prescribed bodies for health and social care in Northern Ireland.

On 15 June 2016 RQIA received written information from a whistleblower regarding concerns about:

- Insufficient staffing levels in an identified group room on a specified date and time.
- The Trust's Datix records may not be accurate as care staff have been advised by management to downplay the seriousness of "aggressive behavioural incidents" occurring between identified service users.
- There are "aggressive behavioural incidents" occurring with service users that are not being recorded on the Trust's datix system. The whistleblower made particular reference to identified entries on the Datix dated 7 June 2016 and 10 June 2016.
- Notifiable incidents are not being reported to RQIA.

On 16 June 2016 RQIA contacted the whistleblower and advised them RQIA would review the concerns identified in the correspondence and take appropriate action.

Following consideration it was agreed that an unannounced inspection to the centre should be undertaken. Each concern identified by the whistleblower was reviewed during this inspection and following the inspection additional supporting evidence was also requested from the Trust.

During the inspection we spoke to the registered manager and four members of staff and reviewed a range of records relevant to the focus of this inspection.

The findings from the inspection established that one concern raised by the whistleblower was substantiated, one concern was partially substantiated and two concerns were found to be unsubstantiated.

Two requirements and two recommendations are made as a result of this inspection; these are detailed in the quality improvement plan (QIP).

On 19 July 2016 a meeting was held in RQIA's offices with the registered manager of Benbradagh Resource Centre and the Trust's Community Service Manager. The purpose of this meeting was to discuss the findings of the inspection, discuss the Trust's investigation and the learning from the outcomes of their investigation and the unannounced inspection.

RQIA were assured that appropriate action had been taken and that learning from the concerns identified by the whistleblower had been cascaded to the staff team.

This inspection was underpinned by The Day Care Setting Regulations (Northern Ireland) 2007, the DHSSPS Day Care Settings Minimum Standards (January 2012) and The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

1.1 Inspection outcome

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

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

1.2 Actions/enforcement taken following the most recent care inspection

The most recent inspection of Benbradagh Resource Centre was an unannounced care inspection which took place on 18 August 2015. No enforcement or any other action has been taken following this inspection.

2.0 Service details

Registered organisation/registered provider: Western HSC Trust/Mrs Elaine Way CBE	**Registered manager:** Carla Anne Devine
Person in charge of the day service at the time of inspection: Carla Devine	**Date manager registered:** 30 July 2015
Categories of care: DCS-LD(E), DCS-LD	**Number of registered places:** 79

3.0 Methods/processes

Prior to inspection following records were analysed:

- Nine notification of untoward incidents and accidents received by RQIA from 18 August 2015

Specific methods/processes used in this inspection included the following:

- Discussion with the registered manager

- Discussion with four care staff (senior day care worker, two day care workers and one care assistant)
- Observation of care practices in the Cedarwood group room
- Twenty-three RQIA staff questionnaires and 10 service users' questionnaires were forwarded to the manager to issue.
- Evaluation and feedback

The following records were examined during the inspection:

- Two service users' care files
- Twenty-nine accidents and untoward incidents recorded on Datix from 25 January – 10 June 2016
- Benbradagh Resource Centre staffing structure
- Staff rotas for the week commencing 13 June 2016
- Records stating how staff are deployed throughout the centre

The following records were reviewed after the inspection:

- Twenty returned staff questionnaires and seven service user questionnaires
- Western HSC Trust's Incident Reporting Policy and Procedures 2014
- Western HSC Trust's Incident Report Guidance Table 2016
- Benbradagh Resource Centre's Incident Reporting and Recording Staff Guidance
- Western HSC Trust's Risk Matrix (with effect from 1 October 2013)
- Western HSC Trust's Impact Table (with effect from 1 October 2013)

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 18 August 2015

The most recent inspection of the day care setting was an unannounced care inspection. The completed QIP was returned and processed by the care inspector. This QIP was not reviewed on this occasion and will be reviewed by the care inspector during the centre's next inspection.

4.2 Inspection findings

An unannounced inspection of Benbradagh Resource Centre took place on 20 June 2016 from 11.15 to 16.30 hours. The focus of this inspection was to respond to a number of concerns raised by a whistleblower in written correspondence that was received by RQIA on 15 June 2016. Each concern is detailed below and the outcome of the inspection findings reported on in this section.

1. On the afternoon of 13 June 2016 between 13.00 and 14.40 hours, an identified group room with nine service users was short-staffed.

On the day of inspection staff stated if they were concerned about staffing levels they would initially raise this with their day care worker or senior day care worker who would discuss it with

the registered manager. During individual discussions with three care staff who were working in two different service user group rooms, they expressed that staffing levels were adequate in meeting the assessed needs of service users. Examples were given of the numbers of staff in each of these group rooms and which service users had been assessed as needing 1:1 staff. The information provided concurred with specific staffing rotas completed by the registered manager for the identified days discussed.

The duty rota for the week commencing 13 June 2016 showed there was one day care worker and either two or three care assistants in the identified group which was referenced in the whistleblower correspondence. On 13 June 2016 the daily rota planner showed a day care worker and three care assistants (one of whom was an agency care assistant) were on duty in this group room. The rota showed the day care worker would be attending a meeting at 13.00 hours and this was confirmed in discussions with the registered manager and staff.

It was confirmed by staff and the registered manager and evidenced in records, that on 13 June 2016 there were two care staff supervising approximately nine service users between 13.00 – 14.40 as detailed in the whistle-blower's correspondence. One of the staff members had recently commenced employment in the centre and the other was an agency care assistant (first day of employment in Benbradagh Resource Centre). A senior day care worker was 'floating' between this group room and another group room at this time.

The review of documentation and discussions with the registered manager and staff supported the concern identified by the whistleblower, that experienced care staff were not appropriately deployed on this occasion in the identified group room on the afternoon of 13 June 2016 between 13.00 – 14.40 hours. Therefore, this concern is substantiated and is an area identified for improvement.

2. The Trust's Datix records may not be accurate as care staff have been advised by management to downplay the seriousness of "aggressive behavioural incidents" occurring between identified service users.

The whistleblower reported that care staff are being advised by management to downplay the seriousness of aggressive behavioural incidents occurring between identified service users and not to use certain words when recording behavioural incidents on the Trust's datix system.

The inspector met with the registered manager; had individual discussions with a senior day care worker, two day care workers and a care assistant; and reviewed a sample of untoward incidents in an identified service user's care file. Discussions with staff focused on the following topics:

- The information staff record on the Trust's Datix forms
- Examples of service user behaviours that can challenge
- Communication and information sharing in the centre
- Safeguarding vulnerable adults and the Trust's reporting procedures

The staff consulted informed RQIA they have received clear guidance and information from their manager about what is to be recorded on the Trust's Datix forms. Staff said this has been discussed during staff meetings and reviewed in individual supervision sessions. In addition the trust has a range of policies and guidance regarding the reporting of incidents.

Examples of service user behaviours that may challenge were relayed to RQIA, and staff confirmed they have been advised by their manager and senior day care worker that incidents

are to be recorded factually and objectively in the respective service user's care file and a Datix form is to be completed. Guidance has been provided to staff to avoid using subjective language when completing incident and accident reports.

Staff informed RQIA there are regular staff meetings in the centre; these occur on a monthly basis and there are daily morning meetings between the manager, senior day care worker and day care workers. The day care workers cascade information on a needs to know basis to care assistants based in the various group rooms in the centre.

All four staff were complimentary about the registered manager and described her as "supportive", "she listens" and operates an "open door" policy. One staff member stated "the manager goes out of her way to help and guide staff." They all stated they would have no hesitation in approaching the manager if they needed to.

With regards to the safeguarding of vulnerable adults, all four staff said they have received training in this area and they were aware of the reporting procedures should concerns arise. No concerns were raised by staff during individual discussions.

There was no evidence to support the concern raised by the whistleblower therefore this concern was found to be unsubstantiated.

3. There are "aggressive behavioural incidents" occurring with service users that are not being recorded on the Trust's datix system. The whistleblower made particular reference to an identified entry on the Datix dated 7 June 2016 and 10 June 2016.

A review of the Datix records provided evidence that the incident of 7 June 2016 specified by the whistleblower was recorded. However, it was noted there was no Datix record made regarding an incident of 10 June 2016. This was discussed with the registered manager who explained details of this incident had been discussed with identified staff members in order to obtain their individual accounts for factual accuracy. The information provided by the whistleblower is partially substantiated as the incident of 10 June 2016 was not recorded on the Datix system. Management must ensure all incidents are recorded in a timely manner. It was further noted that the Datix records referred to the service user either by an initial or as service user 'A' or 'B.' In terms of consistency and to identify individual service users, unique identifier codes should be used and all staff made aware of these. This was discussed with the registered manager as an area for improvement.

An identified service user's care file was reviewed during this inspection. The service user's risk assessment and other supporting assessments were in place; these were current and had been reviewed within the last year. The assessments stated the service user required "close supervision" and discussions with the day care worker and registered manager concluded he/she was not assessed to need 1:1 staff. Behaviour Support Plan and Guidelines originally dated November 2012 were in place.

One assessment identified the possible triggers and examples of the various behaviours displayed by the service user. There was clear guidance and examples recorded for staff on how to avoid or manage potential situations; these included adhering to the service user's routines and the use of diversion techniques if the individual was to display inappropriate behaviours.

The service user's care plan had been reviewed in May 2016 and the information was qualitative, user friendly; comprehensive and complied with Minimum Standard 5.

A random sample of his/her care notes in May and June 2016 were examined; these were qualitative and with the exception of one entry dated 25 May 2016 meet Minimum Standard 7. The care note dated 25 May 2016 described an incident which occurred between the identified service user and another service user. The date of this incident does not concur with the incident recorded on the Trust's Datix form as this was dated 24 May 2016. This was discussed with the day care worker who explained the incident had occurred on 24 May 2016. Assurances were given to RQIA that the date of this incident would be correctly recorded respectively. Management must ensure that details in care records are recorded accurately.

An annual review of the service user's day care placement occurred in May 2016 and the record stated there was a "significant reduction in incidents in day care." The annual review records were compliant with Minimum Standard 15.5. With regards to transport used by the service user to and from the centre, it was recommended the care plan should be updated to contain all relevant information regarding the service user's transport arrangements.

There was evidence to support the concern raised by the whistleblower that "aggressive behavioural incidents" are not always being recorded on the Trust's datix system; as stated previously the incident dated 10 June 2016 was not recorded therefore, this concern was found to be partially substantiated.

A requirement is made regarding the need to ensure incidents are recorded on the Datix system in a timely manner and that entries in care records are accurate. A recommendation is also made regarding updating an identified service user's care plan to include their transport arrangements.

4. Notifiable incidents are not being reported to RQIA.

Since the day centre's previous unannounced care inspection of 18 August 2015; RQIA has been notified of six untoward incidents and accidents occurring in Benbradagh Resource Centre. As per the Western HSC Trust's Incident Reporting Policy and Procedures (dated August 2014), accidents and incidents are recorded on an on-line Datix Incident Form. On the day of inspection we reviewed a summary of 29 incidents recorded on the Trust's Datix system. This review provided evidence that the registered manager and staff in Benbradagh Resource Centre are notifying RQIA of accidents and untoward incidents as per Regulation 29 of The Day Care Setting Regulations (Northern Ireland) 2007. No areas for improvement were noted and this concern was found to be unsubstantiated.

In conclusion, one of the concerns identified in the correspondence from the whistleblower was found to be substantiated, one was found to partially substantiated and two were found to be unsubstantiated.

RQIA Questionnaires

On 23 June 2016, 33 RQIA questionnaires were forwarded to Benbradagh Centre for distribution to 23 staff members and 10 service users. A total of 27 completed questionnaires were returned to RQIA (seven from service users and 20 from staff).

It was good to note that the responses in the seven returned service users questionaires were all positive and no concerns were raised. In the 20 returned staff questionnaires the responses were also noted to be positive with no concerns being raised.

Two requirements and two recommendations are made as a result of this inspection.

Additional information

On 19 July 2016 a meeting took place at RQIA offices with the registered manager of Benbradagh Resource Centre and the Western HSC Trust's community services manager. The purpose of this meeting was to discuss the findings of the inspection, discuss the Trust's investigation and the learning from the outcomes of their investigation and the unannounced inspection.

The registered manager and community services manager updated RQIA on the action taken by the Trust in response to the concerns and allegations raised.

The registered manager reported that following the unannounced care inspection of 20 June 2016, a meeting was arranged on 29 June 2016 with staff to discuss incident reporting documentation. This included the Trust's incident reporting procedures; notifications to RQIA; Adult Safeguarding reporting and the list of service users' unique identifier codes. Copies of the Trust's Incident Reporting Guidance table; the Trust's incident procedures and other relevant documentation was distributed to care staff during this meeting. Care staff attending the meeting were asked to share this information with care staff in their respective teams. Copies of the Trust's Incident Reporting Flowchart, Risk Matrix and Impact Table were also provided to each staff member for their group room.

RQIA were assured that appropriate action had been taken and that learning from the concerns identified by the whistleblower had been cascaded to the staff team.

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Carla Devine, registered 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 centre. 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 taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to day.care@rqia.org.uk 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 19 (3) **Stated:** First time **To be completed by:** No later than 30 June 2016	The registered provider must ensure: (a) Datix records are kept up to date and entries are completed in a timely manner. (b) With regards to the behavioural incident which occurred on 24 May 2016; the respective entry in the service user's care records should be reviewed and amended so it accurately reflects the correct date of this incident.
	Response by registered provider detailing the actions taken: 1a.Staff are aware of and debriefed as necessary on Datix reporting procedures. The majority of Datix's are completed within 5 days as per policy. A meeting was held on 29th June 2016 with staff to focus and refresh awareness of Trust Incident Reporting Procedures, RQIA reporting & Adult Safeguarding reporting. Documentation was distributed to staff. Information shared: * Incident Reporting Policy (2014) * Incident Reporting Guidelines (June 2016) * Incident Reporting Guidance Table (June 2016) *Impact Table (Appendix E) * Root Cause Analysis - "A Brief Guide" All staff received DATIX training on 6th July 2016.

	Adult Safeguarding Operational Procedures (August 2016) & Protocol for Joint Investigation of Adult Safeguarding (August 2016) distributed to staff 4th October 2016 and was discussed at meeting 12th October 2016. Day Care Workers attending the meetings were asked to share all this information with care staff in their respective teams. 1b. The entry in service users care records was amended on the day of the inspection 20th June 2016 when highlighted to Day Care Worker. (Evidence on file). During a meeting held on 29th June 2016 staff were reminded to ensure all documentation is accurate and correct dates are on all records.
Requirement 2 **Ref**: Regulation 20 (1) (a) **Stated:** First time **To be completed by:** No later than 30 June 2016	The registered provider must ensure experienced, competent and skilled care staff are appropriately deployed in group rooms at all times to meet the assessed needs of vulnerable service users.
	Response by registered provider detailing the actions taken: Rota planning is completed on a weekly basis. This is reviewed and set on a daily basis to meet the needs of the service. Records of weekly and daily rotas are on site. Manager & Senior Day Care Worker ensure experienced, skilled and competent staff are appropriately deployed in each group on a daily basis. Staff are rotated around the groups to gain knowledge and experience of working within different groups and with service users. This enables staff to be competent to work within any group to maintain high standards of Care and maintain Health & Safety. New staff employed are given a WHSCT induction and a further induction in the centre on their arrival. As part of the induction process staff are given time to make themselves aware of all policies & procedures. Updated policies are shared with all staff, regularly. Manager/Senior Day Care Worker/Day Care Worker meetings are held, follow up meetings are held in all areas to keep all staff up to date with any changes. Staff get an opportunity to express during supervision/appraisal their own mandatory, personal and professional requirements they wish to achieve to enhance their own development.
Recommendations	
Recommendation 1 **Ref**: Standard 5.2 **Stated:** First time **To be completed by:**	The registered provider should ensure the transport section of the identified service user's care plan is amended so that it fully and adequately reflects the service user's transport arrangements.
	Response by registered provider detailing the actions taken: The usual method of transport is Trust buses; Occasionally a private taxi company is used to transport a service user from his/her home. Identified service user Care Plan was updated accordingly 20th June 2016, so it adequately reflects the service users transports needs.(Evidence on file). During a meeting held 29th June 2016 staff were reminded to ensure all information from recent reviews or other updates are added and included in service users Care Plans.

Recommendation 2 **Ref**: Standard 17.14 **Stated:** First time **To be completed from:**	The registered provider should ensure staff use unique identifier codes for service user's names when completing the Trust's Datix records.
	Response by registered provider detailing the actions taken: Codes have been distributed to all staff for all incident reporting, this includes DATIX & RQIA. All staff have been advised to use these codes for all Incidnet reporting.

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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