Inspection Report

3 May 2023

Barnlee

Type of service: Residential Care Home
Address: 37 Lisnaskea Road, Barnhill, Lisnaskea, BT92 0HD
Telephone number: 028 6772 3233

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: FACT **Registered Person:** Ms Una Lindsay	**Registered Manager:** Ms Geraldine O'Neill **Date registered:** 01 April 2005
Person in charge at the time of inspection: Ms Melissa Mallaby, Senior Care Assistant	**Number of registered places:** 23
Categories of care: Residential Care (RC): LD – Learning disability LD(E) – Learning disability – over 65 years PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 19
Brief description of the accommodation/how the service operates: This home is a registered Residential Care Home which provides health and social care for up to 23 residents. The home is divided in two units. One unit known as Barnlee has 18 beds and the other unit known as Lee Cottage has five beds. Both units are within the same grounds and are managed and staffed by the same Manager and staff.	

2.0 Inspection summary

An unannounced inspection took place on 3 May 2023, from 9.40am to 2.25pm by a care inspector.

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

There was safe, effective and compassionate care delivered in the home and the home was well led by the management team.

It was evident that staff promoted the dignity and well-being of residents and that staff were knowledgeable and well trained to deliver safe and effective care.

Residents said that living in the home was a good experience. Residents who were unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

No areas requiring improvement were identified during this inspection.

RQIA were assured that the delivery of care and service provided in Barnlee was safe, effective, compassionate and that the home was well led.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with residents, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Ms Melissa Mallaby, Senior Care Assistant at the conclusion of the inspection.

4.0 What people told us about the service

In accordance with their capabilities, residents said that they were happy with their life in the home, their relationship with staff, and the provision of meals. Two comments made by residents included the following statements; "I am alright. I am very happy here. I like all the staff." and "Everything is very good."

Staff spoke in positive terms about the provision of care, their roles and duties, teamwork, training and managerial support.

Feedback from one returned questionnaire was all positive.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Barnlee was undertaken on 4 April by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. Review of a sample of two recently appointed staff members' recruitment records, confirmed evidence that a robust system was in place to ensure staff were recruited correctly to protect residents.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the Manager was not on duty. Any member of staff who has responsibility of being in charge of the home in the absence of the manager has a competency and capability assessment in place. Competency and capability assessments are reviewed with the staff member on an annual basis. This is good practice.

A check is carried out on a monthly basis to ensure all staff are up-to-date with their registration with the Northern Ireland Social Care Council (NISCC). These checks were maintained appropriately. The Manager is registered with the Nursing and Midwifery Council (NMC).

Staff said that the staff morale was good and there was good team work and that they felt well supported in their role, were satisfied with communication between staff and management.

There was seen to be enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day.

A matrix of mandatory training provided to staff was in place. This gave good managerial oversight into staff training needs. There were systems in place to ensure staff were trained and supported to do their job. Staff confirmed that a range of mandatory and additional training was completed by staff on a regular basis.

5.2.2 Care Delivery and Record Keeping

Staff interactions with residents were observed to be polite, friendly, warm and supportive. It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly. Expressions of consent were evident with statements such as "Are you okay with…" or "Would you like to …" when dealing with care delivery. One resident made the following statement; "All the staff are brilliant here."

Care records were held confidentially.

Care records were maintained which accurately reflected the needs of the residents. Staff were knowledgeable of individual residents' needs, their daily routine wishes and preferences.

Residents' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs; and included any advice or recommendations made by other healthcare professionals.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. There was choice of meals offered. There was a variety of drinks available.

There was evidence that residents' weights were checked at least monthly to monitor weight loss or gain. Records were kept of what residents had to eat and drink daily. Residents who had specialist diets as prescribed by the Speech and Language Therapist (SALT) had care plans in place which were in accordance with their SALT assessment. Confirmation was received following this inspection of dates of training scheduled for those staff yet to receive training in dysphagia. Discussions with the senior in charge confirmed knowledge and understanding for residents with SALT assessed needs and the procedures the home had put in place at mealtimes to minimise these.

Examination of records and discussion with staff confirmed that the risk of falling and falls were suitably managed. There was evidence of appropriate onward referral as a result of the post falls review.

Daily progress records were kept of how each resident spent their day and the care and support provided by staff. Any issues of assessed need had a recorded statement of care / treatment given with effect of same recorded.

The outcomes of visits from any healthcare professional were also recorded.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean, tidy and fresh smelling throughout, with a good standard of décor and furnishings being maintained. Residents' bedrooms were nicely furnished and personalised with items important to the resident. Communal areas were suitably furnished and comfortable. Bathrooms and toilets were clean and hygienic.

The laundry department was tidy and well organised.

Cleaning chemicals were stored safely and securely.

The grounds of the home were well maintained, with good accessibility for residents to avail of.

All staff were in receipt of up-to-date training in fire safety. Fire safety records were appropriately maintained with up-to-date fire safety checks of the environment and fire safety drills.

The home's most recent fire safety risk assessment was completed on 3 March 2023. There was corresponding evidence recorded of actions taken in response to the recommendations made from this assessment.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control measures and the use of PPE had been provided. Staff were also seen to adhere to correct IPC protocols.

5.2.4 Quality of Life for Residents

Observations of care practices confirmed that residents were able to choose how they spent their day.

It was also observed that staff offered choices to residents throughout the day which included preferences for food and drink options.

The genre of music and television channels played was appropriate to residents' age group and tastes.

The atmosphere in the home was relaxed with residents seen to be comfortable, content and at ease in their environment and interactions with staff. Residents were engaged in pastimes of choice, such as playing games, listening to music, crafts or relaxing.

The range of activities included social, community, cultural, religious, spiritual and creative events. Records, including photographic records of activities and events were well maintained. Some residents talked about events, such as a visit local hotel for a meal they had attended and also events they planned to attend.

5.2.5 Management and Governance Arrangements

Staff spoke positively about the managerial arrangements in the home, saying there was good support and availability. Staff also said that the management were very approachable and felt that if they raised any concerns these would be taken seriously and managed appropriately.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The Manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults. Discussions with staff confirmed knowledge and understanding of the safeguarding policy and procedure. Staff also said that they felt confident about raising any issues of concern to management and felt these would be addressed appropriately.

Accidents and incidents were notified, if required, to resident's next of kin, their care manager and to RQIA. A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported to the relevant stakeholders.

There was a system of audits and quality assurance in place. These audits included; infection prevention and control and environmental audits.

The home was visited each month by the registered person to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in excellent detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed.

7.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Melissa Mallaby, Senior Care Assistant, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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