Unannounced Care Inspection Report
8 April 2019

Barnlee

Type of Service: Residential Care Home
Address: 37 Lisnaskea Road, Barnhill, Lisnaskea, BT92 0HD
Tel No: 028 6772 3233
Inspector: Laura O'Hanlon and Kate Maguire

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 provider 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 registered to provide care and accommodation for 23 persons in the categories of care cited on the home's certificate of registration and detailed in section 3.0 of this report.

3.0 Service details

Organisation/Registered Provider: FACT **Responsible Individual:** Ruth Hill	**Registered Manager:** Geraldine O'Neill
Person in charge at the time of inspection: Geraldine O'Neill	**Date manager registered:** 1 April 2005
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 registered places:** 23 To accommodate 18 in Main House and 5 in Lee Cottage. The home is also approved to provide care on a day basis only to 3 persons

4.0 Inspection summary

An unannounced inspection took place on 8 April 2019 from 10.30 to 18.50.

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 was undertaken following information received by RQIA in relation to poor infection prevention and control practices and inadequate staffing arrangements in the home. In addition further concerns were identified by the WHSCT in regards to the safeguarding arrangements in the home.

It is not the remit of RQIA to investigate complaints/ adult safeguarding concerns made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, if RQIA is notified of a potential breach of regulations or minimum standards, it will review the matter and take appropriate action as required; this may include an inspection of the home.

The following areas were examined during the inspection:

- staffing including induction records
- environment
- infection prevention and control practices
- management and governance arrangements

Serious concerns were identified throughout the inspection in regards to the quality of the environment and inadequate infection prevention and control practices. In addition there was a lack of robust quality monitoring and governance arrangements in place which had the potential to place residents at risk of harm. As a result of this inspection enforcement action was taken and two failure to comply notices were issued. This is discussed further in section 4.1 of this report.

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

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Geraldine O'Neill, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this inspection.

Following the inspection senior management in RQIA met and it was agreed that the responsible individual would be invited to attend a meeting in RQIA, with the intention of issuing two failure to comply notices in regards to the registered person: general requirements and health and welfare of residents.

The intention meeting was held on 12 April 2019 and the manager and an appointed person acting on behalf of the responsible individual were in attendance. The manager outlined the actions that would be taken to address the concerns identified. RQIA were not sufficiently assured that the necessary improvements to ensure full compliance with the regulations had been made and were concerned about the potential impact this may have on the delivery of care in the home.

As a result two failure to comply notices were issued under The Residential Care Homes Regulations (Northern Ireland) 2005: Regulation 10.- (1) registered person: general requirements and Regulation 13.- (7) health and welfare of residents.

A further inspection will be undertaken to validate that compliance has been achieved and sustained.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection 15 December 2018.

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 returned QIP and any written and verbal communication received since the last care inspection.

During the inspection the inspectors met with approximately 15 residents, four staff, the improvement lead and the manager.

The following records were examined during the inspection:

- Staff duty roster
- Induction records
- Three residents care records
- Record of staff meetings
- Record of accidents and incidents
- Regulation 29 reports

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 15 December 2018

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

6.2 Review of areas for improvement from the last care inspection dated 15 December 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 25.1 **Stated:** Second time	The registered person shall undertake a comprehensive review of staffing levels to ensure that the assessed needs and subsequent care of residents are being met.	**Escalated to enforcement**
	Action taken as confirmed during the inspection: This standard was escalated to form part of the failure to comply notice issued. Refer to section 6.3.2. of this report for full details. This will be reviewed during the compliance inspection.	

6.3 Inspection findings

6.3.1 Environment/Infection Prevention and Control Practices.

On arrival to the home the inspectors met with the manager and explained that they wished to tour the building. In general the home presented as dated and needed to be refreshed. There were malodours on arrival which was explained as part of the early morning routine and continence issues. The inspectors went to the laundry room and met with the house keeper/domestic. The laundry was a small space which presented as untidy, cluttered and inadequate for carrying out the function of laundering for the amount of people living in the home and the changing needs of the residents. This was made worse by a domestic style ironing board and iron having been set up. It was quickly apparent that there was no system in place for effective laundering of linen and clothing. In the small laundry area clean clothing was stored beside soiled clothing, increasing the risk of contamination. We met with the housekeeper on duty who advised that there was only one washing machine working in the home. We were advised that the machine had been out of operation from at least February 2019. Given the number and changing needs of the residents this meant that it was difficult to maintain the volume of laundry required in the home.

The housekeeper further advised that they remain in the laundry until it is completed; this may take up to 2pm in the afternoon. Following this, the cleaning of the home is undertaken. There was no set time for the laundry work to be completed and the cleaning of the home to commence. It is not acceptable that the cleaning of the home does not commence until the afternoon.

Following from the laundry the inspectors proceeded to walk through the remainder of the home including bathroom and bedrooms. The following concerns were identified significant rust on shower chairs; water leaks were identified in ensuite bathrooms and this had resulted in stains on the flooring. Tiles in ensuite bathrooms were missing or were not appropriately secured to the wall presenting a risk to health and safety of residents and staff. A build-up of dust and debris was observed in residents' bedrooms. There was also a malodour in the home.

There was a stained sheet observed on a resident's bed. Further inspection of this bed later in the day identified that this sheet was not changed, despite the bed being made by staff. There was an overall lack of attention to detail in residents bedrooms. They were found to be untidy cluttered and unclean. Some were in need of redecoration with worn wallpaper, chipped paintwork and tired furnishings.

A designated toilet for residents which was no longer used but not out of service contained significant storage of incontinence products and archived residents' care records. As a consequence, this bathroom could not be used by residents. This reduction in bathroom accommodation had not been notified to RQIA and a legionella risk assessment had not been carried out.

Staff are asked to complete a daily audit to identify any environmental deficiencies despite this task, nothing had been identified as needing attention. This provided evidence of a lack of managerial oversight. This is discussed further in 6.3.2.

There was a deficit identified in the domestic arrangements in the home. Domestic duties were not appropriately managed; there was insufficient staff to undertake this role to ensure an acceptable level of cleanliness. The home in general presented as cluttered, untidy and unclean in many areas. This not only presented a potential risk of infection but does not demonstrate the values of dignity and respect for the residents in a way which reflects that they are valued and have the right to live in a home that is safe, clean, tidy and well furnished.

At the intention meeting the registered manager advised that some immediate action was taken to address these issues. However given the seriousness of the concerns identified at this inspection, a failure to comply notice was issued under Regulation 13.-(7) of The Residential Care Homes Regulations (Northern Ireland) 2005.

6.3.2 Management and Governance Arrangements

It is essential that all residential care homes demonstrate effective and robust governance arrangements which will alert management within the home of issues as they arise. As part of these arrangements the manager explained that staff complete an environmental audit on a daily basis. This audit should highlight any issues relating to the quality of the environment in order that any remedial action can be taken. A review of this record evidenced that no environmental concerns were identified. This record indicated that the environment was clean and satisfactory despite significant concerns highlighted during inspection. When asked, a member of the care staff was able to identify all the concerns in relation to one bathroom area. This audit was ineffective and RQIA was not assured of the oversight arrangements in respect of this area.

The records of the visits by the registered provider for the period of January to March 2019 were reviewed. These records outline a 'social visit' to the home and not the robust monitoring of systems management and care delivery. There was no process for consultation with relatives. There was no overview of the adult safeguarding investigations ongoing in the home, review of the accidents and incidents and the environment was recorded as clean.

These records did not provide sufficient detail to ensure adequate oversight and assurances in relation to the conduct of the home.

The duty roster was reviewed and found to accurately reflect the staff on duty in the home on the day of the inspection. However further review of the duty rota evidenced specific days where the staffing levels were not adequately maintained. Discussion took place with the manager in relation to this and we were advised that they were maintained with the use of bank care staff. The capacity of these bank staff could not be determined from the duty rota.

The inspectors could not determine if the staffing levels were accurately maintained to meet the needs of the residents. There were residents in the home who required specific provision of staff and other residents who required close monitoring from staff. The staffing levels were observed to be stretched, particularly during the night and it could not be ascertained how the staffing levels would be maintained if an unplanned absence occurred. The arrangements in place for staff who required supervision could not be safely determined. RQIA were concerned that there may be a potential impact on the delivery of safe and effective care to residents.

On the morning of the inspection we were informed of an incident which had occurred in the home on the previous day. This incident was reported to the person in charge of the home in the absence of the manager. This was brought to the attention of the manager during the inspection who was unaware of this incident. During further discussion with the manager we were advised that there were sufficient skilled staff in place. Concerns were raised in relation to the inappropriate management of this incident by the person in charge on the previous day and the failure to report this incident to the manager on their return. RQIA were concerned that there were inadequate reporting arrangements in place from staff to the manager.

Four induction records were reviewed for new staff who commenced work in the home. It was noted on these records where mandatory training particularly in relation to adult safeguarding procedures was not completed. In addition to this the WHSCT had facilitated training for staff specifically in relation to adult safeguarding. This was poorly attended; only three care staff had completed this. This was of significant concern given the high level of adult safeguarding referrals made in relation to the home.

RQIA were concerned regarding the lack of robust quality monitoring and governance systems in place and the potential impact this may have on the delivery of safe care. Given the seriousness of the concerns identified at this inspection, a failure to comply notice was issued under Regulation 10.- (1) of the Residential Care Homes Regulations (Northern Ireland) 2005.

6.3.3 Residents Views

We met with approximately 15 residents during the inspection. The residents were observed to be comfortable and relaxed within their environment. Some residents' comments included:

- "I feel safe here sometimes."
- "The staff are good. If I was upset I would go to the manager."
- "Sometimes I like it here. It would be better if the staff were more kind to me."
- "I feel a bit uncomfortable in here at times."

6.3.4 Care Records

We reviewed three care records. Care plans were in place to inform and direct care staff. However these were found to be cumbersome and difficult to navigate. Records were not always signed and dated when completed and in some instances they were not updated to reflect changes in the residents' situation. They contained a significant amount of historic

information which should be archived. Discussion took place with the manager and this was identified as an area for improvement to ensure that new working resident's files are devised. These should include individualised care plans and risk assessments which accurately reflect the current needs of the residents.

Areas for improvement

One area for improvement was identified during the inspection.

	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 Geraldine O'Neill, registered manager, as part of the inspection process. 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 16 (1) **Stated:** First time	The registered person shall ensure that new working files are devised. These should include up to date care plans which accurately reflect the needs of the residents. These records should be appropriately signed and dated. Ref: 6.3.4
To be completed by: 13 June 2019	**Response by registered person detailing the actions taken:** Working file's in relation to all Residents are in progress, Care management reviews are currently taking place and up to date care plans are being devised to reflect accurately the care and support needs of the residents. On completion and agreement these records will be appropriately signed and dated.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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