The Regulation and Quality Improvement Authority

Secondary Unannounced Care Inspection

Name of Service and ID:	**Mantlin Cottage 1139**
Date of Inspection:	**20 July 2014**
Inspector's Name:	**Bronagh Duggan and Ruth Greer**
Inspection ID:	**IN020294**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General information

Name of Service:	Mantlin Cottage Residential Care Home
Address:	Mantlin Road Kesh County Fermanagh BT93 1RF
Telephone number:	(028) 6863 1248
E mail address:	derekmaxwell@praxiscare.org.uk
Registered Organisation/ Registered Provider:	Praxis Care Group
Registered Manager:	Mr Derek Maxwell
Person in charge of the home at the time of inspection:	Mr Ian Keys, Team Leader
Categories of care:	RC - LD RC - LD(E)
Number of registered places:	9
Number of residents accommodated on Day of Inspection:	9
Scale of charges (per week):	£426.00 - £2107.23
Date and type of previous inspection:	16 March 2014 Secondary Unannounced Inspection
Date and time of inspection:	Sunday 20 July 2014 11:40 - 2:15pm
Name of Inspector:	Bronagh Duggan and Ruth Greer

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect residential care homes. A minimum of two inspections per year are required.

This is a report of an unannounced inspection which was undertaken in response to an anonymous allegation received by RQIA regarding a specific resident. The caller alleged that the resident was accommodated in a locked area within Mantlin Cottage. This report details findings from observations made during the inspection, an examination of records, and discussion with staff on duty.

The details of the allegation were:

1. An identified resident was frequently locked in a bedroom and lounge area within the home.

2. Sometimes a staff member would be supervising the resident on a one to one basis but not always.

3. Staff had expressed concerns to the manager about locking the door but nothing had been done.

3.0 Methods/Process

Two inspectors visited the home to establish if there was evidence to validate the allegations made. A weekend visit was organised to ensure that the resident was present in the home.

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

- An examination of records
- Observation of care delivery and care practice
- Discussions with staff
- An inspection of the premises
- An evaluation of findings and feedback.

4.0 Profile of service

Mantlin Cottage Residential Care home is situated in the Village of Kesh in Co Fermanagh. The home is within walking distance of shops and local amenities. It is owned and operated by Praxis care group. Derek Maxwell is manager of the home.

Accommodation is provided in a single storey building which consists of nine single “en suite” bedrooms, kitchen, dining area, lounge, bathroom, shower room, toilet facilities, laundry room and an office. A small lounge area is situated to the front of the home. There is also a staff “sleep over” room.

To the rear of the home is a court yard and garden area with seating for residents.

There is ample car parking facilities to the side and rear of the home.

The home is registered to provide care for a maximum of nine persons under the following categories of care:

Residential care

LD	Learning Disability
LD(E)	Learning Disability – over 65 years

5.0 Inspectors' Findings

On arrival at the home inspectors requested to be shown to the specific area were the identified resident was accommodated. Inspectors found the resident was accommodated in a separate area of the home which was locked. This area could only be accessed through the activation of a key pad system. Staff confirmed that the resident could not operate the key pad access system. This area of the home was only accessible by staff. This separate area of the home consisted of a bedroom with ensuite bathroom, a small lounge area and a small hallway. One staff member was supervising the resident. Views to the outside of the home and into the communal areas of the home were restricted as the windows were obscured with an opaque covering.

A review of the residents care plan identified that there were specific periods of the day when the key pad system should be activated. These periods were stipulated around meal times up to a maximum of four hours per day. Throughout the duration of the inspection from 11.40am until 2.15 pm the resident remained in the locked area of the home.

It was noted that that the plan of care which had initially been implemented as a specific time limited intervention to manage behavioural difficulties had been expanded upon to the point where the resident was spending significant periods of time within the locked area of the home, thus depriving the resident of opportunities to move freely around the home.

The care plan did was developed by Praxis staff and not reflect multi-disciplinary input. There was no evidence of independent services from the multi-disciplinary community based team being involved in the development or the implementation of the care plan.

Inspectors were told by staff that the resident receives one to one supervision between the hours of 8am and 11pm an examination of records indicated that the resident would often be awake prior to 8 am, the time when day staff come on duty. A review of wakening times for the first 19 nights of July detailed that the resident had been awake from 5am on one occasion, and from 7am or shortly after on 10 occasions. Staff stated that on the occasions when the resident wakes before 8am he/she can be seen standing or sitting behind the opaque covered door and can be heard banging the door until day staff come on duty.

The residents care plan and level of support had not been amended to reflect the early wakening or include measures to be put in place at the time. An examination of the staff duty rota confirmed that there was one wakened night duty staff member on duty to meet the needs of nine residents. A review of staff handover and allocation records showed that there

were at least two residents in the home assessed as requiring high level one to one support from staff. Considering the home was operating with one wakened night duty staff member there was the potential resident's welfare would be compromised if the home were to experience any issues requiring staffs attention during the night.

One staff member informed the inspectors the lounge area is locked during the night and is not opened until day staff come on duty, therefore further restricting the residents' movement within an already restricted part of the home.

Inspectors discussed the residents care with four members of staff on duty. One member of staff stated that the resident can display challenging behaviours around meal times and this was why he/she was being accommodated in a separate part of the home. This arrangement had been in place since the resident was admitted to the home in 2012. Staff also informed inspectors that the resident can experience difficulties when in close proximity to other residents as a result had only limited access to communal areas of the home. The model of care in a residential home should reflect the values and the provisions of the minimum standards which place an emphasis on the promotion of independence and a model of communal living. There was no evidence that this resident was integrated into the communal living within the home. In view of the high degree of restrictive practice this brings into question the suitability of this residents' placement.

6.0 Conclusion

This inspection was undertaken in response to an allegation which was received by RQIA on 15 July 2014. It related to an identified resident frequently being locked in an area consisting of a bedroom and lounge and this was found to be the case. The fact that the resident remained in the locked part of the home for the duration of the inspection highlighted that this situation had become normal practice within the home.

There are times; most notably in the early mornings when the resident had to spend periods of time in the locked area alone, with no access to liquids.

In relation to staff having expressed concern previously to the manager about the door being locked, of the four staff spoken with during the inspection none were aware that the issue had been raised with the manager.

Due to the urgency of response required regarding the serious issues raised as a result of this unannounced inspection this issue has become subject to RQIA's enforcement procedures and processes. Further to this RQIA referred these issues to the Western Health and Social Care Trust to be dealt with through their safeguarding processes.

Bronagh Duggan
Inspector/Quality Reviewer

No requirements or recommendations resulted from the unannounced inspection of Mantlin Cottage which was undertaken on 20 July 2014 and I agree with the content of the report. Return this QIP to **care.team@rqia.org.uk**

Please provide any additional comments or observations you may wish to make below:

NAME OF REGISTERED MANAGER COMPLETING	Tracey Marshall
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING	Willie McAllister on behalf of Irene Sloan

Approved by:	**Date**
Bronagh Duggan	17/10/14