Unannounced Care Inspection Report
15 June 2018

Ballymacoss Mental Health Hostel

Type of Service: Domiciliary Care Agency
Address: 12 - 14 Mourneview Park, Brokerstown Road, Lisburn, BT28 2UQ
Tel No: 02892676277
Inspector: Aveen Donnelly

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 from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Ballymacoss Mental Health Hostel is a domiciliary care agency (supported living type) which provides a range of personal care services to 11 people living in their own homes. Service users have a range of needs including mental health issues and require support to live as independently as possible in a range of accommodation.

3.0 Service details

Organisation/Registered Provider: South Eastern HSC Trust **Responsible Individual:** Hugh Henry McCaughey	**Registered Manager:** Janet Wilson (Acting Manager): Application not required
Person in charge at the time of inspection: Janet Wilson	**Date manager registered:** Not applicable

4.0 Inspection summary

An unannounced inspection took place on 15 June 2018 from 10.00 to 16.00 hours.

This inspection was underpinned by the Domiciliary Care Agencies Regulations (Northern Ireland) 2007 and the Domiciliary Care Agencies Minimum Standards, 2011.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the agency was delivering safe, effective and compassionate care and if the service was well led.

There were examples of good practice found throughout the inspection in relation to adult safeguarding, induction and staff development. Care records were generally well maintained. Communication between service users, agency staff and other key stakeholders was well maintained. The culture and ethos of care in the agency, generally promoted treating service users with dignity and respect, where service users and their representatives were listened to and valued. There were good governance and management arrangements in relation to the day to day operations of the service.

An area for improvement relating to fire safety checks was stated for the second time. Two new areas for improvement were identified in relation to the verification of staff fitness and staff training records.

Service users said that they were very happy with the care and support provided.

The findings of this report will provide the agency with the necessary information to assist them to fulfil their responsibilities, enhance practice and service users' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	3	0

Details of the Quality Improvement Plan (QIP) were discussed with Janet Wilson, acting 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.

4.2 Action/enforcement taken following the most recent care inspection dated 9 November 2017

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 9 November 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- previous inspection reports
- all correspondence received by RQIA since the previous inspection

The following records were examined during the inspection:

- four staff recruitment records
- staff induction records
- supervision and appraisal records
- staff training records
- records confirming registration of staff with the Northern Ireland Social Care Council (NISCC)
- daily logs returned from the service users' homes
- four service user records regarding review, assessment and care planning
- RQIA registration certificate
- a selection of policies and procedures
- complaints records
- service user guide/agreements
- statement of purpose
- monthly quality monitoring reports

During the inspection the inspector spoke with the manager, two care staff, two relatives and one Health and Social Care (HSC) representative.

At the request of the inspector, the manager was asked to display a poster prominently within the agency's registered premises. The poster invited staff to give their views and provides staff with an electronic means of providing feedback to RQIA regarding the quality of service provision. No responses were received.

The inspector requested that the person in charge place a 'Have we missed you"' card in a prominent position in the agency to allow service users and family members who were not available on the day of the inspection to give feedback to RQIA regarding the quality of service provision. No feedback was received.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 9 November 2017

The most recent inspection of the agency was an announced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 9 November 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with the Domiciliary Care Agencies Regulations (Northern Ireland) 2007		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 23(1) (2) (3) **Stated**: First time	(1)The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. (2) At the request of the Regulation and Improvement Authority, the registered person shall supply to it a report, based upon the system referred to in paragraph (1), which describes the extent to which, in the reasonable opinion of the registered person, the agency- (a) arranges the provision of good quality services for service users; (b) takes the views of service users and their representatives into account in deciding- (i) what services to offer them, and (ii) the manner in which such services are to be provided; and has responded to recommendations made or requirements imposed by the Regulation and Improvement Authority in relation to the agency over the period specified in the request. (3) The report referred to in paragraph (2) shall be supplied to the Regulation and Improvement Authority within one month of the	**Met**

	receipt by the agency of the request referred to in that paragraph, and in the form and manner required by the Regulation and Improvement Authority.	
	Action taken as confirmed during the inspection: A review of the records confirmed that the monthly monitoring visits had been undertaken from February 2018. Refer to section 6.7 for further detail.	
Area for improvement 2 **Ref:** Regulation 15 (9) **Stated**: First time	The registered person shall make arrangements to prevent service users being placed at risk of harm.	**Not met**
	Action taken as confirmed during the inspection: Whilst there was evidence that the staff had been undertaking regular safety checks in the service users' homes, the review of the records did not identify enhanced checks in relation to smoking safety. This related to staff recording checks of identified areas within the house, where one service user was known to smoke. This area for improvement was not met and has been stated for the second time. Refer to section 6.4 and 6.7 for further detail.	
Action required to ensure compliance with the Domiciliary Care Agencies Minimum Standards, 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 14.1 **Stated**: First time	The registered person ensures that the policies for protecting vulnerable adults are in accordance with legislation, DHSSPS guidance, regional protocols and local processes issued by Health and Social Services Boards and HSC Trusts.	**Met**
	Action taken as confirmed during the inspection: A review of the policy identified that this area for improvement had been met.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to service users from the care, treatment and support that is intended to help them.

The agency's registered premises are located at 12 – 14 Mourneview Park, Lisburn and were suitable for the purposes of the agency.

At the time of the inspection, the agency had a manager in post, who managed the agency with the support of a team of domiciliary care staff. All those consulted with stated that the required staffing levels were consistently adhered to. The agency's staffing arrangements were discussed and the inspector was advised that there were no staff vacancies.

The organisation has a dedicated human resources department which oversees the recruitment processes, including the completion of appropriate pre-employment checks. However, there was no evidence of a statement by the responsible person or registered manager as to the fitness of staff member to carry out their role. This has been identified as an area for improvement.

There was a system in place to monitor the registration status of staff in accordance with NISCC. The manager discussed the system in place to ensure that all staff were registered with NISCC and to identify when staff are due to renew their registrations.

A review of records confirmed that all staff, had received a structured induction programme in line with the timescales outlined within the regulations.

There were systems in place to monitor staff performance and to ensure that they received support and guidance. A review of the records confirmed that the staff received regular supervisions and appraisals on an annual basis. Competency and capability assessments in relation to medicines management were also completed annually.

A review of the training records confirmed that training had been provided in all mandatory areas. However records were not consistently kept up to date and records specifically relating to bank staff were not available for inspection. This has been identified as an area for improvement.

Discussion with staff member confirmed that they were knowledgeable about their specific roles and responsibilities in relation to adult protection and how they should report any concerns that they had. The manager advised that there had been no incidents referred to adult safeguarding from the date of the last care inspection. Arrangements were in place to embed the new regional operational safeguarding policy and procedure into practice. The role of the Adult Safeguarding Champion (ASC) was discussed during the inspection and the inspector was advised that an identified person within the organisation holds this responsibility and ensures that the organisation's safeguarding activity is in accordance with the regional policy and procedures.

A review of the accident and incident records confirmed that they were managed appropriately and were notified to the relevant Trust representatives in keeping with local protocols.

During the inspection the inspector reviewed the agency's arrangements for identifying, managing and where possible eliminating unnecessary risk to service users health, welfare and safety. As previously discussed in section 6.2, whilst there was evidence that the staff had been undertaking regular safety checks in the service users' homes, the review of the records did not identify enhanced checks in relation to smoking safety. This related to staff recording checks of identified areas within the house, where one service user was known to smoke. An area for improvement has been stated for the second time in this regard.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to monitoring of staff performance, adult safeguarding and the management of incidents.

Areas for improvement

An area for improvement in relation to safety checks was not met and has been stated for the second time. Two new areas for improvement were identified in relation to the verification of staff fitness and staff training records.

	Regulations	Standards
Total number of areas for improvement	3	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The full nature and range of service provision was detailed in the Statement of Purpose and Service User Guide. The agency's arrangements for appropriately assessing and meeting the needs of the service users were examined during the inspection.

The inspector examined two service users' care records and found these to be detailed and reflective of the individuals' preferences.

The manager advised that care reviews with the HSC Trust representatives were held annually or as required and that care and support plans were updated to reflect changes agreed at the review meetings.

The agency had quality monitoring systems in place to audit and review the effectiveness and quality of care delivered to the service users. Quality monitoring reports indicated consultation with a range of service users, relatives, staff and as appropriate HSC Trust representatives.

It was clear from discussions with service users and relatives that the staff had a good knowledge of the service users' needs and preferences; and how they worked with the service users to minimise any challenging behaviours.

There was evidence of effective communication with the service users, their representatives and with relevant HSC Trust representatives, as required. Staff meeting' minutes reflected that there was effective communication between all grades of staff.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the quality of the care records and the agency's engagement with the service users.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The inspection sought to assess the agency's ability to treat the service users with dignity and respect; and to fully involve them/their representatives in decisions affecting their care and support.

The culture and ethos of care was found to promote dignity, respect, independence, rights, equality and diversity. This was reflected through the care records, monthly monitoring reports and consultation with service users and their representatives.

The review of the care records identified that the service users had information within their records that outlined what was important to them and what they wanted people to know about them. Where a service users' consent was not given in relation to photography, this was respected by the staff.

Participation in activities in the local and wider community were encouraged, with appropriate staff support.

The agency maintained a range of quality monitoring systems to evaluate the quality of services provided, including monthly quality monitoring visits and reports which specifically ascertained and included the views of the service users and their representatives.

The service users consulted with informed the inspector that they were encouraged to raise any concerns they may have. The views of services users and their' representatives were also sought as part of the monthly quality monitoring process.

During the inspection, the inspector spoke with four service users, who appeared relaxed and happy with the staff member who accompanied them. The inspector also spoke with, two staff members, two relatives and one HSC representative. Some comments received are detailed below:

Service Users

- "They are all very good, I have no concerns."
- "They are fantastic, very hard workers and they are very good to me."
- "I like it here, they are very nice."
- "I want to go home, but they are very good to me here."

Staff

- "It is all very good."
- "Absolutely fine here, I have no concerns."

Representatives

- "I have no concerns."
- "We are happy with everything."

HSC representative

- "There are no concerns noted."

At the request of the inspector, the manager was asked to issue ten questionnaires to the service users and their representatives. No questionnaires were received.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of care, promoting dignity and respect, listening to and valuing the service users and their representatives.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The inspector reviewed the management and governance systems in place within the agency to meet the needs of the service users; it was identified that the agency has effective systems of management and governance in place.

Staff and service users were aware of the organisational structure of the service and were aware of who to contact should they have any concerns.

The staff members spoken with confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. All those consulted with described the manager in positive terms; comments reflected that they felt that the agency was well led.

The manager explained the procedures in place to ensure that any complaints received would be managed in accordance with legislation, standards and the agency's own policies and procedures. All those consulted with were confident that staff/management would manage any concern raised by them appropriately. There had been no complaints received from the date of the last inspection.

As previously discussed in section 6.2, monthly quality monitoring visits were completed in accordance with Regulation 23 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. An action plan was generated to address any identified areas for improvement; discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed. Following the inspection, the inspector discussed the submission of the monthly quality monitoring reports with the person delegated with the responsibility for undertaking the visits. It was agreed that he would continue to confirm to the inspector, by email, when the visits had taken place.

The inspector discussed arrangements in place in relation to the equality of opportunity for service users and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of the service users. The agency collected equality data on service users such as; age, gender, race, disability, marital status via the referral process.

There was a system in place to ensure that the agency's policies and procedures were reviewed at least every three years. Policies were available electronically and plans were in place to keep hard copies, for staff who had difficulty accessing the electronic database.

Review of records pertaining to accidents and incidents confirmed that these were appropriately managed.

There was evidence of effective collaborative working relationships with key stakeholders, including the HSC Trust representatives, families of the service users and staff. .

On the date of inspection the registration certificate was up to date and displayed appropriately.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	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 Janet Wilson, acting 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 agency. 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 Domiciliary Care Agencies Regulations (Northern Ireland) 2007 and/or the Domiciliary Care Agencies Minimum Standards, 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 Domiciliary Care Agencies Regulations (Northern Ireland) 2007

Area for improvement 1 **Ref**: Regulation 15.9 **Stated**: Second time **To be completed by**: Immediate from the date of the inspection	The registered person shall make arrangements to prevent service users being placed at risk of harm. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: Daily monitoring is undertaken by support staff at Balymacoss in relation to those tenants who smoke in their accommodation. Daily reports are provided at handover, to ensure all staff are aware of any concerns. Fire risk assessment has been completed for the Ballymacoss facility. The annual Fire Risk Assessment for Ballymacoss was completed by the Estates Department in April 2018 A specific assessment of one tenant's accommodation has previously been completed, due to their tendancy to smoke in their bedrrom area. An extra sensitive smoke alarm is in place, which has minimised the risk of fire in the upper floor and the tenant no longer smokes in her bedroom. Trust staff have advised all tenants about the dangers and risks of smoking and they work with the tenants in an effort to help them minimise any risks. This includes any long-term risk in relation to physical health and also any potential immediate fire risk to themselves or fellow tenants. All staff (including Bank Staff), but one, attended Fire training in April 2018. This staff member has subsequently attended Fire Officer training along with her colleagues (8/8/18). An individual risk assessment has been completed for each tenant, on MAXIMS, and individual support plans are also kept updated. Any identified risks are recorded and monitored through daily visiting, which is increased if required for any reason. Smoking has been identified as a risk. Incidents in relation to smoking are recorded and the care plans adjusted as required. Adult Safeguarding Policy and Procedures are available to staff and continue to be an area for discussion at handover and during staff supervision. Staff are aware of the Designated Adult Prototection Officer (DAPO) role and their contact details, along with current procedures to consult with the DAPO. Safeguarding of Children and Adults continues to be part of mandatory training and the training records for staff are displayed in the staff

	room.
Area for improvement 2 **Ref:** Regulation 13 (d) **Stated**: First time **To be completed by**: 13 August 2018	The registered person shall ensure that no domiciliary care worker is supplied by the agency unless— (d)full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3. This refers specifically to a statement by the registered provider, or the registered manager, as the case may be, that the person is physically and mentally fit for the purposes of the work which he is to perform. Ref: 6.4
	Response by registered person detailing the actions taken: Checks concerning staff ability to safely carry out the duties of their post is managed through Human Resources (HR) in the first instance, at the time of appointment. Available records for current staff have been requested from HR, in order that they be kept in the staff member's file. The ability of staff to continue to attend to their duties is discussed in supervision and any appropriate action that needs to be taken is completed - e.g referrral to Occupational Health, review of competency, exploration of re-deployment should there be specific concerns in relation to the staff member's ability to continue to work in the supported living environment. Staff records indicate newly acquired and updated training - e.g. medication management, management of finances, safeguarding. Registration details with NISCC are held on staff files. There is also a central register managed by the Mental Health sub-directorate which alerts the Trust to when registration is due for renewal. Trust staff are issued with identication badges confirming that they are a staff member with the Trust. Training records/certificates are maintained in staff files. Copies of certificates are forwarded to the Team Leader when a staff member attends and successfully completes training provided from within the Trust. A review of staff information held in their files will be carried out along with confirmation that they are fit for the purposes of the work, which they are required to perform..

Area for improvement 3 **Ref:** Regulation 16(2)(a) **Stated**: First time **To be completed by**: 13 August 2018	The registered person shall ensure that each employee of the agency— (a)receives training and appraisal which are appropriate to the work he is to perform; This refers specifically to training records of bank staff. Ref: 6.4
	Response by registered person detailing the actions taken: Permanent staff KSF appraisals are up to date. KSF appraisals for bank staff are being completed. Staff supervision files, including those pertaining to bank staff, are included in file samples viewed during monthly monitoring meetings. Staff mandatory and other training needs are identified on an on-going basis and this is also discussed with staff on duty during visits by the Monitoring Officer. Training records for all permanent and bank staff are on display in the office. Bank Staff: The Monitoring Officer has initiated a scoping exercise to determine any shortfall in the training needs of bank staff. Bank staff have access to necessary training and are encouraged to identify and attend training by their manager. Training is accessed through the bank office as bank staff do not have accessto the electronic log on system.

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