



The **Regulation** and
Quality Improvement
Authority

Home Treatment House
RQIA ID: 12209
Old See House
603 Antrim Road
Belfast
BT15 4DX

Inspector: Sharon McKnight
Inspection ID: IN021937

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**Unannounced Care Inspection
of
Home Treatment House**

10 December 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 10 December 2015 from 09 50 hours to 14 50 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 28 April 2015.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Belfast HSC Trust Martin Joseph Dillon	Registered Manager: Domenica Gilroy
Person in Charge of the Home at the Time of Inspection: Domenica Gilroy	Date Manager Registered: 25 November 2014
Categories of Care: NH-MP, NH-MP(E)	Number of Registered Places: 6
Number of Patients Accommodated on Day of Inspection: 6	Weekly Tariff at Time of Inspection: There is no charge to patients for this service.

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively**Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)****4. Methods/Process**

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

- discussion with the registered manager
- discussion with staff
- discussion with patients
- review of records
- observation during a tour of the ground floor premises
- evaluation and feedback

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report

During the inspection, we met with four patients and completed questionnaires on their views of the service. We met with a registered nurse, two support workers and a patient advocate who was visiting during the inspection.

The following records were examined during the inspection:

- a care record of one patient
- policies and procedures
- record of complaints and compliments
- reports produced following the monthly visits required in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- staff training records
- incident and accident records

The Inspection

4.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 28 April 2015. The completed QIP was returned and approved by the care inspector.

4.2 Review of Requirements and Recommendations from the last care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 Ref: Standard 28.6 Stated: Second time	It is recommended that staff training records are further developed to include: <ul style="list-style-type: none"> • the signatures of those attending the training • the date of the training • the name and qualification of the trainer or the training agency • content of training 	Met
	Action taken as confirmed during the inspection: Staff training records reviewed included the date the training took place, signature of staff who attended the training and the qualification of the trainer. The content of the training was available in the home. This recommendation has been met.	
Recommendation 2 Ref: Standard 35.7 Stated: First time To be Completed by: 30 June 2015	It is recommended that an update on the action taken to address outstanding issues is included in the monthly report.	Met
	Action taken as confirmed during the inspection: A review of the reports prepared following the monthly visit evidenced that outstanding issues from the previous report were reviewed. This recommendation has been met.	

4.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

The registered manager confirmed that patients' communication needs were identified during the pre-admission assessment. This assessment considered the patient's ability to communicate verbally and also their literacy needs. The registered manager explained that much information was provided to patients in written form, for example the Home Treatment information folder which included service users guidance, information with regard to accessing advocacy services and a range of support leaflets. Therefore, if staff were unaware of the patient's ability to read, this could impact on their recovery; for example in the area of medicines management. There was a pathway in place for patients to avail of adult literacy support, if appropriate. Staff spoken with were aware of the sensitivity around this area for patients.

Staff spoken with were knowledgeable regarding the potential barriers to communication and provided examples of how they had supported patients with communication difficulties. Referral pathways were in place for patients who had sensory impairments. The registered manager confirmed that interpreting services were available during normal working hours and also out of hours. The interpreting services included access to sign language services and a range of interrupters for patients whose first language was not English.

The environment of the home provided patients with private space to meet with healthcare professionals and visitors and to make and receive phone calls. We observed that there were a number of rooms available on the ground floor for staff and healthcare professionals to meet with patients and their relatives, if required.

Is Care Effective? (Quality of Management)

Review of one patient's care records evidenced that communication needs were identified as part of the admission process. A recovery care plan was drawn up, in consultation with the patient, and focused on the period the patient would be in the Home Treatment House. A discharge plan was included in the recovery care plan. The registered manager explained that meaningful patient involvement ensured that the patient remained empowered in making decisions regarding their care.

Communication between healthcare professionals was discussed with the registered manager who confirmed that a multi-disciplinary meeting was held weekly with the relevant healthcare professionals and the patient. Generally the registered manager attended this meeting and then disseminated the outcomes to staff.

Whilst staff confirmed that the majority of patients had mobile phones, a telephone was available for patients in the quiet room on the ground floor. A wireless internet connection was also available for patients throughout the home.

Advocacy services were available for patients. The contact details were displayed in the home and included in the information folder provided to each patient on admission. We met with the patient advocate who was visiting in the home during the inspection; he explained that he visited in the home weekly and was available to discuss any queries patients may have regarding advocacy and to provide support to patients, if needed, to have their voice heard.

We met with three patients individually and received a completed questionnaire for another patient following the conclusion of the inspection. Patients commented positively with regard to the service they were receiving. Patients confirmed that they were involved in the care planning process and were of the opinion that there was good communication with the staff in the home and with other healthcare professional involved in their care, for example community psychiatric nurses (CPN) and consultant psychiatrists. The following comments were received from patients:

“Ten out of ten for providing a good service. I get to see all the people I need to and it’s good that they are kept up to date with how I am.”

“There is a buzzer in room and it was explained on admission how and when to use it.”

“It’s a good gateway to other services.”

Three patient questionnaires were issued for those patients who were unavailable to meet with us during the inspection. None were returned.

Numerous compliments had been received by the home from former patients and relatives. These are examples of comments received:

“Thank you for all your help and time spent getting me on the road to recovery. It is greatly appreciated by me and my family.”

“Thank you for all your care and support.”

“I really appreciate all your care and attention during these six weeks.”

Is Care Compassionate? (Quality of Care)

Discussion with the registered manager and staff and observations of staff interactions with patients confirmed that communication was well maintained and patients were observed to be treated with dignity and respect. Staff were observed responding to patients’ promptly and cheerfully, and taking time to reassure patients as was required from time to time.

Discussion with three patients individually evidenced that they were satisfied with the support and service delivery in the home.

There were no relatives or representatives visiting at the time of the inspection. Questionnaires were left for relatives/representatives. Four relative’s questionnaires were issued. One was returned following the inspection. The relative indicated that they were very satisfied that the care was safe, effective and compassionate. The following comment was included:

“The staff are courteous and friendly and a room is made available privately to relations. Any concerns about the patient is discussed to the satisfaction of the family.”

Areas for Improvement

There were no areas for improvement identified with this standard.

Number of Requirements:	0	Number of Recommendations:	0
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4.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

The Belfast Health and Social Care Trust (BHSCT) had policies and procedures on the management of palliative care and end of life care which could be accessed on the BHSCT intranet by staff. Arrangements were in place for staff to make referrals to specialist palliative care services. Arrangements were in place for timely access to specialist equipment and medication.

Discussion with the registered manager confirmed that there was multi-disciplinary working across the BHSCT; if someone receiving palliative care was admitted to the Home Treatment House the relevant teams would remain involved in the patient's care and co-ordinate care as required.

Is Care Effective? (Quality of Management)

Patients' biological, psychological and social needs were assessed on admission. As previously discussed care planning within the Home Treatment House focused on the mental health needs of the patient and how these needs had impacted on the patient's well-being; care planning centred on patient recovery and discharge. The registered manager confirmed that as part of the admission process patients were asked to identify a person to contact in the event of an emergency; this would include if the patient became suddenly unwell.

The registered manager explained that patient need was assessed on an individual basis. If a patient was admitted with a terminal illness and/or receiving palliative care their needs would be assessed accordingly.

A review of the training records evidenced that staff had attended a range of training relevant to patient need, for example communicating effectively, adult safeguarding, personal safety and disengagement. The registered manager explained that a wide range of training was available within the BHSCT and could be accessed as required.

Is Care Compassionate? (Quality of Care)

Staff spoken with demonstrated understanding and compassion towards the patients. It was evident from discussion with staff that they were knowledgeable of patients' needs, wishes and preferences. Six staff questionnaires were issued, one was returned prior to the issue of this report. The staff member indicated they were very satisfied that care in the home was safe, effective and compassionate.

The Home Treatment House is registered to provide care to patients who required care and support with mental health issues. Since the registration of the Home Treatment House with RQIA in November 2014 the registered manager confirmed that there had been no patients admitted who required palliative care during their stay; neither have there been any occasions when staff were required to deliver end of life care.

Areas for Improvement

There were no areas for improvement identified with this theme.

Number of Requirements:	0	Number of Recommendations:	0
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5.0 Additional Areas Examined

5.1.1 Staffing

The registered manager and staff spoken with confirmed that the planned staffing was sufficient to meet the needs of the patients. Procedures were in place with the community home treatment team for the provision of additional staff, at short notice, to accommodate patient need, when required.




A review of the staffing roster for the week of the inspection confirmed that the planned staffing was adhered to.

5.1.2 Accidents and incidents

A review of the accidents and incidents recorded in the home evidenced that RQIA were notified appropriately of events in the Home Treatment House.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that any requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager		Date Completed	11/1/16
Registered Person		Date Approved	12/1/16
RQIA Inspector Assessing Response		Date Approved	2-2-16

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

Please complete in full and returned to Nursing.Team@rqia.org.uk from the authorised email address