Unannounced Care Inspection Report
17 August 2017

Hillview

Type of Service: Residential Care Home
Address: 182a Moyarget Road, Ballycastle, BT54 6JQ
Tel No: 028 2075 2058
Inspector: John McAuley

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

This is a residential care home with three beds that provides care for adults with a learning disability.

3.0 Service details

Organisation/Registered Provider: Hillview **Responsible Individual:** Mary McAllister	**Registered Manager:** Denis McAllister
Person in charge at the time of inspection: Rosaleen McTaggart – senior care assistant	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 3

4.0 Inspection summary

An unannounced care inspection took place on 17 August 2017 from 10.30 to 13.15.

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

Evidence of good practice was found in relation to staff training, adult safeguarding, infection prevention and control and the home's environment. Good practice was also found in relation to care records and communication between residents, their representatives and aligned health care professionals and maintenance of good working relationships.

One area of improvement was identified during the inspection. This was with regard to updating the fire safety risk assessment.

The two residents in the home at the time of this inspection appeared comfortable, content and at ease in their environment and interactions with staff. Both residents appeared well cared for with attention to personal care and attire. General observations of care practices found these to be organised and yet relaxed and homely.

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

Details of the Quality Improvement Plan (QIP) were discussed with Rosaleen McTaggart, senior care assistant, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent premises inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 16 May 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: the previous inspection report and notifiable event records.

During the inspection the inspector met with two residents, one staff member and the registered manager.

A total of eight questionnaires were provided for distribution to residents' representatives and staff for completion and return to RQIA.

The following records were examined during the inspection:

- Staff duty rota
- Staff training schedule/records
- One resident's care file
- Complaints and compliments records
- Infection control register/associated records
- Equipment maintenance/cleaning records
- Accident/incident/notifiable events register
- Monthly monitoring report
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- Individual written agreement
- Programme of activities

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 16 May 2017

The most recent inspection of the home was an announced premises follow up inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

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

There were no areas for improvements made as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

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

The senior care assistant confirmed the staffing levels for the home and that these were subject to regular review to ensure the assessed needs of the residents were met. No concerns were raised regarding staffing levels during discussion with staff.

An inspection of the duty roster confirmed that it accurately reflected the staff working within the home.

Discussion with staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities.

Discussion with staff confirmed that mandatory training of staff was regularly provided. A schedule for mandatory training was inspected and was found to be appropriately maintained.

Staff confirmed that competency and capability assessments were undertaken for any person who is given the responsibility of being in charge of the home for any period in the absence of the manager; records of competency and capability assessments were retained.

Discussion with the senior care assistant confirmed that no staff had been recruited since the previous inspection and that staffing in the home was very stable, therefore staff personnel files were not inspected on this occasion.

Arrangements were in place to monitor the registration status of staff with their professional body.

The adult safeguarding policy and procedure in place was consistent with the current regional guidance and included definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed. A safeguarding champion had been established.

Discussion with staff confirmed that they were aware of the new regional guidance (Adult Safeguarding Prevention and Protection in Partnership, July 2015) and a copy was available for staff within the home. Staff were knowledgeable and had a good understanding of adult safeguarding principles. They were also aware of their obligations in relation to raising concerns about poor practice and whistleblowing. An inspection of staff training records confirmed that mandatory adult safeguarding training was provided for all staff.

Discussion with the registered manager and staff identified that the home did not accommodate any individuals whose assessed needs could not be met.

Staff confirmed that no restrictive practices were undertaken within the home and on the day of the inspection none were observed.

Staff training records confirmed that all staff had received training in infection prevention and control in line with their roles and responsibilities. Discussion with staff established that they were knowledgeable and had understanding of infection prevention and control policies and procedures. Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered.

Good standards of hand hygiene were observed to be promoted within the home among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

Staff reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with home's policy and procedures, reported to the Public Health Agency, the trust and RQIA, with appropriate records retained.

The home was found to be clean and tidy with a good standard of décor and furnishings being maintained. A programme of redecoration had recently taken place with good effect. Residents' bedrooms were comfortable and nicely personalised.

Inspection of the internal environment identified that the home was kept tidy, safe, suitable for and accessible to residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff.

The home's fire risk assessment was dated May 2016. All the recommendations were reported to of been appropriately addressed. This assessment was in need of review and has been identified as an area of improvement in respect of the legislation.

Inspection of staff training records confirmed that staff completed fire safety training and fire safety drills twice annually. Records were retained of staff who participated and any learning outcomes. Fire safety records identified that fire-fighting equipment, fire alarm systems, emergency lighting and means of escape were checked on a regular and up to date basis. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place.

Areas of good practice

There were examples of good practice in respect of this domain found throughout this inspection in relation to staff training, adult safeguarding, infection prevention and control and the home's environment.

Areas for improvement

One area of improvement was identified during the inspection. This was with regard to updating the fire safety risk assessment.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

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

Discussions with the registered manager and the senior care assistant established that staff in the home responded appropriately to and met the assessed needs of the residents.

An inspection of one resident's care records confirmed that this was maintained in line with the legislation and standards. They included an up to date assessment of needs, life history, risk assessments, care plans and daily/regular statement of health and well-being of the resident.

Care needs assessments and risk assessments such as manual handling, nutrition and swallowing were reviewed and updated on a regular basis or as changes occurred.

The care records also reflected the multi-professional input into the resident's health and social care needs, and were found to be updated regularly to reflect the changing needs of the individual residents. The resident's representative was encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. The care records reviewed were observed to be signed by the resident's representative.

Discussion with staff confirmed that a person centred approach underpinned practice. This was evidenced through the staff in-depth knowledge and understanding of individual resident needs. Staff also had an excellent knowledge and understanding of residents' communication needs.

An individual agreement setting out the terms of residency was in place and appropriately signed.

Records were stored safely and securely in line with data protection.

The senior care assistant confirmed that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. It was also confirmed that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included multi-professional team reviews, staff meetings and staff shift handovers.

The registered manager and staff confirmed that management operated an open door policy in regard to communication within the home.

Observation of practice evidenced that staff were able to communicate effectively with residents.

An inspection of care records, along with accident and incident reports, confirmed that referral to other healthcare professionals was timely and responsive to the needs of the residents.

Areas of good practice

There were examples of good practice found throughout this inspection in relation to care records and communication between residents, their representatives and aligned health care professionals.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

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

The inspector met the two residents in the home at the time of this inspection. Due to levels of dependencies neither could articulate their views about the home. However, they both appeared comfortable, content and at ease in their environment and interactions with staff. Both residents appeared well cared for with attention to personal care and attire.

A range of policies and procedures were in place which supported the delivery of compassionate care.

Discussion with staff confirmed that residents' spiritual and cultural needs, including preferences for end of life care, were met within the home.

Discussions with the registered manager and senior care assistant confirmed that action was taken to manage any pain and discomfort in a timely and appropriate manner. This was further evidenced by inspection of care records with care plans in place for management of pain, which included trigger factors and prescribed interventions.

The senior care assistant confirmed that consent was sought in relation to care and treatment. Staff confirmed their awareness of promoting residents' rights, independence and dignity, and were able to demonstrate how residents' confidentiality was protected.

It was confirmed that residents were listened to, valued and communicated with in an appropriate manner. Observation of care practice and social interactions demonstrated that

residents were treated with dignity and respect. Observations of care practices confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff.

There were systems in place to ensure that the views and opinions of residents, and or their representatives, were sought and taken into account in all matters affecting them. These included care review meetings and day to day contact with management.

One resident in the home was out at a day care placement. The other two residents were resting in their rooms, relaxing with music being played in an appropriate genre of age group and choice.

Arrangements were in place for residents to maintain links with their friends, families and wider community. These included close contact with the residents' representatives in involving them with consultations, feedback and welcoming into the home.

Areas of good practice

There were examples of good practice in respect of this domain found throughout this inspection in relation to general observations of care practices and atmosphere in the home.

Areas for improvement

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

	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 registered manager and senior care assistant confirmed that the needs of residents were met in accordance with the home's statement of purpose and the categories of care for which the home was registered with RQIA.

A range of policies and procedures was in place to guide and inform staff.

There was a complaints policy and procedure in place which was in accordance with the legislation and Department of Health (DoH) guidance on complaints handling. Discussion with staff confirmed that they were knowledgeable about how to receive and deal with complaints. No expressions of complaint had been received.

There was an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. An inspection of accidents/incidents/notifiable events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. Learning from accidents and

incidents was disseminated to all relevant parties and action plans developed to improve practice.

There was a system to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

Discussion with the senior care assistant and inspection of staff training records confirmed that staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents.

A monthly monitoring visit was undertaken by the registered manager's wife (the registered provider) as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, trust representatives and RQIA to read.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability. This was outlined in the home's Statement of Purpose and Residents Guide.

Inspection of the premises confirmed that the RQIA certificate of registration and employer's liability insurance certificate were displayed.

The senior care assistant confirmed that there were effective working relationships with internal and external stakeholders.

The home had a whistleblowing policy and procedure in place and discussion with staff established that they were knowledgeable regarding this. The registered manager confirmed that staff could also access management to raise concerns and that appropriate support will be given.

Discussion with senior care assistant confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised. The senior care assistant also confirmed there were open and transparent methods of working and effective working relationships with internal and external stakeholders.

Areas of good practice

There were examples of good practice in respect of this domain found throughout this inspection in relation to governance arrangements and maintenance of good working relationships.

Areas for improvement

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

	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 Rosaleen McTaggart, senior care assistant, 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 to Care.Team@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan	
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 27(4)(a) **Stated:** First time	The registered person shall ensure that update the home's fire safety risk assessment is updated by an the appropriately certificated professional. Ref: 6.4
To be completed by: 17 September 2017	**Response by registered person detailing the actions taken:** Fire training and risk assessment completed .

Please ensure this document is completed in full and returned to Care.Team@rqia.org.uk from the authorised email address

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