The Regulation and Quality Improvement Authority

Calder Fountain
RQIA ID: 1584
Centenary House
2 Victoria Street
Belfast

Inspector: Alice McTavish
Inspection ID: IN023288

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Unannounced Care Inspection of Calder Fountain

4 February 2016

1. Summary of inspection

An unannounced care inspection took place on 4 February 2016 from 10.50 to 13.15. On the day of the inspection we found the home to be delivering safe, effective and compassionate care. The standards we inspected were assessed as being met.

The Salvation Army plans to deregister Calder Fountain as a residential care home and only one resident was accommodated. We were advised that the local Health and Social Care Trust was working to identify suitable alternative accommodation for the resident.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and The DHSSPS Residential Care Homes Minimum Standards (2011).

1.1 Actions/enforcement taken following the last inspection

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

1.2 Actions/enforcement resulting from this inspection

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

1.3 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

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: The Salvation Army/Kirsten Watters	**Registered Manager:** Elaine Hamill
Person in charge of the home at the time of inspection: Elaine Hamill	**Date manager registered:** 01 October 2007
Categories of care: RC-A, RC-D, RC-MP, RC-E	**Number of registered places:** 4
Number of residents accommodated on day of inspection: 1	**Weekly tariff at time of inspection:** £470

3. Inspection focus

The inspection sought to determine if the following standards had been met:

Standard 5 **Each resident has an up-to-date assessment of their needs**

Standard 6 **Each resident has an individual and up-to-date comprehensive care plan**

4. Methods/processes

Prior to inspection we analysed the following records; the returned QIP from the previous inspection and notifications of accidents and incidents.

During the inspection we met with one resident, the registered manager and one support worker.

We examined the care records of one resident, the accident and incident register and the complaints and compliments register.

5. The inspection

5.1 Review of requirements and recommendations from previous inspection

The previous inspection of the home was an unannounced care inspection dated 22 October 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of requirements and recommendations from the last care inspection

Previous inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13 (8)	The registered manager must ensure that people accommodated elsewhere within the building cannot have free access to the residential unit.	Met
	Action taken as confirmed during the inspection: Discussion with the registered manager and inspection of the premises confirmed that a swipe card entry system was installed to ensure that people accommodated elsewhere in the building could not have free access to the residential unit. The resident was in possession of a card to allow free access to and from the residential unit.	

Previous inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 21.1	The registered manager should ensure that the policy for end of life care references current best practice guidance.	Met
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that the relevant department within The Salvation Army was advised of the need to update the policy for end of life care to reference current best practice guidance.	

5.3 Standard 5: Each resident has an up-to-date assessment of their needs

Is care safe? (Quality of life)

We inspected the care records of one resident and found that the resident was involved in the process of assessment of their individual needs. The home had completed an initial assessment of need at the time of referral and this was revised shortly after admission. The needs assessments contained comprehensive details of the resident's physical, social, emotional, psychological and spiritual needs. Information was present about the resident's life history and current situation. Where risks had been identified, these were noted along with clear direction as to how care should be safely delivered. The care records noted the names and contact details of other professionals or agencies providing a service to the resident.

Is care effective? (Quality of management)

The care needs assessment was kept under continual review, amended as changes occurred and were kept up to date to accurately reflect at all times the needs of the resident. This supported effective care.

Is care compassionate? (Quality of care)

The assessment of need was signed by the resident. We found that the written care needs assessment took into account the privacy and dignity of the resident. It also clearly reflected the values which underpin compassionate care.

Areas for improvement

There were no areas of improvement within the standard inspected. This standard was met.

Number of requirements:	0	Number of recommendations:	0

Standard 6: Each resident has an individual and up-to-date comprehensive care plan

Is care safe? (Quality of life)

In our inspection of the care plan for one resident we found that the daily care, support, opportunities and services provided by the home and others were comprehensively detailed. Where the resident's specific needs and preferences were identified, the care plan indicated how these were met.

The care plan described how identified risks were managed, minimised, reported, monitored and reviewed. The care plan reflected information about the resident's lifestyle and this was used to inform care practice. The resident's daily routines and weekly programmes were set out. Where restrictions arising from risk assessments were in place, or any behaviours likely to pose a risk for the resident or others, these were recorded.

Is care effective? (Quality of management)

We found that the care plan was signed by the resident, by the staff member responsible for drawing it up and the registered manager. We found that the care plan was reviewed monthly and was amended to reflect the current needs of the resident. The care plan was reviewed monthly and any changes in the care required were noted.

Is care compassionate? (Quality of care)

In our discussions with the registered manager and with care staff we found that the resident had been encouraged to actively contribute to the care planning process. We found that the care plan was written in a manner which reflected a respectful approach to care delivery. This supports the delivery of compassionate care.

Areas for improvement

There were no areas of improvement within the standard inspected. This standard was met.

Number of requirements:	0	**Number of recommendations:**	0

5.4 Additional areas examined

5.4.1 Residents' views

We met with the resident who indicated that they were happy with their life in the home, their relationship with staff and the provision of care.

Some comments included:

- "It's going well here."

5.4.2 Staff views

We met with one staff member who spoke positively about their role and duties, staff morale, teamwork and managerial support within the residential care unit. Staff indicated to us that they felt well supported by training and are given the necessary resources to fulfil their duties.

5.4.3 Environment

We found the home to be clean and tidy.

5.4.4 Staffing

At the time of inspection the following staff members were on duty:

- 1 x manager
- 1 x support worker

One support worker was scheduled to be on duty later in the day. One support worker was scheduled to be on overnight duty. The registered manager advised us that staffing levels were appropriate for the dependency level of the resident accommodated.

5.4.5 Care practices

In our discreet observations of care practices we were satisfied that the resident was treated with dignity and respect.

5.4.6 Accidents/incidents

A review of the accident and incident notifications since the previous inspection established that these had been reported and managed appropriately.

5.4.7 Complaints/compliments

Our inspection of the complaints register confirmed that complaints are recorded and managed appropriately.

Areas for improvement

There were no areas of improvement within the additional areas inspected.

Number of requirements:	0	**Number of recommendations:**	0

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Elaine Hamill	**Date completed**	7/3/16
Registered Person		**Date approved**	08/03/16
RQIA inspector assessing response	Alice McGavigh	**Date approved**	11/04/2016

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

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