

Inspection Report

17 June 2021



Barnvale Cottage

Type of Service: Residential Care Home
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Greenvale House Responsible Individual: Mrs Margaret Foster	Registered Manager: Mrs Barbara Frances Foster Date registered: 18 June 2013
Person in charge at the time of inspection: Mrs Barbara Frances Foster	Number of registered places: 7 The home is also approved to provide care on a daily basis only to 2 persons for 5 days each week (mon-fri 9am-4pm) ensuring there is no more than 7 persons in the home at any one time.
Categories of care: Residential Care (RC) LD – Learning disability. LD(E) – Learning disability – over 65 years.	Number of residents accommodated in the residential care home on the day of this inspection: 7
Brief description of the accommodation/how the service operates: This is a registered Residential Home which provides health and social care for up to seven persons who have a learning disability. Resident bedrooms are located over two floors. Residents have access to communal lounges, a dining room and gardens.	

2.0 Inspection summary

An unannounced inspection took place on 17 June 2021 from 9.50am to 5.00pm by two care inspectors.

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

Residents spoke positively on living in the home. Residents unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. It was evident that staff promoted the dignity and well-being of residents through their practices and when communicating with them. Comments received from residents and staff are included in the main body of this report.

One area for improvement was identified in relation to staffs' training. Addressing the area for improvement will further enhance the quality of care and services in Barnvale Cottage. Good practice was observed with the delivery of compassionate care, the environment, provision of activities, record keeping and with the governance measures in place to monitor the care provision in the home.

RQIA was assured that the delivery of care and service provided in Barnvale Cottage was safe, effective and compassionate and that the home was well led.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with residents, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were discussed with Barbara Foster, Registered Manager, at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we engaged with all seven residents in the home; the staff member on duty and the registered manager. The residents were clearly happy living in the home and described how they spent their day and the things that they enjoyed doing. The staff on duty confirmed that they were happy working in the home; that they felt well supported from management and that they enjoyed working with all the residents.

There were no responses received from questionnaires or the online survey.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 4 April 2021		
Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005		
Area for improvement 1 Ref: Regulation 13 (4) Stated: First time	The registered person shall ensure that the personal medication records are fully and accurately maintained.	Met
	Action taken as confirmed during the inspection: Four personal medication records were reviewed. They were up to date and correlated with the pre-printed medication administration records. For two residents the allergy status was not recorded. This was discussed with the manager who agreed to update.	
Area for improvement 2 Ref: Regulation 13 (4) Stated: First time	The registered person shall ensure that the medication administration records are accurately maintained.	Met
	Action taken as confirmed during the inspection: The four medication administration records reviewed had been accurately maintained.	

Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011)		Validation of compliance
Area for improvement 1 Ref: Standard 4 Stated: First time	The registered person shall ensure that the identified resident's nutrition care plans are updated to reflect the resident's current nutritional plan of care. Any changes to residents' care files should be signed and dated by the person making the change.	Met
	Action taken as confirmed during the inspection: The resident's care file had been updated appropriately.	
Area for improvement 2 Ref: Standard 30 Stated: First time	The registered person shall implement a robust audit system which covers all aspects of the management of medicines.	Carried forward to the next inspection
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. Staff were provided with a comprehensive induction programme to prepare them for working with the residents.

There were systems in place to ensure staff were supported to do their job. For example, staff received regular training in a range of topics such as infection prevention and control (IPC), resident moving and handling and fire safety. A training matrix was maintained to monitor staffs' compliance with training, however, a review of this matrix evidenced gaps in the training compliance where training had either not been completed or had lapsed. As there was only one staff member allocated to work in the home at any given time, this was discussed with the manager and identified as an area for improvement.

The staff member confirmed that they felt well supported in their role and were satisfied with the level of communication between staff and management. The staff member was of the opinion that one staff could easily meet the needs of the seven residents accommodated in the home. A duty rota was maintained to evidence which staff worked in the home and when.

Residents spoke highly on the care that they received. It was observed that care was delivered in a caring and compassionate manner. It was clear through observation of the interactions between the residents and the staff member that they knew one another well and enjoyed each other's company.

5.2.2 Care Delivery and Record Keeping

Staff met at each shift change to discuss any changes in the needs of the residents. Residents' care records were maintained which accurately reflected their needs. Staff were knowledgeable of residents' individual needs, their daily routines, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner and by offering personal care to residents discreetly. This was good practice. Residents were presented well in their appearance.

There were no wounds in the home and there were no practices in the home which would be considered as restrictive such as the use of bed rails, alarm mats or tag monitors. Residents were free to go out for a walk when they wanted and no resident was under continuous supervision in the home.

The number of falls in the home was low. On admission a falls risk assessment was completed to determine the risk of falls and identified the actions to take should a fall occur. This assessment was reviewed on a monthly basis. There was a system in place to ensure accidents and incidents were notified, if required, to residents' next of kin, their care manager and to RQIA.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this could include simple encouragement through to full assistance from staff. The mealtime was a pleasant and unhurried experience for the residents. Food was freshly prepared in the kitchen and residents dined together in the dining area. Residents were involved in the mealtime experience through various activities such as setting the table, pouring drinks, escorting other residents safely to the dining area, serving meals and with clearing the table.

The food served was attractively presented and smelled appetising and portions were generous. There was a variety of drinks available served with meals. Residents spoke positively on the food that they received. Residents, who could, had access to the kitchen to make their own cup of tea or preferred drink and get snacks when they wanted. Other residents had these provided regularly. Residents' weights were monitored monthly and there was no notable residents' weight loss in the home.

Residents' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs and included any advice or recommendations made by other healthcare professionals. Residents' care records were held confidentially.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

Residents' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each residents' care needs and what or who was important to them.

Daily records were kept of how each resident spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces, the kitchen, laundry and communal areas such as lounges and bathrooms. The home was warm, clean and comfortable. It was noted that staff adhered to best practice in infection prevention and control. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible.

Residents' bedrooms were personalised with items important to them. Bedrooms and communal areas were tastefully decorated and suitably furnished. Residents could choose where to sit; in one of the communal rooms, their bedrooms or outside and staff were observed supporting residents to make these choices.

One storage area was observed to have wooden slot shelving which could not be effectively cleaned. Photographic evidence sent to RQIA following the inspection showed that the shelving had been replaced with an easily wipeable surface.

Outside of the home, the gardens and surrounding areas were well maintained. Peacocks roamed freely around the gardens and guinea fowl were also kept in an identified area. Residents had access to walk in the gardens when they wanted to. There was also an enclosed area with a swing and a seated area along with a table and benches. This area led to an activity room which residents also had access to whenever they wanted.

The manager told us that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for residents and staff. To date there has been no outbreaks of infection in the home.

All visitors to the home had a temperature check and symptom checks when they arrived at the home. They were also required to wear personal protective equipment (PPE). Visiting arrangements were managed in line with Department of Health and IPC guidance. Residents were free to leave the home with their visitors adhering to PPE and DOH guidelines.

Review of records, observation of practice and discussion with staff confirmed that effective training on IPC measures and the use of PPE had been provided. We did discuss the provision of additional hand hygiene measures for staff which the manager agreed to review. The manager monitored the staffs' hand hygiene practice and PPE usage regularly and infection control audits were maintained monthly.

5.2.4 Quality of Life for Residents

Discussion with residents confirmed that they were able to choose how they spent their day. For example, residents could have a lie in or stay up late to watch TV. Residents confirmed that they could go out for a walk when they wanted, remain in their bedroom or go to a communal room when they requested.

The provision of social activities was discussed and agreed at residents' meetings. Activities were provided on a resident group basis but also took into account those who did not wish to engage in group activities. The activities provided included arts and crafts, games, drawing, pampering, music and the activities room had a pool table, air hockey, gym, Pac Man video game, foot spas and a variety of games.

Residents spoke fondly of regular outings from the home to several destinations of interest to them and how they enjoyed going for ice cream, McDonalds takeaway and/or picnics. Infection control measures were taken during outings.

Residents also discussed how they assisted in household tasks in the home. Some were involved with hoovering and dusting in the home and some were involved in baking and cooking. The household tasks were voluntary.

The residents also spoke of how special days such as birthdays were celebrated in the home. There was evidence of a recent birthday party at the dining area with birthday balloons still inflated. Residents told us that they get their favourite foods served at these parties.

Individual residents' records of activity involvement were maintained.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Visiting arrangements were in place with positive benefits to the physical and mental wellbeing of residents.

There was evidence that residents were supported to have meaning and purpose to their day.

5.2.5 Management and Governance Arrangements

The staff member was aware of their own role in the home and how to raise any concerns or worries about residents, care practices or the environment. There has been no change in the management of the home since the last inspection. Mrs Barbara Foster has been the registered manager in this home since 18 June 2013.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to residents. The manager or members of the team completed regular audits to support the safe delivery of care and the smooth running of the home.

There was a system in place to manage complaints. There had been no complaints recorded for the home. We discussed that any area of dissatisfaction should be recorded as a complaint. A compliments file had been maintained and shared with staff.

The staff member commented positively about the manager and the management team and described them as supportive, approachable and always available for guidance. Discussion with the manager and the staff member confirmed that there were good working relationships between staff and management.

Records of accidents and incidents which had occurred in the home were maintained and monitored monthly. The number of accidents/incidents in the home was low. None of the recorded accidents/incidents were notifiable to RQIA. The manager was aware of the incidents which were notifiable to RQIA.

The home was visited each month by a representative of the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These were available for review by residents, their representatives, the Trust and RQIA.

6.0 Conclusion

Residents in the home were afforded choice on how to spend their day and staff supported residents with their choices. The residents told us that they were happy living in the home. Systems were in place to ensure the safe running of the home and management were always available to provide assistance and/or guidance. The delivery of care in the home was both caring and compassionate. Records were maintained to evidence how residents spent their day. Residents care records had been well maintained. The environment was warm clean and comfortable and the home and surrounding grounds had been maintained well.

Based on the inspection findings and discussions held there was evidence that this service is providing safe and effective care in a caring and compassionate manner and that it is well led by the manager/management team.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes' Minimum Standards (August 2011).

	Regulations	Standards
Total number of Areas for Improvement	0	2*

*The total number of areas for improvement includes one which has been carried forward for review to the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Barbara Foster, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011)	
Area for improvement 1 Ref: Standard 30 Stated: First time To be completed by: From the date of the inspection	The registered person shall implement a robust audit system which covers all aspects of the management of medicines. Ref: 5.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection.
Area for improvement 2 Ref: Standard 23.3 Stated: First time To be completed by: 17 August 2021	The registered person shall review the system to monitor staffs' mandatory training to ensure completion of the training in a timely manner. Ref: 5.2.1
	Response by registered person detailing the actions taken: A system has been put in place to ensure staffs mandatory training is completed in a timely manner.

Please ensure this document is completed in full and returned via Web Portal



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