The Regulation and Quality Improvement Authority

Beltany House
RQIA ID: 1868
15 Beltany Road
Omagh
BT78 5NA

Inspector: Laura O'Hanlon
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Unannounced Care Inspection of Beltany House

10 December 2015

1. Summary of inspection

An unannounced care inspection took place on 10 December 2015 from 10.30 to 15.45. On the day of the inspection the home was found to be delivering safe, effective and compassionate care. The standards we inspected were assessed as being met. No areas for improvement were identified.

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: Western Health and Social Care Trust	**Registered Manager:** Margaret Dolan (acting)
Person in Charge of the Home at the Time of Inspection: Stefanie Broderick	**Date Manager Registered:** Awaiting appointment of permanent manager
Categories of Care: RC-LD(E), RC-LD	**Number of Registered Places:** 3
Number of Residents Accommodated on Day of Inspection: 3	**Weekly Tariff at Time of Inspection:** Night rates £9.00 – £12.00 Day sitting rate - £2.per hour

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 previous inspection report, the returned quality improvement plan and the notification of accidents and incidents.

We met with three residents, one service user who avails of a sitting service and two members of the care staff.

We inspected the following records: two care records, accident /incident reports, registered provider visits, fire safety records, complaints/compliments records and the record of residents meetings.

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 6 August 2015. The completed QIP was returned and was approved by the care inspector.

5.2 Review of requirements and recommendations from the last care inspection dated 6 August 2015

Previous Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref:** Regulation 17 (1)	The registered person must ensure that an annual quality monitoring report is undertaken no less than annually. The registered person must complete the annual quality report for 2014-15.	**Met**
	Action taken as confirmed during the inspection: An annual quality review report was completed for 2014-15. This report was available during the inspection.	

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

Is care safe? (Quality of life)

The person in charge confirmed that residents and /or their representatives are encouraged and enabled to participate in the assessment process. The two care records inspected contained an assessment completed by the professionals involved. The care records noted the names and contact details of other professionals or agencies providing a service to the resident.

In addition to this, a client profile was completed by the parents/carers of the residents. This person centred assessment contained comprehensive details of each resident's physical, social, emotional, psychological and spiritual needs including identified risks. Information was also present in regard to the resident's life history and current situation. This assessment referred to specific needs of residents, for example particular bedtime habit/routine. This practice is to be commended.

Is care effective? (Quality of management)

The home had a policy in place named 'Assessment, care planning and reviewing the care of residents and their needs.' The care needs assessment was kept under continual review. At each respite admission to the home a care plan review was completed to reassess the needs of the residents. A review of two care records confirmed that the care plan review was completed and signed by the resident or their representative.

Is care compassionate? (Quality of care)

We found the assessment to be appropriately signed. We noted 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 for improvement identified within the standard inspected. This standard was assessed as being 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)

The person in charge of the home confirmed that residents and /or their representatives are encouraged and enabled to participate in the care planning process. The two care records inspected contained a comprehensive care plan which were appropriately signed.

We noted care plans reflected residents' daily care needs and support, opportunities and the services provided by the home. Where residents' specific needs and preferences were identified, the care plan indicated how these were met.

The two care plans outlined the management of risks and how identified risks were managed, minimised, reported, monitored and reviewed. The care plans reflected information about each resident's lifestyle and this was used to inform care practice. The residents' 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. We found evidence that restrictions were regularly reviewed and removed when no longer required.

Is care effective? (Quality of management)

We found that the care plans were appropriately signed. We found that care plans were reviewed and amended to reflect the current needs of the residents. The care plans were supported by separate dependency assessments, manual handling risk assessments, falls risk assessments and continence assessments.

Is care compassionate? (Quality of care)

In our discussions with the care staff we found that residents and/or their representatives had been encouraged to actively contribute to the care planning process. We found that the care plans were 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 for improvement identified within the standard inspected. This standard was assessed as being met.

Number of requirements:	0	Number of recommendations:	0

5.4 Additional areas examined

5.4.1 Residents' views

We met with three residents and one service user who availed of a sitting service. We observed residents relaxing in the communal lounge area. In accordance with their capabilities, residents expressed that they were happy and content with their life in the home. They expressed their satisfaction with the facilities and services provided and their relationship with staff.

A comment made was:

- "The food is good. I am well looked after, they all know me well."

5.4.2 Staff views

We spoke with two care staff members individually. Staff advised us that they felt supported in their respective roles. The staff related that they had been provided with the relevant resources to undertake their duties. Staff demonstrated to us that they were knowledgeable of the needs of individual residents. The staff stated that they felt supported by the current acting manager and advised that she was very approachable.

A comment made was:

- "We are all a family and we treat each other as family. An exceptional standard of care is provided."

5.4.3 Relative's views

We spoke with one relative. This relative praised the standard of care provided in the home. He commented that the staff knew his relative very well and staff were approachable in regard to any areas of concern.

5.4.4 Environment

We found that the home was clean, organised and adequately heated. We observed residents' bedrooms to be homely and personalised. Décor and furnishings were found to be of a satisfactory standard.

5.4.5 Care practices

We found the atmosphere in the home was friendly and welcoming. We observed staff to be interacting with residents in a respectful, polite, warm and supportive manner. Residents were well dressed with attention to personal detail.

5.4.6 Fire safety

The fire safety risk assessment which was available during the inspection was dated 22 October 2014. The person in charge subsequently confirmed by email that an updated fire safety risk assessment had been completed on 5 November 2015.

We reviewed the fire safety records and could confirm that fire safety training was last undertaken on 8 September 2015. The records indicated that a fire drill took place on 3 December 2015.

5.4.7 Accidents / incident reports

We reviewed accident/incident records which have occurred since the previous inspection and found these to be appropriately managed and reported.

5.4.8 Complaints / compliments records

In our inspection of complaint records and discussion with the person in charge we confirmed that complaints had been managed appropriately.

5.4.9 Visits by the Registered Provider

We reviewed the record of monthly monitoring visits and could confirm these visits were unannounced and were undertaken on a monthly basis.

Areas for improvement

There were no areas of improvement identified with the additional areas examined.

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	Margaret Dolan	**Date Completed**	23.12.15
Registered Person	Elaine Way	**Date Approved**	6.1.16
RQIA Inspector assessing response	Laura Hall	**Date Approved**	25.1.16

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

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