The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rigby Close

Provider: Belfast Health and Social Care Trust (BHSCT)

Date of Inspection: 6 January 2025

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Belfast Health and Social Care Trust (BHSCT)
Responsible Individual:	Mrs Maureen Edwards
Registered Manager:	Mrs Arlene Kerr
Service Profile: This is a registered residential care home which provides social care for up to two residents under and over the age of 65 years with learning disability. Resident areas are located on ground floor level and there is a communal lounge and kitchen. Residents have access to an enclosed yard and a small patio area.	

2.0 Inspection summary

An unannounced inspection took place on 6 January 2025 from 11 am to 2 pm, by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to residents and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of residents and that staff were knowledgeable and well trained to deliver safe and effective care.

This inspection resulted in no areas for improvement being identified.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the 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 resident's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

No residents or relatives were present in the home at the time of the inspection and no questionnaire responses were received following the inspection.

Staff said that they were happy working in the home and that they had no concerns about staffing arrangements or the running of the home. No staff survey responses were received following the inspection.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of residents. There was evidence of robust systems in place to manage staffing.

Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.

Review of the staff duty rotas evidenced that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide the residents with a choice on how they wished to spend their day. For example, supporting residents to move around the communal areas of the home or attending day centre.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of residents. Staff were knowledgeable of individual residents' needs, their daily routine wishes and preferences.

Discussion with staff and review of care records evidenced that staff had a good understanding of the residents' needs and recognised any early signs of distress or illness, including non-verbal cues.

Discussion with the manager and observations of the environment established that the manager ensured that the environment was conducive to the residents' needs. For example, ensuring that furnishings were appropriately positioned so that residents could move with ease around the communal areas.

At times some residents may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard residents and to manage this aspect of care.

Where a resident was at risk of falling, measures to reduce this risk were put in place. For example, keeping communal areas clutter free to reduce trip hazards.

Examination of care records confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Discussion with staff and review of care records evidenced that staff ensured that residents were provided with meals they enjoyed. Staff provided assistance and encouragement with meals where required.

Review of records indicated that there were robust systems in place to manage residents' nutrition and mealtime experience.

Review of records evidenced that life story work was completed with the resident and significant others, such as family and Trust key workers. Staff were knowledgeable about the resident's interests and this enabled staff to engage in a more meaningful way with the resident.

Activities were planned daily and bespoke to the residents' preferred interests and routine.

3.3.3 Management of Care Records

Residents' needs were assessed by a suitably qualified member of staff 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 person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. Care staff recorded regular evaluations about the delivery of care. 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.

3.3.4 Quality and Management of Residents' Environment Control

The home was clean and tidy. For example, the resident's bedroom was personalised with items important to the resident. Bedrooms and communal areas were suitably furnished, warm and comfortable.

Some areas of the home were in need of repair and redecorating. The manager provided evidence of a refurbishment plan and confirmed that the request for these improvements had been approved by the BHSCT. This will be reviewed at the next inspection.

Review of records and discussion with the manager confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home was safe to live in, work in and visit. For example, fire safety checks, resident call system checks, electrical installation checks and water temperature checks.

Fire safety measures were in place. Fire doors were free from obstruction and fire extinguishing equipment was available and accessible. The most recent fire risk assessment was conducted on 11 March 2024 and resulted in no recommendations being made. Records evidenced that all staff participated in fire drills and the manager had oversight of this.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.4 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Andrea Kerr has been the manager in this home since 10 February 2021.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the management team responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

While no residents or relatives were present during the inspection to ask their opinions on the running of the home, the manager confirmed that a satisfaction survey had recently been sent to all relevant parties. There had been no responses at the time of inspection, this will be reviewed at the next care inspection.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Andrea Kerr, Manager, as part of the inspection process and can be found in the main body of the report.

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews