The Regulation and Quality Improvement Authority

# Inspection Report

## 8 April 2024

# Haypark

**Type of Service: Residential Care Home**
**Address: 36 Whitehall Parade, Belfast, BT7 3GX**
**Tel no: 028 9064 1784**

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:**<br>Haypark Homes Ltd<br><br>**Registered Person/s OR Responsible Individual:**<br>Mr J McWhirter | **Registered Manager:**<br>Mrs Jennifer McClean<br><br>**Date registered:** 01 April 2005 |
| **Person in charge at the time of inspection:**<br><br>Madge Murphy – Senior Care Manager | **Number of registered places:**<br>30<br><br>There shall be one identified resident in category RC-MP/MP (E). RC-DE for a maximum of five residents only. |
| **Categories of care:**<br>Residential Care (RC)<br>I – Old age not falling within any other category.<br>DE – Dementia.<br>MP – Mental disorder excluding learning disability or dementia.<br>MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. | **Number of residents accommodated in the residential care home on the day of this inspection:**<br><br>25 |
| **Brief description of the accommodation/how the service operates:**<br>This home is a registered Residential Care Home which provides health and social care for up to 25 residents. The home is divided over three floors. Residents have access to communal lounges, a dining room and outside space. | |

## 2.0 Inspection summary

An unannounced inspection took place on 8 April 2024, from 8.50 am to 5.15 pm by a care inspector.

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.

The home was clean, tidy and well maintained. The majority of staff were attentive to the needs of residents and carried out their work in a compassionate manner.

There was a concern identified by the inspector in relation to an interaction between one staff member and one resident. This was escalated, by the inspector, to the management team and the Belfast Health and Social Care Trust for action.

Specific comments from residents and staff are included in the main body of this report.

Areas requiring improvement have been identified during this inspection and details of these can be found in the main body of this report and in the Quality Improvement Plan (QIP) in section 6.0.

Addressing the areas for improvement will further enhance the quality and care of services in Haypark. The findings of this report will provide the manager with the necessary information to improve staff practice and the residents' lived experience.

## 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.

Questionnaires 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 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.

The findings of the inspection were discussed with the management team at the conclusion of the inspection.

## 4.0 What people told us about the service

Residents told us they were happy living in the home, they felt well looked after and listened to by staff and management. Residents comments included “staff are lovely”, “the manager is great” and “staff are kind”.

Staff spoke positively in terms of the provision of care in the home and their roles and duties. Staff told us that management were supportive, team work was good and that they enjoyed working in the home.

Four questionnaire responses were received from residents and family members and all confirmed they were satisfied with the care provided in the home.

## 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 27 April 2023** | | |
|---|---|---|
| **Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref:** Regulation 21 (a) (b)<br><br>**Stated:** First time | The registered person shall ensure that all persons are recruited in accordance with best practice and legislation, prior to commencing employment in the home; and that this is fully evidenced in staff recruitment records.<br>With specific reference to ensuring:<br>• there are two written references, one of which should be from the employees present or most recent employer prior to commencing employment<br>• files have a clear documented start date of the staff member<br>• evidence is available that the person is physically and mentally fit for the purposes of their duties. | **Met** |

| | | |
|---|---|---|
| | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was met. | |
| **Area for improvement 2**<br><br>**Ref:** Regulation 20 (1) (c) (i)<br><br>**Stated:** First time | The registered person shall ensure that newly appointed staff are provided with a robust induction programme, and this is completed in a timely manner, signed off by the manager and available for inspection in staff recruitment records. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was met. | |
| **Area for improvement 3**<br><br>**Ref:** Regulation 10 (1)<br><br>**Stated:** Second time | The registered person shall implement robust governance and management systems to ensure effective managerial monitoring and oversight of the day to day service provided by the home.<br><br>This relates specifically to the robust completion and/or oversight of governance quality assurance audits by the manager. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was met. | |
| **Area for improvement 4**<br><br>**Ref:** Regulation 16 (1) and (2) (b)<br>**Stated:** First time | The registered manager should ensure that the written care plan is prepared in consultation with the resident as to how the residents needs are to be met, and that this plan is kept under regular review. | **Not met** |
| | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was not met and it has been stated for a second time | |
| **Area for improvement 5**<br><br>**Ref:** Regulation 27(4)(a). | The registered manager should ensure that the action plan attached to the home's fire risk assessment is fully implemented within the timeframe stipulated. | **Met** |

| | | |
|---|---|---|
| **Stated:** First time | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was met. | |
| **Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref:** Standard 25<br><br>**Stated:** Second time | The registered person shall ensure that the duty rota identifies the person in charge of the home in the absence of the manager. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was met. | |
| **Area for improvement 2**<br><br>**Ref:** Standard 24.2<br><br>**Stated:** First time | The registered person shall ensure that staff have recorded formal supervision no less than every six months. | **Not met** |
| | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was not met and it has been stated for a second time. | |
| **Area for improvement 3**<br><br>**Ref:** Standard 35<br><br>**Stated:** First time | The registered person shall ensure there is a managed environment that minimises the risk of infection. This is stated in relation to the storage of continence products. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was met. | |
| **Area for improvement** 4<br><br>**Ref:** Standard 32.1<br><br>**Stated:** First time | The registered person shall ensure that medicines are stored safely under conditions that confirm to manufacturers requirements. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was met. | |
| **Area for improvement** 5<br><br>**Ref:** Standard 13 | The registered person shall ensure that the programme of activities is displayed in a suitable format and location, and that a record is kept of all activities that take place. | **Partially met** |

| | | |
|---|---|---|
| **Stated:** First time | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was partially met and it has been stated for a second time. | |
| **Area for improvement** 6<br><br>**Ref:** Standard 1.2<br><br>**Stated:** First time | The registered person shall ensure the home has systems where residents can express their views and be consulted about the running of the home. This is stated in relation to resident's meetings. | **Not met** |
| | **Action taken as confirmed during the inspection**:<br>There was evidence that this area for improvement was not met and has been stated for a second time. | |

## 5.2 Inspection findings

### 5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect residents.

There were systems in place to ensure staff were trained and supported to do their job. A review of staff records confirmed that all staff had completed an induction within the home. A review of the staff training matrix evidenced that Deprivation of Liberty Safeguards (DoLS) training had not been completed by staff or management. An area for improvement has been identified.

The staff duty rota accurately reflected the staff working in the home. The duty rota identified the person in charge when the manager was not on duty.

Although it was established that there were enough staff in the home to respond to the needs of residents in a timely way, it was evident that the skills mix of staff on duty required to be reviewed by management. For example, the staff on duty was a combination of new staff, who were still on induction; agency staff and one senior care assistant who was completing medication tasks. This was discussed with the manager who agreed to review the rota to ensure, where possible, the staffing skills mix was more evenly balanced with experienced staff. This is an important way to ensure consistency and continuity for the care of residents. An area for improvement has been identified.

There were competency and capability assessments in place for staff left in charge of the home in absence of the manager.

Review of the staff supervision matrix highlighted that staff had not received supervision in line with the required minimum standard of twice per year. An area for improvement has been identified for a second time.

All staff received an annual appraisal and records were maintained.

There were systems in place to monitor staff registration with the Northern Ireland Social Care Council (NISCC).

Staff spoke positively about teamwork, and confirmed that management team supported them to fulfil their role and that communication between staff and management was good.

### 5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of residents. Staff demonstrated their knowledge of individual resident's needs, preferred daily routines and likes/dislikes.

The majority of staff were observed to be prompt in recognising residents' needs and any early signs of distress, including those residents who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs. However; there was one particular interaction between one staff member and resident that was not managed well and required the inspector to intervene and escalate through to the management team and the Belfast Health and Social Care Trust (BHSCT) for their consideration.

It was observed that staff respected resident's 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.

There was a concern noted with one resident's foot care. Details were discussed with the management team who agreed to ensure arrangements were put in place to review the need for podiatry services for all residents and the named residents care manager was to be informed of their specific issue. This was confirmed as completed following the inspection, however due to the number of residents this involved and the lack of any effective monitoring system, an area for improvement has been identified.

Review of care records confirmed that residents' needs were assessed at the time of admission to the home. Following initial assessment, care plans were developed to direct staff on how to meet residents' needs. This included any advice or recommendations made by other healthcare professionals; for example, the Speech and Language Team (SALT).

Some care records had not been regularly reviewed or updated to ensure they continued to meet the residents' needs. For example, one resident who was assessed as needing a Deprivation of Liberty Safeguard (DoLS), had no care plan for this. Another resident who required one to one staff support to manage specific care needs, had no care plan or risk assessment in place for this. Two areas for improvement have been identified, one for a second time.

Daily records were kept in relation to how each resident spent their day and the care and support provided by staff; these records were person centred.

There was a concern noted with the storage of some of the residents' records as they were left unattended and accessible outside residents' bedrooms, there was also information about individual residents' dietary needs available on a notice board in the dining room for anyone entering the dining room to read. These were removed by the inspector and the responsible individual and provided to management to store confidentially. An area for improvement has been identified.

Examination of records and discussion with the management team confirmed that where a resident was at risk of falling, measures to reduce this risk were put in place and were well managed.

A review of how restrictive practices and Deprivation of Liberty Safeguards (DoLS) were managed indicated that some of the records in place lacked information. Details were discussed with the management team who agreed to follow the specific residents needs with their care manager. This was confirmed after the inspection by email as completed.
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 may include simple encouragement through to full assistance from staff. There was a menu on display and residents were provided with a choice of food options at each meal time.

Staff ensured that residents were comfortable, had a pleasant social experience and a meal that they enjoyed. However, it was noted that one staff member continued to stand while assisting a resident with their lunch. This is not good practice and was discussed with the management team for them to address it with the staff member concerned.

The food was freshly prepared in the kitchen and appeared appetising, residents told us that they enjoy the food in the home. Kitchen staff told us how they were informed of resident's nutritional needs and confirmed that residents care records were important to ensure residents receive the right diet. However, it was observed that one resident's dessert was not modified in keeping with their Speech and Language recommendations. This was quickly resolved by kitchen staff who were present in the dining room. Advice was provided to the management team about the importance of staff using Speech and Language placemats for residents that require them and utilising the mealtime matters 'safety pause' and to help embed good practice during all mealtimes in the home. An area for improvement has been identified.

There was evidence that residents' weights were checked at least monthly to monitor weight loss or gain and onward referral to the relevant professionals where necessary.

### 5.2.3 Management of the Environment and Infection Prevention and Control

The home is an older, period style building that has been converted into a residential care facility. The home was warm and comfortable for residents. Bedrooms were clean, tidy and personalised with photographs and other personal belongings. There were no malodours detected in the home.

There were three wardrobes not attached to the walls of resident's bedrooms, as per health and safety requirements. This was brought to the attention of the management team who provided assurances that this would be actioned without delay, written confirmation was received post-inspection that this had been completed.

Observation of the home's environment evidenced that cleaning chemicals and medicines were not safely stored in keeping with Control of Substances Hazardous to Health (COSHH) regulations and medicines management requirements. This was brought to the attention of the management team immediately for removal of the items to a safe storage facility to reduce the risk of harm to anyone using or potentially accessing them. An area for improvement has been identified.

There was a bath panel that was cracked and needed to be replaced. The management team confirmed post inspection that this had been completed.

Corridor's and fire exits were clear of clutter and obstruction. The Fire Risk Assessment for the home was completed on 15 January 2024 and all actions had been completed as required.

Systems and processes were in place for the management of infection prevention and control. For example, there were ample supply of personal and protective equipment (PPE) and domestic staff confirmed good availability of cleaning products.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with regional guidance.

### 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, spend time in their bedrooms, in the communal lounge or have visits with loved ones.

Haypark has some double rooms available for residents and the residents we spoke with told us that they were very happy that they were able to stay together and that this was very important to them.

An activity planner was available for residents and their representatives to view. Activities offered in the home included, movie nights, bingo, music man, coffee morning and quiz night.

However, the activity planner that was available was not operating on the correct week and no activities took place on the day of inspection. This was discussed with the management team who told us that the activity co-ordinator had been on leave. It is important that the management team ensure that the provision of activities for residents is allocated to other staff to cover periods of leave and to ensure records are maintained. An area for improvement has been identified for a second time.

## 5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Jennifer McClean has been the Registered Manager in Haypark since April 2005.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to residents. There was evidence of auditing across various aspects of care and services provided by the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Residents spoken with said that they knew how to report any concerns and said they were confident that the manager would address these.

There was a system in place to manage complaints.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about residents, care practices or the environment.

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to residents' next of kin, their care manager and to RQIA.

There were no records of staff or residents' meetings available, this was discussed with the management team who explained these had not taken place. Two areas for improvement have been identified, one for a second time.

The home was visited each month by 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; however, where action plans for improvement were identified there was no evidence that actions had been addressed as the actions identified had been carried over for three months and no date to be achieved by was recorded. An area for improvement has been identified.

## 7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes' Minimum Standards (December 2022) (Version 1:2)

| | Regulations | Standards |
|---|---|---|
| **Total number of Areas for Improvement** | 4* | 9* |

* the total number of areas for improvement includes four that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team, 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 Regulations (Northern Ireland) 2005** | |
| **Area for improvement 1**<br><br>**Ref:** Regulation 16 (1) 2 (b)<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>8 April 2024 | The registered person should ensure that the written care plan is prepared in consultation with the resident as to how the residents needs are to be met, and that this plan is kept under regular review.<br><br>Ref: 5.1 and 5.2.2 |
| | **Response by registered person detailing the actions taken:**<br>All residents care plans have been reviewed with residents to ensure residents needs are being met. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 14 (2) (b) (c)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>8 April 2024 | The registered person shall ensure that any resident who requires a modified diet, receives a meal in line with the assessed recommendations by the Speech and Language Team.<br><br>The registered person must also ensure that staff who provide support for residents with eating and drinking are informed of the recommendations for residents and that the relevant regional guidance for Dysphagia management is embedded into staffs' practice. |

| | |
|---|---|
| | Ref: 5.2.2 |
| | **Response by registered person detailing the actions taken**:<br>All residents requiring a modified or special diet are referred for assessment to the SALT team and this is recorded in the residents care plans. Staff and chef informed of the recommendations to ensure that the correct meals are received .All Staff have received the necessary training. |
| **Area for improvement 3**<br><br>**Ref:** Regulation 14 (2) (a) (c)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>8 April 2024 | The registered person shall ensure that all areas of the home to which residents have access are free from hazards to their safety, and staff are made aware of their responsibility to recognise potential risks and hazards and how to report, reduce and eliminate the hazard.<br><br>This area for improvement is made with specific reference to the supervision and storage of cleaning chemicals and medicines.<br><br>Ref: 5.2.3 |
| | **Response by registered person detailing the actions taken**:<br>All cleaning chemicals are stored in a secure key coded store,all medicines no longer in use have been returned to the pharmacist. |
| **Area for improvement 4**<br><br>**Ref:** Regulation 29<br><br>**Stated:** First time<br><br>**To be completed by:**<br>8 April 2024 | The registered person shall ensure that where actions are identified by the person conducting the monthly monitoring visit these are dated/timed and completed in a timely manner to evidence improvements made.<br><br>Ref: 5.2.5 |
| | **Response by registered person detailing the actions taken**:<br>Actions identified by the registered individual are dated and timed to confirm completion. |
| **Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)** | |

| | |
|---|---|
| **Area for improvement 1**<br><br>**Ref:** Standard 24.2<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>1 July 2024 | The registered person shall ensure that staff have recorded formal supervision no less than every six months.<br><br>Ref: 5.1 and 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>Staff supervision records are completed every six months |
| **Area for improvement 2**<br><br>**Ref:** Standard 13<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>8 April 2024 | The registered person shall ensure that the programme of activities is displayed in a suitable format and location, and that a record is kept of all activities that take place.<br><br>Ref: 5.1 and 5.2.2 |
| | **Response by registered person detailing the actions taken:**<br>There is a full programme of activities displayed on the activity notice board for residents and familes to view. |
| **Area for improvement 3**<br><br>**Ref:** Standard 1.2<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>8 April 2024 | The registered person shall ensure the home has systems where residents can express their views and be consulted about the running of the home. This is stated in relation to resident's meetings.<br><br>Ref: 5.1 and 5.2.5 |
| | **Response by registered person detailing the actions taken:**<br>We have created a system of consulting with the Residents and recording their views on the running of the Home |

| | |
|---|---|
| **Area for improvement 4**<br><br>**Ref:** Standard 23.4<br><br>**Stated:** First time<br><br>**To be completed by:** 1 July 2024 | The registered person shall ensure that staff complete Deprivation of Liberty Safeguards Training Level 2 and/or Level 3 commensurate with their role and function in the home.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>All staff have completed level 2 DOLS and management level 3. |
| **Area for improvement 5**<br><br>**Ref:** Standard 25<br><br>**Stated:** First time<br><br>**To be completed by:** 8 April 2024 | The registered person shall ensure that staffing arrangements in the home are kept under review and consider the skills mix of the staff on shift.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>The staffing arrangements in the home are constantly under review and the mix of staff skills on duty is monitored by the Manager |
| **Area for improvement 6**<br><br>**Ref:** Standard 9.5<br><br>**Stated:** First time<br><br>**To be completed by:** 8 April 2024 | The registered person shall ensure that a system is in place to monitor the frequency of residents' podiatry appointments and referrals made as necessary to the service. If issues should arise, the responsible person should seek advice from the residents care manager and records kept.<br><br>Ref: 5.2.2 |
| | **Response by registered person detailing the actions taken:**<br>All residents requiring to be seen by podiatry have been attended to and a system created to ensure ongoing vigilance in this area. |

| | |
|---|---|
| **Area for improvement 7**<br><br>**Ref:** Standard 6<br><br>**Stated:** First time<br><br>**To be completed by:** 8 April 2024 | The registered person shall ensure that individual risk assessments are completed to inform the care planning process and kept under review for the residents.<br><br>Ref: 5.2.2 |
| | **Response by registered person detailing the actions taken:**<br>All residents care plans have been reviewed ensuring risk asssessments have been completed for each individual resident. |
| **Area for improvement 8**<br><br>**Ref:** Standard 22.6<br><br>**Stated:** First time<br><br>**To be completed by:** 8 April 2024 | The registered person shall ensure that residents information and records are maintained confidentially and securely stored at all times.<br><br>Ref: 5.2.2 |
| | **Response by registered person detailing the actions taken:**<br>All residents care plan records are maintained confidentially and securely in the ground floor office and are only removed if staff need to record information in them and then returned back to safe storage. |
| **Area for improvement 9**<br><br>**Ref:** Standard 25.8<br><br>**Stated:** First time<br><br>**To be completed by:** 1 July 2024 | The registered person shall ensure that staff meetings take place on a regular basis and at least quarterly and records maintained.<br><br>Ref: 5.2.5 |
| | **Response by registered person detailing the actions taken:**<br>A staff meeting schedule is in place and shall be monitored on a regular basis First meeting has been held on 26th April 2024 |

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

**Tel** 028 9536 1111
**Email** info@rqia.org.uk
**Web** www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care