

Inspection Report

Name of Service: Home Treatment House

Provider: Belfast Health and Social Care Trust

Date of Inspection: 19 August 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
Responsible Person:	Mrs Maureen Edwards
Registered Manager:	Mrs Lynsey Anne McGrann
Service Profile – This home is a registered nursing home, which provides nursing care for up to 8 patients with a mental disorder for over and under 65 years of age. Patients' bedrooms are located over both floors in the home. Communal lounges and a dining area are located on the ground floor and patients have access to a courtyard garden area.	

2.0 Inspection summary

An unannounced inspection took place on 19 August 2025 from 9:30 am to 3 pm. The inspection was carried out by a care inspector and an inspector from the mental health team.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 23 July 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

Patients said that living in the home was a good experience; they spoke in positive terms about the care and support provided. Staff said that they enjoyed working in the home. It was evident that staff promoted the dignity and well-being of the patients.

RQIA were assured that the delivery of care and service provided in Home Treatment House was safe, effective, compassionate and that the home was well led.

As a result of this inspection, four areas for improvement were assessed as having been addressed by the provider. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

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 patients, 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. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

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

Patients spoke positively about the care and treatment they received. They described staff as kind, supportive, knowledgeable with comments such as "staff are very professional and very friendly" and "staff treat me well and I feel well supported" 'staff are approachable and caring, very happy with my care and treatment'.

Patients were aware of their discharge plans and stated the care and treatment they had received had enabled them to view their discharge positively. This included the support staff gave patients in relation to their physical health needs.

Four responses were received from the patient questionnaires following the inspection with comments such as "the care has been excellent, all the staff have been kind and professional" and "I feel all the staff both day and night are very kind and approachable which make me feel safe".

Following the inspection, no responses were received from the relative or staff questionnaires within the timescale specified.

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 patients. Recruitment records are managed centrally by the Business Service Organisation. A checklist is kept in the Home to evidence that the appropriate recruitment checks have been carried out prior to commencing employment.

There was evidence of systems in place to manage staffing, however review of records evidenced that not all staff had received an annual appraisal. An area for improvement was identified.

Patients said that there was enough staff on duty to help them. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels.

Observation of the delivery of care evidenced that the number and skills of the staff on duty met patients' needs. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

Patients were admitted to the home on a voluntary basis. The home provides acute short-term care and early intervention with the aim of preventing hospital admission although the length of admission can vary depending on individual needs and circumstances. Staff told us that the patients tend to be fairly independent in their daily living needs but require additional support with their mental health needs. It was observed that the care provided was compassionate and person centred.

Staff said they met for a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff demonstrated their knowledge of individual patient's needs, preferred daily routines, likes and dislikes. Staff were seen to respect patients' privacy and dignity; they knocked on doors before entering bedrooms and offered discreet assistance when required.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients had a choice of meals available to suit their dietary needs and preferences. The mealtime was seen to be a sociable and inclusive experience. Staff provided assistance in a discreet and unobtrusive manner. Staff demonstrated a flexible approach to mealtimes; patients were able to choose when to have their meals and snacks.

Patients said they enjoyed the food on offer and that there was a good variety available. Staff were seen to effectively communicate with the patients and to provide them with appropriate levels of care and support.

Discussion with patients confirmed that they were able to choose how they spent their day. Patients said that the routine was flexible; they could get up and go to bed at their preferred times and make drinks and snacks whenever they wanted to.

Patients were encouraged to participate in regular meetings, which provided an opportunity for them to comment on aspects of the running of the home. A record of these meetings was maintained.

Patients were enabled to take trips out of the home, either independently or with staff, according to their assessed needs. These trips might include shopping or to visit family.

Some of the patients had been attending weekly cookery classes and had been helping with the upkeep of flowers and plants in the outside courtyard area.

The planned activity schedule was on display; this included arts and crafts, movies and coffee mornings, therapy dog visits. Staff recognised the importance of providing therapeutic and meaningful activities for the patients to help them build up confidence and maintain their independence.

Patients spoke very positively about their experience of the home and the care and support provided by staff.

3.3.3 Management of Care Records

Comprehensive pre-admission assessments were completed prior to admission to the home. The care records reviewed included relevant risk assessments and care plans to direct the care required for the individual patients. Care records were individualised and reflected the assessed needs of the patients. Care plans were clearly written in language that would be easily understood by the patient and there was evidence of consultation and discussion with patients regarding their care planning.

Patients care records were held confidentially.

3.3.4 Quality and Management of Patients' Environment Control

The home was clean, tidy and well maintained. For example, patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

The courtyard garden area was overgrown and unkempt. This was discussed with the manager and assurances were given that this was being addressed. This will be reviewed at the next inspection.

A Ligature Anchor Point Survey (LAPS), with recommendations, was undertaken in September 2024. A General Risk Assessment (GRA) was completed for ligature and self-harm risks identified in the LAPS, this was reviewed in July 25. The GRA included existing control measures and an overall risk rating using the HSC Regional Risk Matrix was recorded. On examination of the GRA, it was identified that the overall risk rating had been incorrectly calculated and the potential consequences of an event may not have been fully considered.

The Trust should review the GRA to ensure that all risks have been adequately assessed and that mitigations are appropriate to ensure the safety of patients. This was brought to the manager's attention during the visit and assurances provided that this would be reviewed. Confirmation was received from the manager after the inspection that this had been addressed. This will be reviewed at the next inspection.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Lyndsey Anne McGrann has been the manager in this home since 24 July 2023.

Staff commented positively about the management team and described them as supportive, approachable and able to provide guidance.

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 manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and the quality of services provided by the home.

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

Compliments received about the home were kept and shared with the staff team

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Lynsey Anne McGrann, Manager and Saoirse McCann, Deputy 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 Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 40 Stated: First time To be completed by: 31 October 2025	The registered person shall ensure that all staff have an annual appraisal and records are of these are maintained. Ref: 3.3.1 Response by registered person detailing the actions taken: All staff in work have had their SDR Appraisals completed. Staff on long-term sickness absence will have their SDR Appraisals completed on their return to work.

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



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