Creamery House
RQIA ID: 1145
38 Main Street
Kesh
BT93 1TE

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

12 May 2015

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 12 May 2015 from 10.00 to 15.00. On the day of the inspection the home we found the home was delivering safe, effective and compassionate care.

This inspection was underpinned by the Residential Care Homes Regulations (Northern Ireland) 2005, The DHSPSS Residential Care Homes Minimum Standards (2011), NICE guidelines on the management of urinary incontinence in women (September 2013), NICE guidelines on the management of faecal incontinence (June 2007) and Guidance and Audit Implementation Network (GAIN) guidelines available for palliative care.

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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 Mrs Elaine Way	**Registered Manager:** Lynette Mc Hugh
Person in Charge of the Home at the Time of Inspection: Lynette Mc Hugh	**Date Manager Registered:** April 2005
Categories of Care: RC-LD, RC-LD(E)	**Number of Registered Places:** 11
Number of Residents Accommodated on Day of Inspection: 8	**Weekly Tariff at Time of Inspection:** £470.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standard and theme has been met:

Standard 14: **The Death of a Resident is Respectfully Handled as They Would Wish.**
Theme: **Residents Receive Individual Continence Management and Support.**

4. Methods/Process

Prior to inspection we analysed the following records: returned QIP from last inspection and notifications of incidents and accidents.

We met with five residents, two care staff, two ancillary staff and the registered manager.

We inspected the following records: four care records, accident / incident reports, fire safety records, complaints/compliments and policies and procedures available relating to continence management and death and dying.

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of Creamery House was an announced estates inspection dated 6 May 2015. At the time of writing this report, the report of the estates inspection is in the process of being completed.

5.2 Review of Requirements and Recommendations from the last Care Inspection

Previous Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 30 (1) (f)	**<u>Accidents / Incidents</u>** The manager must ensure that RQIA is notified of any accident occurring in the home in accordance with Regulation 30 of The Residential Care Homes Regulations (Northern Ireland) 2005.	**Met**
	Action taken as confirmed during the inspection: Review of accidents /incidents records and care records confirmed that RQIA is informed of any accident in the home or event in the home which adversely affects the care, health, welfare or safety of any resident.	
Previous Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 27.12	**<u>Environment</u>** The manager is requested to forward written confirmation to RQIA on the completion of the internal and external environment work which is taking place. (Section 11.11)	**Met**
	Action taken as confirmed during the inspection: All internal and external work has been completed in Creamery House.	
Recommendation 2 **Ref**: Standard 19.1	**<u>Policy / Procedure</u>** It is recommended that the registered person ensures that the policy and procedures for staff recruitment fully detail the recruitment process and comply with legislative requirements and DHSSPS guidance.	**Met**
	Action taken as confirmed during the inspection: This policy has been reviewed by the HSC Trust and this document is due to be signed off by the HSC Trusts equality team.	

Recommendation 3 **Ref**: Standard 10.1	**Training** It is recommended that training in challenging behaviour and MAPPA is provided for staff who did not attend scheduled training.	**Met**
	Action taken as confirmed during the inspection: Challenging behaviour training was completed on 7 May 2015 by seven staff. Further training is scheduled for 19 May 2015.	
Recommendation 4 **Ref**: Standard 13.1	**Policy/Procedure Development** It is recommended that a policy / procedure is developed for the provision of resident therapeutic activities.	**Met**
	Action taken as confirmed during the inspection: A policy is in place named 'Planning and reviewing activities of residents.'	
Recommendation 5 **Ref**: Standard 13.6	**Activity Records** Ensure that the duration of organised activities is recorded in the daily of activity record.	**Met**
	Action taken as confirmed during the inspection: The duration of activities is recorded on the activity record.	
Recommendation 6 **Ref**: Standard 13.7	**Commissioned Activity** Ensure any activity undertaken by the commissioned person is recorded within the activity log book.	**Met**
	Action taken as confirmed during the inspection: All activities undertaken are recorded within the activity log.	

Recommendation 7 **Ref**: Standard 13.9	**Recording Named Person Responsible** Ensure all activities and the named person leading the activity is documented within the activity records.	**Met**
	Action taken as confirmed during the inspection: The person leading the activities is documented within the activity records.	
Recommendation 8 **Ref**: Standard 12.4	**Daily Menu** The manager must ensure that staff displays the correct daily menu. (Section 11.9)	**Met**
	Action taken as confirmed during the inspection: The correct daily menu was on display during the inspection.	
Recommendation 9 **Ref**: Standard 22.5	**Care Records** The manager is to ensure that staff refrain from leaving spaces between daily notes in care records. (Section 11.0)	**Met**
	Action taken as confirmed during the inspection: The daily notes were inspected and no spaces were noted between entries.	

5.3 Standard 14: The Death of a Resident is Respectfully Handled as They Would Wish

Is Care Safe? (Quality of Life)

Residents can and do spend their final days in the home unless there are documented health care needs to prevent this.

The home has a spiritual ethos. Clergy and lay ministers visit the home throughout the week on an organised basis. Residents are encouraged to attend their place of worship, where possible.

In our discussions with the registered manager and staff we confirmed that arrangements can be put in place so that spiritual care can be made available for residents who are dying, if they so wish. Family members, friends, other residents and staff who may wish to offer comfort for a resident who is dying are enabled to do so if the resident wishes. Following a death, the

body of the deceased resident is handled with dignity and respect and in accordance with his or her expressed social, cultural and religious preferences.

We reviewed a sample of compliment letters and cards. These were received from families of deceased residents. In these correspondences there were nice messages of praise and gratitude for the compassion and kindness received during this period of care. This included welcoming relatives to the home with provision of refreshments and kind, caring staff interactions.

We noted that within the home's policy, when a death of a resident occurs, the resident's next of kin or family deal with the deceased resident's belongings. This is done at a sensitive and convenient time after the burial.

Is Care Effective? (Quality of Management)

We noted that the home had a written policy in place on the death of a resident dated April 2015.

We noted that a dignity plan had been put in place for each resident. This dignity plan details the wishes of the resident or representative following their death. Spiritual and cultural wishes were recorded within this record. The dignity plan is signed by the resident and/or their representative. This document is reviewed annually. This practice is to be commended.

In our discussions with the registered manager and staff they confirmed to us that the district nursing service attached to the home would take the lead in the management of palliative care.

The registered manager is currently in the process of sourcing specific training in this area of care.

Is Care Compassionate? (Quality of Care)

In our discussions with staff and the registered manager they shared their experience of a death in the home. Staff confirmed that the other residents were informed as a small group and in a sensitive manner. The other residents were supported by staff to visit the deceased resident.

Within residents bedrooms we observed a photographic display named 'cherished memories of our friends. This was completed by staff as a tribute to the deceased residents. In another bedroom we noted a pictorial format to assist a resident with limited speech to understand his feelings following death.

In our discussions with staff they demonstrated to us that they had knowledge and understanding in this area of care. Staff also confirmed to us that there was a supportive ethos within the management of the home. The management assist residents and staff deal with dying and death.

Areas for Improvement
There were no areas of improvement identified with the standard inspected. Overall, this standard is assessed to be safe, effective and compassionate.

Number of Requirements	**0**	**Number Recommendations**:	**0**

5.4 Theme: Residents Receive Individual Continence Management and Support

Is Care Safe? (Quality of Life)

We reviewed four care records. We found that a needs assessment was completed and that care plans were in place. These are reviewed regularly to reflect the changing needs of the resident. A specific care plan was in place for those with continence needs. Care plans were appropriately signed.

We spoke with staff members and they were able to describe the system of referral to community district nursing services for specialist continence assessment.

The registered manager is also currently sourcing training in continence management. In our discussions with staff, we found that they were able to demonstrate knowledge in the area of continence care.

From our discreet observations, discussion with staff and review of care records we identified no mismanagement in this area of care such as malodours or breakdown of skin integrity.

We found adequate provision of continence products, laundered bed linen and towels, also that gloves, aprons and hand washing dispensers were available.

Is Care Effective? (Quality of Management)

We found that the home had a policy in place on continence promotion which was reviewed in April 2015.

Staff were able to verify to us that any issues of assessed need are reported to the district nursing services for advice and guidance. Continence assessments were in place.

Is Care Compassionate? (Quality of Care)

From our discreet observations of care practices we found that residents were treated with care, dignity and respect when being assisted by staff. From our discussion with residents, we endorsed that staff provide assistance with continence care in a sensitive and caring manner.

Areas for Improvement
There were no areas of improvement identified with the standard inspected. Overall, this standard is assessed to be safe, effective and compassionate.

Number of Requirements	**0**	**Number Recommendations**:	**0**

5.5 Additional Areas Examined

5.5.1 Residents Views

We met with five residents either individually or as part of a group. We observed residents relaxing in the communal lounge area. Residents were involved in activities. 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. Residents were praising of the staff. Residents advised us that there was good communication with staff and they are respectful during care interventions.

5.5.2 Staff Views

We spoke with three staff members individually, in addition to the registered manager. Staff advised us that they felt well 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. Some comments made by staff were:

- "This is a good place to work, everyone gets on with their work."
- "The care provided here is genuine, there is a good staff team and everyone is treated like family."
- "This is a homely environment for residents; the staff knows the residents very well."

5.5.3 Environment

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

5.5.4 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. We observed residents to be well dressed.

5.5.5 Accidents / Incident reports

We reviewed accident/incident records from the previous inspection and found these to be appropriately managed and reported.

5.5.6 Fire Safety

We confirmed that the home's most recent fire safety risk assessment was dated 23 June 2014.

We reviewed the fire safety records and could confirm that fire safety training was carried out on 11 November 2014 attended by fourteen staff and 9 February 2015 by one staff member. Further fire training is scheduled for 20 May 2015 and 28 May 2015. The registered manager confirmed that a fire drill took place on 10 April 2015.

The records identified that different fire alarms have been tested weekly with written records maintained. There were no obvious fire safety risks observed. All fire exits were unobstructed and fire doors were closed.

Areas for Improvement

There were no areas of improvement identified within these additional areas inspected.

Number of Requirements	**0**	**Number Recommendations**:	**0**

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Lynette McHugh	**Date Completed**	02/06/15
Registered Person	Elaine Way	**Date Approved**	12.6.15
RQIA Inspector Assessing Response	Lara O'Hara.	**Date Approved**	19.6.15.

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

Please complete in full and returned to care.team@rqia.org.uk