

Unannounced Care Inspection Report 16 March 2017



Hilltop Respite Unit

Type of Service: Nursing Home

**Address: Flat 1, South Tyrone Hospital, Carland Road, Dungannon,
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Inspector: Sharon Loane

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Hilltop Respite Unit took place on 16 March 2017 from 14.00 to 15.30 hours.

The inspection sought to assess progress with any issues raised during and 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.

Is care safe?

A review of information evidenced that safe care was provided. A range of risk assessments were completed to reduce any potential risks. The home was staffed appropriately in accordance with the needs of the identified service user. Training was provided to ensure that mandatory training requirements were met and additional training was provided in response to the needs of the service user.

Is care effective?

A review of care records and discussion with the registered manager evidenced that the care delivered was effective to meet the care needs identified. An admission checklist record and risk assessments are completed and reviewed at the time of each respite admission. A discharge report is completed at the end of the respite period a copy of which is provided to the patient's representatives.

Is care compassionate?

Currently, only one service user avails of the respite service. From discussion with the registered manager it was evident that care is delivered in line with the patient's wishes and needs. The service user arrived to the home towards the completion of the inspection and it was evident from the interactions that the service user knew the staff well and vice versa.

Is the service well led?

Written policies and procedures were available for staff to access and refer to as necessary. These were not examined during the inspection.

A review of audits and monthly quality monitoring reports indicated that satisfactory outcomes had been achieved.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 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 were discussed with Maureen Currie, registered manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care and medicines management inspection undertaken on 24 February 2016. No requirements and recommendations resulted from this inspection. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Southern HSC Trust Mr Francis Rice	Registered manager: Ms Maureen Currie
Person in charge of the home at the time of inspection: Ms Maureen Currie	Date manager registered: 19 July 2012
Categories of care: NH-LD	Number of registered places: 1

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of notifications to RQIA since the last care inspection – no notifications had been reported to RQIA since the last care inspection

Questionnaires were issued to patients, patients' representatives and staff with a request that they were returned within one week from the date of this inspection.

We met with the registered manager, one registered nurse and one support worker.

The following information was examined during the inspection:

- staff duty rota
- one care record
- incident and accident records
- review of monthly monitoring reports in accordance with Regulations (Northern Ireland) 2005
- records of complaints
- quality audits

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 February 16

The most recent inspection of the home was an unannounced care inspection. No Quality Improvement Plan (QIP) was issued as a result of this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 24 February 2016

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

The registered manager confirmed that staffing levels for the home were planned to meet the needs of the patient accommodated for respite care. A review of the staffing rota for week commencing 13 March 2017 evidenced that the planned staffing levels were adhered to. The duty rota was maintained in accordance with Care Standards for Nursing Homes, DHSSP 2015.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff working in the respite unit were provided by a nearby Trust facility due to the operational needs of the service.

A discussion with the registered manager confirmed that staff had completed any mandatory training requirements. An inspection undertaken in August 2016 of the service from which staff are provided confirmed this information.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding.

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of management audits for falls and/ incidents confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

A review of the home's environment was undertaken and was found to be warm and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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4.4 Is care effective?

Review of a care record for an identified patient evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. The registered manager advised that risk assessments and care plans are reviewed at least once a month.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as speech and language therapist (SALT) or dieticians.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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4.5 Is care compassionate?

Staff interactions with the patient on respite care were observed to be compassionate and caring. Interactions demonstrated that staff afforded the patient choice, privacy, dignity and respect.

Staff demonstrated a detailed knowledge of the patient's wishes, preferences and assessed needs as identified within the patients' care plan.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Five were returned within the time frame from staff who advised that they were either 'very satisfied' or 'satisfied' across all four domains. Written comments received in questionnaires returned have been shared with the Trust for consideration and actions as deemed appropriate.

One questionnaire was returned from a patient who advised that they were very satisfied with all aspects of the care and other services provided in the home. No concerns were raised.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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4.6 Is the service well led?

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. The patient availing of respite care at the time of the inspection was observed interacting with the registered manager and it was evident that they knew each other well.

Policies and procedures were available for staff to access and refer to as required.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. No notifications were received since the last care inspection and a review of information confirmed that none were required.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Discussion with the registered manager and review of records evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards.

An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

As previously discussed in section 4.5, questionnaires returned by five staff indicated that they were either 'very satisfied' and/or 'satisfied' with the care provided and that the service was 'well led'. Some additional comments were received in two of the questionnaires returned. The comments made were in relation to some aspects of the management of the service and these have been shared with the Trust for further consideration and actions as deemed necessary.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards.



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