Hilltop Respite Unit
RQIA ID: 11938
Flat 1, South Tyrone Hospital
Carland Road
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Inspector: Sharon Loane
Inspection ID: IN024014
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Unannounced Care Inspection
of
Hilltop Respite Unit

24 February 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 24 February 2016 from 10.45 to 13.15.

The focus of this inspection was continence management which was underpinned by selected criteria from:

Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Health care and Standard 39: Staff Training and Development.

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 09 June 2014.

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: Southern HSC Trust/Mrs Paula Mary Clarke	**Registered Manager:** Ms Maureen Edna Currie
Person in Charge of the Home at the Time of Inspection: Ms Maureen Edna Currie	**Date Manager Registered:** 19 July 2012
Categories of Care: NH-LD	**Number of Registered Places:** 1
Number of Patients Accommodated on Day of Inspection: 1	**Weekly Tariff at Time of Inspection:** Trust rates apply plus patient contribution

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the selected criteria from the following standards have been met:

Standard 4: Individualised Care and Support, criteria 8
Standard 6: Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8and 15
Standard 21: Health Care, criteria 6, 7 and 11
Standard 39: Staff Training and Development, criteria 4

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the registered manager
- discussion with staff
- discussion with one patient
- review of a selection of records
- observation during a tour of the premises
- evaluation and feedback

Prior to inspection the following records were analysed:

- the registration status of the home
- written and verbal communication received since the last care inspection
- the previous care inspection report

The following records were examined during the inspection:

- staff duty rota
- staff training records
- two care records
- a selection of policies and procedures
- incident and accident records
- regulation 29, monthly monitoring reports
- guidance for staff in relation to continence care and other areas of practice
- records of complaints

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced estates inspection dated 07 August 2014. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 09 June 2014

No requirements or recommendations were made at this inspection.

5.3 Continence management

Is Care Safe? (Quality of Life)

Policies and procedures regarding continence management, catheter care and stoma care were available to guide staff. These policies were last reviewed September 2015.

A resource folder on continence management was available for staff to consult.

Discussion with staff and the registered manager confirmed that staff had completed training in continence management previously and that it was included as part of the training plan for 2016.

A review of care records and discussion with staff on duty demonstrated that staff had an understanding of each patient's continence care needs, including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Staff advised that during the patient's respite period, patients would generally bring their own individually assessed continence products.

An inspection of the environment confirmed that it was clean and tidy, suitably maintained toilet facilities were available and personal protective equipment (PPE) was available for staff use.

Is Care Effective? (Quality of Management)

Review of two patient care records evidenced that continence assessments and risk assessments were completed and/or reviewed by nursing staff, at every respite admission. The continence assessment clearly identified the patient's incontinence needs.

Continence care plans were in place for each patient with evidence that patients and/or their representatives had been involved in discussions regarding the development of care plans.

The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Assessments and care plans were specific and person centred in content.

Assessments and care plans clearly indicated if the patient had any preference regarding the gender of staff attending to their personal care needs including continence care.

A bowel management record was available and completed for each patient during their period of respite. The staff referred to the Bristol Stool Chart when recording bowel movements.

A review of care records evidenced that an admission checklist record and all risk assessments are completed and/or reviewed at the time of each respite admission. A report is also completed upon the completion of the respite period a copy of which is provided to the patient's representatives. This is commended.

Is Care Compassionate? (Quality of Care)

Staff were observed to treat the patient with dignity and respect. Good staff and patient relationships were evident at the time of inspection. Staff demonstrated a very good understanding of the patient's needs likes and dislikes and responded to them promptly. The patient accommodated on the day of inspection acknowledged by their gestures that they enjoyed coming to Hilltop and appeared to be happy and content**.**

Areas for Improvement

No areas of improvement were identified.

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

5.4 Additional Areas Examined

5.4.1. Accidents and incidents

A review of accident/incident records evidenced that there had been no recorded accident/ incidents between May 2015 and January 2016. There was recorded evidence that this area of practice was reviewed during monthly monitoring visits by the monitoring officer representing the responsible individual.

5.4.2. Complaints

A review of the complaints record evidenced that there had been no recorded complaints for 2015.

5.4.3. Staffing

A review of the duty rota evidenced that staffing levels were appropriate to meet the needs of the patient accommodated during the period of respite care. The duty rota was signed by the registered manager at the end of each respite period to confirm that the hours highlighted had been actually worked by staff. Some recorded entries were completed in pencil and an explanation for this was provided by the registered manager however, the registered manager was advised that all records should be maintained in accordance with the NMC guidance on record keeping. The registered manager agreed to action this accordingly.

Areas for Improvement

No areas of improvement were identified.

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

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Maureen Currie	**Date Completed**	18/03/16
Registered Person	Miceal Crilly	**Date Approved**	22.03.16
RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	22.03.2016

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

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