The Regulation and Quality Improvement Authority

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Inspector: John McAuley
Inspection ID: IN22583

Unannounced Care Inspection of Thackeray Place

7 May 2015

1. Summary of Inspection

An unannounced care inspection took place on 7 May 2015 from 10am to 1:45pm. Overall on the day of the inspection the home was found to be delivering safe, effective and compassionate care. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report.

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.

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: Mrs Elaine Way CBE	**Registered Manager:** Mrs Kathryn Mary Cochrane
Person in Charge of the Home at the Time of Inspection: Mrs Kathryn Cochrane	**Date Manager Registered:** 1 November 2006
Categories of Care: RC-I	**Number of Registered Places:** 32
Number of Residents Accommodated on Day of Inspection: 31	**Weekly Tariff at Time of Inspection:** £470

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

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

- Prior to inspection we analysed the following records were analysed: notification reports and previous inspection report.
- During the inspection we met with twenty residents, five staff of various grades and two visiting relatives.
- We inspected the following records: residents' care records, accident / incident reports, complaints and compliment records, policies and procedures and aligned guidance available to standards inspected.

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 5 September 2014. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the last care inspection

Previous Inspection Statutory Requirements		Validation of Compliance
Requirement 1 The registered person shall – (a) Maintain in respect of each resident a record a record which includes the information, documents and other records specified in Schedule 3 relating to the resident, Schedule 3 (3) (k) A contemporaneous note of all care and service provided to the resident, including a record of his condition and any treatment or other intervention. Reference to this is made in that the content of the progress records must be reviewed to include a clear statement of the resident's well-being and if there is an assessment of need, there needs to be a subsequent statement of care / treatment given and effect(s) of same. **Ref**. Regulation 19 (1) (a) Schedule 3 (3) (k	The registered manager must ensure that the content of the progress records must be reviewed to include a clear statement of the resident's well-being and if there is an assessment of need, there needs to be a subsequent statement of care / treatment given and effect(s) of same. **Action taken as confirmed during the inspection:** A review of residents' care records confirmed that issues of assessed need had a recorded statement of care / treatment given with effect(s) of same.	**Met**

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 of life in the home. This is unless there is a documented health care need that prevents this.

In our discussions with staff they advised that they considered the care as compassionate. The registered manager provided an example on how with the resident's wish, other residents and staff who wished to comfort a resident who was dying were enabled to. The registered manager also explained that other residents and staff are informed in a sensitive manner of the death of a resident. Other residents and staff have opportunity to pay respect and are provided with support if needed. In our discussions with staff we can confirm that they felt supported in dealing with this aspect of care.

We noted that within the home's policy, when a death of a resident occurs, their belongings are handled with care and respect. The room is permitted to be vacant. The resident's next of kin or family take the lead in dealing with the deceased resident's belongings at a sensitive and convenient time after the burial.

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.

Spiritual needs of the resident were assessed. In our discussions with staff we confirmed they had knowledge and understanding of residents' spiritual requests and choices at this time of care.

Is Care Effective? (Quality of Management)

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

A care plan is put in place for each resident who is receiving palliative care by district nurses.

We reviewed residents' care records and could confirm that a care plan was in place pertaining to this need. Details included arrangements with spiritual care, if so wished.

Is Care Compassionate? (Quality of Care)

The home has policies and procedures pertaining to terminal and palliative care and death of a resident. These policies and procedures guide and inform staff on this area of care.

Staff have received specific training in this area of care. This training is also disseminated to other staff members during their induction and at staff meetings.

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

Areas for Improvement

There were no areas of improvement identified with this standard inspected. The overall assessment of this standard considered this standard to be compassionate, safe and effective.

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

5.4 Theme: Residents Receive Individual Continence Management and Support

Is Care Safe? (Quality of Life)

Staff have received training in continence management. In our discussions with staff they also demonstrated knowledge and understanding of this area of care.

We reviewed residents' care records and found that an individualised assessment and plan of care was in place. Issues of assessed need are referred to district nursing services. The district nurse in consultation with the resident and the home prescribes a plan of care. This plan of care includes provision of incontinence aids.

From our observations we found there to be adequate supplies of aprons, gloves and hand washing dispensers.

In our discussions with staff, general observations together with a review of care records we identified no mismanagement of this area of care, such as malodours or breakdown of skin integrity.

Is Care Effective? (Quality of Management)

The home has policies and procedures pertaining to the management of continence. There are also associated guidance and information available for staff.

Staff have received training in continence management.

Identified issues of assessed need are reported to the district nursing services, for advice and direction.

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. Continence care was undertaken in a discreet private manner.

Areas for Improvement

There were no areas of improvement identified with this standard inspected. The overall assessment of this standard considered this standard to be compassionate, safe and effective.

Number of Requirements	0	Number Recommendations:	0

5.5 Additional Areas Examined

We met with twenty residents in the home at the time of this inspection. In accordance with their capabilities, all expressed or indicated that they were happy with their life in the home, their relationship with staff, and the provision of meals.

Some of the comments made included statements such as;

- "The care is marvellous"
- "No problems, it is a great home"
- "I would hate this home to close, I love it here"
- "We're all very happy here"

5.4.2 Relatives' Views

We met with two visiting relatives. Both were very complimentary about the provision of care and the kindness and support received from staff and management.

5.4.3 Staff Views

We met with five members of staff of various grades on duty. All staff spoke positively about their roles and duties, staff morale, teamwork and managerial support. Staff informed us that they felt a good standard of care was provided for and they had the necessary resources and skills to provide for.

Ten staff questionnaires were distributed via post after this inspection for return.

5.4.4 General Environment

We found that the home was clean and tidy, with good housekeeping arrangements in place. The general décor and furnishings were of a reasonable standard.

5.4.5 Accident / Incident Reports

We reviewed these reports from the previous inspection and found these to be appropriately managed and reported.

5.4.6 Care Practices

Throughout our discreet observations of care practices we evidenced residents being treated with dignity and respect. Care duties were organised at an unhurried pace, with time afforded for interactions with residents. Staff interactions with residents were found to be polite, friendly warm and supportive.

A homely atmosphere was in place with residents being comfortable, content and at ease.

An appetising dinner time meal was provided for.

A visiting hairdresser was in attendance, which many residents availed of. Other residents in the home were engaged in pastimes of choice such as reading, socialising with one another and relaxing.

5.4.7 Fire Safety

A review of the home's most recent fire safety risk assessment, dated 22 October 2014, was undertaken. This assessment contained evidence that the one recommendation made from it, had been attended to.

Fire safety training including fire safety drills were maintained on an up to date basis.

At the time of this inspection we observed no obvious risks within the environment in terms of fire safety, such as wedging opening of doors or inappropriate storage in the electrical switch room.

Areas for Improvement

There were no areas of improvement identified with these additional areas examined.

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	K Cochrane	**Date Completed**	19.5.15
Registered Person	Elaine Hay	**Date Approved**	26.5.15
RQIA Inspector Assessing Response		**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 from the authorised email address