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Unannounced Care Inspection
of
Peacehaven

28 January 2016

The Regulation and Quality Improvement Authority
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1. Summary of inspection

An unannounced care inspection took place on 28 January 2016 from 09.35 to 13.40. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report.

We were unable to examine policies and procedures relating to the standard and theme inspected, staff training records, the accident and incident register, complaints and compliments records and fire safety records. This was due to these records being held in an office adjacent to the home and the staff on duty not being able to access them.

We stated, for a third time, a requirement that records are at all times available for inspection in the home by any person authorised by RQIA to enter and inspect the home. We also made a recommendation that the staff duty rota should accurately reflect the capacity in which staff members work and should record accurately the hours worked by the registered manager.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005, The DHSSPS 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 resulted from the findings of this inspection. We found that one requirement, in relation to the access to records, made on two prior occasions was not met. The issue was escalated within RQIA and a Serious Concerns meeting was held on 10 February 2016. The registered person, Ms Mary O'Hanlon, provided sufficient assurances that robust arrangements were in place to ensure that records could be accessed by any inspector and relevant staff at the home. A further inspection will be untaken to ensure full compliance.

1.3 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	1

The details of the QIP within this report were discussed with Theresa McClory, senior care assistant, on the day of inspection and with Ms Mary O'Hanlon by telephone on 2 February 2016 as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service details

Registered Organisation/Registered Person: Mary Helen O'Hanlon	**Registered Manager:** Mary Helen O'Hanlon
Person in charge of the home at the time of inspection: Theresa McClory, senior care assistant	**Date manager registered:** 01 April 2015
Categories of care: RC-DE	**Number of registered places:** 8
Number of residents accommodated on day of inspection: 8	**Weekly tariff at time of inspection:** £470

3. Inspection focus

The inspection sought to assess progress with the issues raised during and since the last inspection and to determine if the following standard and theme had 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/processes

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

We met with four residents and two care staff. No residents' representatives and no visiting professionals were present in the home on the day of inspection.

We also provided eight resident views questionnaires and ten staff views questionnaires for completion and return to RQIA. Three residents' views questionnaire were completed and returned to RQIA, one of which was completed by the representative of a resident. We included the comments provided within the main body of the report.

We examined the care records of four residents.

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 7 July 2015. The completed QIP was returned and approved by the specialist inspector.

5.2 Review of requirements and recommendations from the last care inspection dated 7 July 2015.

Previous inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 19 (2)	The registered manager must ensure that records required to be maintained are held in the home and are at all times available for inspection in the home by any person authorised by the RQIA to enter and inspect the home. Failure to meet this requirement may result in enforcement action.	Not met
	Action taken as confirmed during the inspection: We found that records required to be maintained were not held in the home and the records were not available for us to inspect.	
Previous inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 20.15	The registered manager should ensure that RQIA is notified of any accidents or incidents. Failure to meet this recommendation may result in enforcement action.	Met
	Action taken as confirmed during the inspection: Discussion with the senior care assistant and inspection of care records identified that no accidents or incidents had occurred since the last care inspection. This area will be kept under review.	

5.3 Standard 14: The death of a resident is respectfully handled as they would wish

Is care safe? (Quality of life)

The person in charge confirmed to us that residents can spend their final days in the home unless there are documented health care needs to prevent this.

We inspected four residents' care records and could confirm that care needs assessments, risk assessments and care plans were in place and were kept under continual review. Documentation was amended as changes occurred to residents' medical conditions. The records were kept up to date to accurately reflect at all times the needs and preferences of the resident. The needs assessments were appropriately signed.

We noted that care plans contained details of the residents' wishes regarding any specific arrangements at the time of his or her death. Care plans also noted the spiritual and cultural wishes of the residents. Where there had been discussion with the General Practitioner relating to medical interventions, this was noted within the care records.

Is care effective? (Quality of management)

In our discussion with the senior care assistant she advised us that the home had policies and procedures in place relating to caring for a resident at the end of life and dealing with the death of a resident. We were unable to verify this as we could not access the relevant documentation.

In our discussions with staff they confirmed that they had received First Aid training and would be able to respond appropriately to an accident or sudden illness. We were unable to verify this as we could not access the relevant documentation.

Staff advised us that the last death in the home had occurred approximately seven years ago. Whilst staff had not received formal training in the home in end of life care and dealing with dying and death of a resident, the senior staff in the home had also been employed in the Peacehaven Domiciliary Care Agency and had experience of attending people in the community who were at the end of life.

In our discussions with staff they confirmed that they would be able to recognise the possibility that a resident may die within the next few days or hours. Staff members were knowledgeable about obtaining multi-professional community supports (GP, District Nursing, Occupational Therapy, Speech and Language Therapy, Dietician etc). Staff also confirmed to us that they were aware of the importance of encouraging nutrition and fluid intake and of ensuring good skin care to a resident at the end of life. Staff confirmed to us that they would liaise closely with district nursing staff to ensure appropriate pain management. Notification of a death would be made to all relevant parties in a timely manner.

Staff confirmed to us that there was a supportive ethos within the management of the home in helping residents, relatives and staff deal with dying and death.

Is care compassionate? (Quality of care)

Staff members we spoke with explained that they felt prepared and able to deliver care in a compassionate and sensitive manner. Staff were also able to articulate those values that underpin care within the home as they related to dying and death of a resident.

The senior care assistant explained to us that the news of the death of a resident would be shared with fellow residents in a sensitive manner. Residents would be given the option to attend the funeral.

In our discussions with the senior care assistant she confirmed that arrangements can be made to provide spiritual care 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 care and respect and in accordance with his or her expressed social, cultural and religious preferences.

The senior care assistant confirmed with us that the deceased resident's belongings are handled with care and his or her representative is consulted about the removal of the belongings. The home takes a flexible approach to the removal of belongings from the room of the deceased resident.

Areas for improvement

A requirement was made to ensure that relevant staff and RQIA have access to records required by legislation at all times.

Number of requirements:	**1**	**Number of recommendations**:	**0**

Theme: Residents receive individual continence management and support

Is care safe? (Quality of life)

The senior care assistant advised us that no residents had complex continence care needs. Should any resident need specialist support in this area, the district nurse or community continence advisor would provide guidance to staff. Additional staff training would also be provided, if necessary. The staff members we interviewed during inspection were able to demonstrate knowledge and understanding of continence care.

We reviewed four residents' care records which confirmed that a person centred assessment and care plan was in place relating to continence.

Staff members were able to describe to us the system of referral to community district nursing services for specialist continence assessment. Care plans were amended as changes occurred to residents' continence needs.

Through our inspection of the premises and in discussion with staff we could confirm that there was adequate provision of continence products. Staff confirmed to us that they had unrestricted access to a plentiful supply of laundered bed linen and towels. We observed that gloves, aprons and hand washing dispensers were present within the home. Staff members were aware of the process for safe disposal of used continence items in line with infection control guidance.

Is care effective? (Quality of management)

In our discussion with the senior care assistant she advised us that the home had policies and procedures in place relating to continence management and promotion and that the policy document reflected current best practice guidance. We were unable to verify this as we could not access the relevant documentation.

In our discussions with staff and through a review of the care records we noted that no residents had reduced skin integrity associated with poor continence management. There were no malodours noted during inspection of the premises

Is care compassionate? (Quality of care)

In our discreet observations of care practices we found that residents were treated with care, dignity and respect when being assisted by staff. In our discussion with staff it was evident that they recognised the potential loss of dignity associated with incontinence.

Areas for improvement

As previously stated, under Standard 14, a requirement was made in relation to ensuring access to records by relevant staff and RQIA. There were no other areas identified for improvement in relation to continence management.

Number of requirements:	**0**	**Number of recommendations**:	**0**

5.4 Additional areas examined

5.4.1 Residents' views / questionnaires

We met with four residents individually in order to obtain residents' views on the quality of care provided within the home. In accordance with their capabilities, all indicated that they were happy with their life in the home, their relationship with staff and the provision of care. Residents' views questionnaires were also provided. Three questionnaires were completed and returned to RQIA. All of the residents who responded indicated full satisfaction with the services provided by the home.

Some comments included:

- "I came here to live a few months ago and I am really enjoying it. The staff are so good to me. They are always around but they are not 'in my face' trying to help me. I'm really glad I came here, for I have good company and the food is lovely."
- "It's good here."
- "I have absolutely no complaints. I like it. We are absolutely spoilt in this place!"
- "The staff are great, you couldn't get better!"

5.4.2 Resident's representative's views

One resident's representative assisted the resident to complete the resident's views questionnaire. The resident's representative indicated a high level of satisfaction with the services provided within the home.

Some comments included:

- "The staff here in Peacehaven have been absolutely wonderful with the care and attention of my (relative). On behalf of my (relative) I can honestly and truly say that my (relative) has received 'the best of care' we could possibly ask for, especially when (my relative) returned to Peacehaven after a short stay in (hospital). I feel the staff worked as a team to make the way for a great recovery for my (relative). Can't thank them enough!!!"

5.4.3 Staff views / questionnaires

We met with two staff members who spoke positively about their role and duties, staff morale, teamwork and managerial support. Staff indicated to us that they felt well supported by training and are given the necessary resources to fulfil their duties.

Staff views questionnaires were also provided. Three questionnaires were completed and returned to RQIA. The staff views questionnaires indicated satisfaction with all aspects of the care provided within the home.

5.4.4 Staffing

At the time of inspection the following staff members were on duty:

- 2 x team supervisor / senior care assistants
- 1 x care assistant

One senior care assistant and one care assistant were scheduled to be on duty later in the day. One care assistant was scheduled to be on overnight duty. The senior care assistant advised us that staffing levels were appropriate for the number and dependency levels of the residents accommodated.

5.4.5 Staff duty rota

We examined the staff duty rota. We noted that the rota did not accurately reflect the capacity in which staff members worked, nor did it record accurately the hours worked by the registered manager. We made a recommendation in this regard.

5.4.6 Environment

The home was found to be clean and tidy. Décor and furnishings were of a good standard.

5.4.7 Care practices

In our discreet observations of care practices we were satisfied that residents were treated with dignity and respect. Care duties were conducted at an unhurried pace with time afforded to interactions with residents in a polite, friendly and supportive manner.

5.4.8 Accidents / incidents

We were advised by the senior care assistant that no accidents or incidents had occurred since the date of the last care inspection. In our inspection of four care records we found that no evidence to suggest that accidents or incidents had occurred. As we did not have access to records, we were unable to fully verify that accidents and incidents were appropriately recorded and managed. This area will be kept under review during future care inspections.

5.4.9 Complaints / compliments

We were advised by the senior care assistant that no complaints or compliments were made since the date of the last care inspection. As we did not have access to records, we were unable to verify that complaints were appropriately recorded and managed. This area will be kept under review during future care inspections.

5.4.10 Fire safety

We were advised by the senior care assistant that the home had a current Fire Safety Risk Assessment. As we did not have access to records, we were unable to verify if any recommendations arising from this assessment had been or were in the process of being addressed. As we did not have access to staff training records, we were unable to confirm that staff had completed fire training twice annually.

Areas for improvement

As previously stated, a requirement was made in relation to ensuring access to records by staff and RQIA. A recommendation was made to ensure that the duty rotas accurately reflected the capacity in which staff worked and the hours worked by the registered manager.

Number of requirements	0	**Number of recommendations**:	1

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Theresa McClory, senior care assistant, on the day of inspection and with Ms Mary O'Hanlon by telephone on February 2016 as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Residential Care Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The DHSSPS Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions taken by the Registered Manager/Registered Person

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to care.team@rqia.org.uk and assessed by the inspector.

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 in this report do not absolve the registered provider/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 provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation Regulation 19 (3) b **Stated:** Third time **To be completed by:** 10 February 2016	The registered person shall ensure that the records required by legislation are accessible at all times by relevant staff and available for inspection by RQIA.
	Response by Registered Person(s) detailing the actions taken: Robust arrangements are now in place to ensure the records required are accessible at all times.
Recommendations	
Recommendation 1 **Ref**: Standard 25.6 **Stated:** First time **To be completed by:** 1 February 2016	The registered person should ensure that the staff duty rota accurately reflects the capacity in which staff members work and should record accurately the hours worked by the registered manager.
	Response by Registered Person(s) detailing the actions taken: The duty rota has been changed as requested.

Registered Manager completing QIP	Mary O'Hanlon	**Date completed**	13.4.16
Registered Person approving QIP	Mary O'Hanlon	**Date approved**	13.4.16
RQIA Inspector assessing response	Alice McTavish	**Date approved**	13/4/16

Please ensure this document is completed in full and returned to care.team@rqia.org.uk from the authorised email address