Peacehaven Residential Home
RQIA ID: 1530
34-38 Newry Street
Rathfriland
BT34 5PY

Inspector: Alice McTavish
Inspection ID: IN022798

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Unannounced Care Inspection
of
Peacehaven Residential Home

7 July 2015

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 7 July 2015 from 10.15 to 13.50. On the day of the inspection we found the home 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 and the DHSSPS Residential Care Homes Minimum Standards (2011).

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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	1	1

The details of the QIP within this report were discussed with the registered manager, Mary O'Hanlon, by telephone on 9 July 2015. 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: Magda Turowska	**Date manager registered:** April 2005
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 previous inspection and to determine if the following standard and theme has been met:

Standard 8: Records are kept in accordance with professional and legislative requirements on each resident's situation, actions taken by staff and reports made to others.

4. Methods/process

Prior to inspection we analysed the following records: returned Quality Improvement Plan from the previous inspection, notifications of accidents and incidents submitted to RQIA.

We met with six residents, two members of care staff, one resident's representative and one visiting professional.

We inspected five care records. We were unable to access the home's policy in relation to records management, the accidents and incidents register, the complaints and compliments register, staff training records and fire safety records. A requirement was therefore restated in this regard.

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 24 February 2015. The completed QIP was returned and was 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 **Ref**: Regulation 19 (2) a	The registered person 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.	**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 to us to inspect.	
Previous inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 9.1	The home has details of each resident's General Practitioner (GP), optometrist and dentist.	**Met**

	All care records should be updated to contain details of the residents' optometrist and dentist, as appropriate.	
	Action taken as confirmed during the inspection: Inspection of a sample of care records confirmed that records had been updated to contain details of the residents' optometrist and dentist, as appropriate.	
Recommendation 2 **Ref**: Standard 20.15	All accidents, incidents, communicable diseases, deaths, and events occurring in the home which adversely affect the wellbeing or safety of any resident are reported promptly to the Regulation and Quality Improvement Authority and other relevant organisations in accordance with legislation and procedures. A record is maintained of all adverse incidents. • Next of kin, Trust and RQIA should be notified of any incident or accident which affects the health, care or welfare of any resident.	**Partially Met**
	Action taken as confirmed during the inspection: Inspection of one resident's care record identified that notification of an accident had been made to the resident's next of kin and to the trust but not been submitted to RQIA.	

5.3 Standard 8: Records are kept in accordance with professional and legislative requirements on each resident's situation, actions taken by staff and reports made to others.

Is care safe? (Quality of life)
In our inspection of individual care records we found that records were maintained of all personal care and support provided. Changes in residents' needs, unusual behaviour or routine and any action taken by staff were recorded. Where there had been contact with a resident's representative about matters or concerns regarding health and welfare of the resident, this had been recorded. Contacts between the staff and primary health and social care services regarding the resident were also noted. Care records contained a recent photograph of each resident.

We noted that care plans were signed and dated by the registered manger, care staff and the residents' representatives.

Is care effective? (Quality of management)
In our inspection of care records we found that a record of personal property of each resident was maintained and updated as necessary. The residents' property records were signed and dated by the staff on duty and by the resident or their representative.

We found the care records to be legible, accurate and up to date. The daily progress notes contained a high level of detail and were countersigned by the supervisor on duty. This was to be commended.

In the daily progress notes of one resident we found that an accident had occurred. The accident had been fully recorded and reported appropriately to the resident's next of kin and to the trust. A notification, however, had not been submitted to RQIA. We restated a recommendation in this regard.

We were unable to access the home's policy in relation to records management, the accidents and incidents register, the complaints and compliments register, staff training records and fire safety records. In our discussions with the registered manager following the inspection, this issue was raised. The registered manager assured us that she was in the process of making robust arrangements to ensure that written records would be available at all times for inspection. The registered manager advised us that it was highly unusual that she was not available on the dates of the last two inspections which were both unannounced. We restated one requirement in this regard.

Is care compassionate? (Quality of care)
In our inspection of individual care records we noted that person centred care plans had been completed and that appropriate risk assessments were present. A monthly review summary had been completed for each resident and minutes of annual care reviews were present. The care records had been completed in a respectful and professional manner.

Areas for improvement
There were two areas of improvement identified from the standard inspected. Overall, this standard was assessed to be safe, effective and compassionate.

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

5.4 Additional areas examined

5.4.1 Residents' views
We met with five residents individually and with others in groups. 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.

Some comments included:

- "I couldn't be in in a better place than here."
- "I'm doing the very best here; all is going well."

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

5.4.3 Resident representatives' views

We met with one resident's representative who expressed a high degree of satisfaction with the care provided within the home.

Some comments included:

- "I am very happy with the care given to (my relative). The staff have been great and have taken such great care of (my relative). I am convinced that they have saved (my relative's) life as (my relative) was so ill and all the care and attention and good nutrition here has led to a good recovery. Nothing is too much trouble for the staff. They keep a very close eye on (my relative) and they report everything to us as a family and are in immediate touch with the GP or the district nurses. I couldn't ask for a better place for (my relative). There is a lovely atmosphere here and everyone is so kind."

5.4.4 Visiting professional's views

We met with one visiting professional who spoke positively about the care provided to residents.

Some comments included:

- "The care here is second to none. The resident I visit appears to be very happy here. There is always plenty of staff around."

5.4.5 Environment

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

5.4.6 Staffing

At the time of inspection the following staff members were on duty:
1 supervisor
2 care assistants

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

5.4.7 Care practices

In our discreet observations of care practices we evidenced 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.

Areas for improvement

There were no areas of improvement identified within the additional areas examined.

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

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager Mary O'Hanlon 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, 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.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref**: Regulation 19 (2) a **Stated:** Second time **To be completed by:** From date of inspection	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.
	Response by Registered Person(s) detailing the actions taken: Arrangements have been put in place to ensure the records required are available for inspection at all times, as discuused with the inspector.

Recommendations	
Recommendation 1 **Ref**: Standard 20.15 **Stated:** Second time **To be completed by:** From date of inspection	The registered manager should ensure that RQIA is notified of any accidents or incidents. Failure to meet this recommendation may result in enforcement action.
	Response by Registered Person(s) detailing the actions taken: All accidents and incidents will be notified to the RQIA as discussed with the inspector.

Registered Manager completing QIP	Miss Mary O'Hanlon	**Date completed**	27/10/2015
Registered Person approving QIP	Miss Mary O'Hanlon	**Date approved**	27/10/2015
RQIA inspector assessing response	Alice McTavish	**Date approved**	02/02/2016

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

Please complete in full and returned to care.team@rqia.org.uk from the authorised email address

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.