Unannounced Care Inspection Report
21 February 2019

Dunlarg Care Home

Type of Service: Residential Care Home
Address: Residential Unit, 224 Keady Road, Armagh BT60 3EW
Tel No: 028 3753 0858
Inspector: Alice McTavish

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 service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home with eight beds that provides care for older residents and for older people who experience mental ill health.

3.0 Service details

Organisation/Registered Provider: Four Seasons (Bamford) Ltd **Responsible Individual:** Maureen Claire Royston	**Registered Manager:** Patricia Graham
Person in charge at the time of inspection: Edel Treanor, deputy manager, until 13.15 Patricia Graham after 13.15	**Date manager registered:** 12 February 2018
Categories of care: Residential Care (RC) I - Old age not falling within any other category MP (E) - Mental disorder excluding learning disability or dementia – over 65 years	**Number of registered places:** 8

4.0 Inspection summary

An unannounced inspection took place on 21 February 2019 from 10.50 to 14.40.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

The inspection sought to assess compliance with the areas for improvement identified during the last care inspection, to review care records and to examine the home's environment.

Residents said that the staff provided very good care and that they were treated very well. The family of a resident said that they were very pleased with the care in Dunlarg and that their relative enjoyed loving there.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and resident experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Patricia Graham, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the Quality Improvement Plan (QIP), no further actions were required to be taken following the most recent inspection on 12 September 2018.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records: the report of the last care inspection, the returned QIP, notifications of accidents and incidents and any written or verbal communication received since the last inspection.

During the inspection the inspector met with the deputy manager and the registered manager, four residents, two relatives of a resident and a senior care assistant.

A total of eight questionnaires was provided for distribution to residents and/or their representatives to enable them to share their views with RQIA. A poster was provided for staff detailing how they could complete an electronic questionnaire. No questionnaires were returned by residents, residents' representatives or staff within the agreed timescale.

The following records were examined during the inspection: records of fire drills and the care files of three residents.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 12 September 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 12 September 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 23.6 **Stated:** First time **To be completed by:** 14 December 2018	The registered person shall ensure the records of fire drills are maintained for the residential care home separate to those of the adjoining nursing home. Ref: 6.4	**Met**
	Action taken as confirmed during the inspection: Discussion with the deputy manager and inspection of fire safety records confirmed that the records of fire drills were maintained for the residential care home separate to those of the adjoining nursing home.	

6.3 Inspection findings

Care records

A review of the care records confirmed that these were maintained in line with the legislation and standards. The records were written in a professional manner using language which was respectful to the individual.

The care files for each resident were stored on an electronic system and staff had access to this. The files contained pre-admission information which allowed staff to become familiar with the specific needs of each individual and to make preparations to meet these needs in the home.

Staff in the home completed care needs assessments, risk assessments and care plans for each resident. The risk assessments covered such areas as moving and handling, choking, nutrition, falls and skin condition, where necessary. The care plans provided staff with guidance as to how the identified needs should be met and how any risks present could be minimised. The care documentation was completed in detail and with a focus on individualised, person-centred care.

All documents were kept up to date, regularly reviewed and appropriately signed and dated. The care plans noted consent and integrated Human Rights considerations throughout. This represented good practice.

It was noted on a diet form that a resident had an allergy to aspirin. The electronic records did not contain this information. This was discussed with the registered manager who immediately updated the care records.

Multi-professional involvement in the residents' health and social care needs was documented where necessary and this was kept up to date to accurately reflect any changes. The care records noted visits from General Practitioners (GPs), community nursing, dieticians, speech and language therapists and other associated professionals.

Residents were weighed regularly and any significant weight loss was appropriately referred to the resident's GPs; this was a rare occurrence, however, and the care staff and the cook reported that there was good communication between care and catering staff to ensure that residents at risk of losing weight were provided with an enriched diet.

There were regular reviews of the care provided in the home which were attended by all relevant parties.

It was evident that there were systems in place to ensure that written and verbal information was accurately and comprehensively recorded. This supported the delivery of safe and effective care whilst also supporting person-centred, compassionate care to the individual residents. It was also evident that the registered manager ensured that care records were maintained to a good standard and that care in the home was well led.

The home's environment

A general inspection of the home was undertaken. All communal areas, bedrooms and bathrooms were found to be clean, warm, comfortably furnished and well decorated. The residents' bedrooms were individualised with photographs, memorabilia and personal items. There were no malodours. The home and grounds were kept tidy, safe, suitable for and accessible to residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff.

Residents spoken with during the inspection made the following comments:

- "The staff are always around to help if we need it and they come to us immediately if we ring the call bell. If I am in any pain, I tell the staff and I get the tablets or the cream I need. We get lots to eat and drink and there are things arranged for us to do. Our rooms are kept very clean and I am able to have my personal possessions here – that's important to me."
- "I like living here. The staff are very good to us all and they know us well."
- "The staff come to me very quickly if I use my call bell, even at night – there is no delay at all. I get everything I need and everywhere is kept lovely and clean. The staff have got to know me very well since I came here. They know my routine and what I like and what I don't like. They are absolutely lovely and they treat me very well. They have the time to sit and chat with me and there's things laid on for me to do, if I want to. I have no complaints at all."

Relatives spoken with during the inspection made the following comments:

- "The staff are always around to make sure the residents are safe. We are kept fully informed if anything happens to (our relative). She loves living here. The staff treat her with great kindness and we are always made to feel welcome when we visit. We are very happy with the care here and have absolutely no complaints. We have the opportunity to discuss (our relative's) care with the staff when we visit and we are due to go to the care review which happens every year."

Staff spoken with during the inspection made the following comments:

- “We have come to know the residents very well as there are only eight. We know the individual preferences of each resident, what they like to do and how they like us to help them. I feel the residents get very good care here.”

Areas of good practice

Good practice was found throughout the inspection in relation to care records, in particular how consent was obtained and how Human Rights were considered for each individual.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or includedas part of this inspection report.

The Regulation and Quality Improvement Authority

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