Inspection Report

15 and 18 November 2021

Ard Cuan

Type of Service: Residential Care Home
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Ard Cuan **Responsible Individual(s):** James Caldwell William McClintock	**Registered Manager:** Mrs Frances Ann Mullan **Date registered:** 21 September 2007
Person in charge at the time of inspection: Ms Frances Ann Mullan –Manager	**Number of registered places:** 17 A maximum of 10 service users in category RC-DE
Categories of care: Residential Care (RC) I – Old age not falling within any other category. DE – Dementia.	**Number of residents accommodated in the residential care home on the day of this inspection:** 14
Brief description of the accommodation/how the service operates: This home is a registered Residential Home which provides social care for up to 17 residents. The home is divided over two floors with bedrooms on both floors and access to a communal dining room, lounge and garden on the ground floor.	

2.0 Inspection summary

An unannounced inspection took place on 15 November 2021, from 9.30am to 1.15pm by a pharmacist inspector and on 18 November 2021, from 9.45 am to 3.45 pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care and pharmacy inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Areas requiring improvement were identified. Details can be found in the Quality Improvement Plan (QIP) in section 7.0.

Residents said that living in the home was a good experience. Residents unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from residents, visiting healthcare professionals and staff, are included in the main body of this report.

RQIA were assured that the delivery of care and service provided in Ard Cuan was safe, effective, compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and service.

Review of medicines management found that residents were being administered their medicines as prescribed. Arrangements were in place to ensure that staff were trained and competent in medicines management. However, five areas for improvement were identified, relating to medicine record keeping, the management of controlled drugs and medicine refrigerator temperature monitoring.

The findings of this report will provide the Manager with the necessary information to improve staff practice and the residents' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, relatives, staff or the Commissioning Trust.

Throughout the inspection residents, their relatives or visitors and staff were asked for their opinion on the quality of the care; and their experience of living, visiting or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

At the end of the inspection the Manager was provided with details of the findings.

4.0 What people told us about the service

We spoke with nine residents, one relative, one visiting professional and two staff.

Residents were complimentary about the care and staff in the home stating "I wouldn't want to go anywhere else", and "the girls (staff) are great." A relative said they were "happy with the staff and they keep me well informed." A visiting professional said "the home is exceptional." Staff commented that there was "good team work and the manager is really supportive.".

No resident or relative questionnaires were received following the inspection and there was no response to the online staff survey.

A record of compliments received in the home were kept and shared with staff

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 20 November 2020		
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 27.5 **Stated:** First time	The registered person shall ensure the following: • an audit is undertaken of all large items of freestanding furniture and corrective action is taken, where necessary • the linen storage room on the lower ground floor is tidied and no items are stored on the floor.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref**: Standard 8.5 **Stated:** First time	The registered person shall ensure that all care records are appropriately signed and dated.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 3 **Ref**: Standard 4.6 **Stated:** First time	The registered person shall ensure that all individual written agreements are kept up to date.	**Met**

	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect residents.

There were systems in place to ensure staff were trained and supported to do their job. Mandatory training was progressing and additional training was provided in dementia awareness, continence care, personal care, catheter care and COVID-19.

Staff said there was good team work and that they felt well supported in their role, were satisfied with the staffing levels and the level of communication between staff and management.

Records confirmed that staff received an appraisal of their work and supervision was being completed. A supervision matrix was required to advise when this had been planned and completed. This was discussed with the manager for her review and action.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty. Staff told us that there was enough staff on duty to meet the needs of the residents. The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the residents were met. Examination of the staff duty rota confirmed this.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day. For example, residents were assisted to spend time in the company of others in the communal rooms or if preferred to spend time in their own bedrooms.

Staff told us that the residents' needs and wishes were important and it was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Residents said staff were around if you needed them and they provided good care. Residents were complimentary of the care provided.

Visiting professionals said there were enough staff in the home, staff were knowledgeable about the needs of residents, followed all recommendations made by the nursing team, ensured good communication with professional colleagues and staff knew the residents well.

5.2.2 Care Delivery and Record Keeping

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs. Staff took time to explain to residents what was happening before providing care or assistance.

At times some residents may be required to use equipment that can be considered to be restrictive. For example, bed rails, alarm mats. It was established that safe systems were in place to manage this aspect of care.

A handover report was provided to staff at the beginning of each shift to discuss any changes in the needs of the residents. Staff were knowledgeable of individual residents' needs, their daily routines, wishes and preferences.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly.

Residents who are less able to mobilise require special attention to their skin care. These residents were assisted by staff to change their position regularly. Care records accurately reflected the residents' needs and if required care staff consulted the district nurse and followed any recommendations they made.

Where a resident was at risk of falling, measures to reduce this risk were put in place. For example, bed rails and buzzer mats were in place following a risk assessment.

Examination of records and discussion with staff confirmed that the risk of falling and falls were well managed. There was evidence of appropriate onward referral as a result of the post falls review.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff. Staff were knowledgeable about modified diets required by residents and posters were displayed in the kitchen describing the International Dysphagia Standardisation Initiative (IDDSI) information.

The dining experience was an opportunity of residents to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed that residents were enjoying their meal and their dining experience. Staff had made an effort to ensure residents were comfortable, had a pleasant experience and had a meal that they enjoyed.

There was choice of meals offered, the food was attractively presented and smelled appetising, and portions were generous. There was a variety of drinks available. Residents were complimentary about the meals and chatted about daily life in the home.

Residents' needs were assessed at the time of their admission to the home.

Following this initial assessment care plans were developed to direct staff on how to meet residents' needs; and included any advice or recommendations made by other healthcare professionals. Residents care records were held confidentially.

Two care records reviewed identified that they had not been regularly reviewed and updated for moving and handling equipment, repositioning needs, food and fluid intake and recording of weight loss to meet residents assessed care needs. An area for improvement was identified.

Residents' individual likes and preferences were reflected throughout the records. Care plans contained specific information on what or who was important to them.

Daily records were kept of how each resident spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

5.2.3 Management of the Environment and Infection Prevention and Control

Observation of the home's environment evidenced that the home was clean, tidy and generally well maintained. For example. residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were well decorated, suitably furnished and comfortable. Residents could choose where to sit or where to take their meals and staff were observed supporting residents to make these choices.

There was evidence throughout the home of 'homely' touches such as the daily newspapers, snacks and drinks available and photographs of residents enjoying the activity programme provided.

Fire safety measures were in place and well managed to ensure residents, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks.

In a bathroom it was observed that a bottle of a chemical spray cleaner was in an unlocked drawer. This was brought to the attention of staff for immediate action. An area for improvement was identified.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for residents, staff and care partners and any outbreak of infection was reported to the Public Health Authority (PHA).

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

Visiting arrangements were managed in line with DoH and IPC guidance.

5.2.4 Quality of Life for Residents

Discussion with residents confirmed that they were able to choose how they spent their day. For example, residents could have a lie in or stay up late to watch TV. Residents could have family in their room during visiting and spent time in communal areas with other residents or in their own bedrooms.

Residents also told us that they were encouraged to participate in regular residents' meetings which provided an opportunity for residents to comment on aspects of the running of the home. This included planning activities, visiting arrangements, décor of the home and menu choices.

It was observed that staff offered choices to residents throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

There was a range of activities provided for residents by staff. As said previously residents had helped plan their activity programme. The range of activities included movies, video sing a long, games and tea and a chat.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted residents to make phone or video calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of residents.

Residents confirmed that they were assisted by staff to stay in contact with relatives throughout the COVID-19 pandemic and were receiving visitor in the home regularly.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Frances Ann Mullan has been the manager in this home since 21 September 2007.

There was evidence that robust systems of auditing were not fully in place to monitor the quality of care and other services provided to residents. This is in relation to care plans, wound care and restraint oversight. An area for improvement was identified.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Residents spoken with said that they knew how to report any concerns and said they were confident that this would be managed well. Review of the home's record of complaints confirmed that these were well managed and used as a learning opportunity to improve practices and the quality of services provided by the home.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about residents, care practices or the environment.

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to residents' next of kin, their care manager and to RQIA.

Staff commented positively about the manager and described her as supportive, approachable and always available for guidance.

The home was visited each month by the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by residents, their representatives, the Trust and RQIA.

5.2.6 Management of Medicines

The audits completed at the inspection indicated that the residents had received their medicines as prescribed.

Personal medication records were in place for each resident. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments. The residents' personal medication records reviewed were mostly accurate and up to date; a couple of anomalies were drawn to the attention of the manager for immediate corrective action. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate.

It is important to have a clear record of which medicines have been administered to residents to ensure that they are receiving the correct prescribed treatment. A sample of the medicine administration records was reviewed. Most of the records were found to have been completed to the required standard; however, there were several instances where they had been inaccurately completed. An area for improvement was identified.

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the resident's medicines are available for administration as prescribed. The records inspected showed that medicines were available for administration when residents required them.

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another. The management of medicines for two residents who had been admitted to this home were reviewed. Staff had been provided with a list of prescribed medicines from the hospital. The residents' personal medication records had been accurately written. Medicines had been accurately received into the home and administered in accordance with the prescribed directions.

Medicines must be stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error. The medicines storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located.

To ensure that medicines requiring cold storage are stored in accordance with the manufacturers' instructions, the refrigerator temperature must be maintained between 2°C and 8°C. Staff should record the temperature range daily. However, the temperature range of the medicine refrigerator had not been recorded since 12 October 2021. The registered person must ensure that the medicine refrigerator temperature range is monitored and recorded each day. An area for improvement was identified.

Records were maintained of the disposal of medicines.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. Some improvement in the standard for the management of controlled drugs was necessary. The receipts, administrations and disposals of controlled drugs were not recorded in a controlled drug record book. On the morning of the inspection, the controlled drugs stock reconciliation record had only been signed by the staff member going off duty and the quantity in stock had not been recorded. A controlled drugs record book must be maintained and controlled drug stock reconciliation checks must be carried out and recorded by the two staff members at each shift handover. Two areas for improvement were identified.

The records of two residents who were prescribed regular analgesia were reviewed; each resident had a pain management care plan.

Residents will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and its effect. The records belonging to one resident were reviewed. Directions for use were clearly recorded on the personal medication records and a care plan directing the use of these medicines was available. The medicine had been infrequently used.

Some residents may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the resident should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the resident. The management of a thickener was reviewed for one resident. A speech and language assessment report and care plan was in place. However, the thickener was not recorded on the personal medication record and the administrations were not recorded. An area for improvement was identified.

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter.

A written record was completed for induction and competency assessments. The manager gave an assurance that additional training would be provided to staff in relation to the areas for improvement identified at this inspection.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. Several areas were the audits could be further developed were discussed with the manager.

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. The audit system in place in this home helps staff to identify medicine related incidents.

6.0 Conclusion

Residents were observed to be relaxed, well dress and attention had been taken with their personal care. Staff and residents were enjoying singing to Elvis Presley songs during the sing along.

Residents were complimentary about the meals and snacks provided and said “it’s a lovely lunch, especially the sticky toffee pudding.”

The home was clean tidy and well decorated and the garden was well maintained for residents use. The staff on duty had their names and pictures displayed on the wall for residents and visitors.

Based on the inspection findings eight areas for improvement were identified. Two were in relation to safe and effective care, one was in relation to the service being well led and five were in relation to the management of medicines – details can be found in the Quality Improvement plan in section 7.0.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Residential Care Homes Regulations (Northern Ireland) 2005 and/or the Residential Care Homes’ Minimum Standards (August 2011) (Version 1:1).**

	Regulations	Standards
Total number of Areas for Improvement	5	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Frances Ann Mullan, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure cleaning chemicals are stored in a secure area to prevent hazards to residents' safety. Ref: 5.2.3
	Response by registered person detailing the actions taken: All cleaning chemicals are stored securely and COSHH training for all staff compeleted
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that medicine administration records are accurately completed Ref: 5.2.6
	Response by registered person detailing the actions taken: Management have ensured that the administrstion of records are completed accurately , this is audtited weekly.
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that a controlled drugs record book is maintained. Ref: 5.2.6
	Response by registered person detailing the actions taken: This is in place.
Area for improvement 4 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that controlled drug stock reconciliation checks are performed and recorded by two staff members at each shift handover. Ref: 5.2.6
	Response by registered person detailing the actions taken: This is in place and audited weekly.
Area for improvement 5 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall ensure that full records of the prescribing and administration of thickeners are maintained. Ref: 5.2.6
	Response by registered person detailing the actions taken:

To be completed by: With immediate effect	Completed and in place before end of inspection.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)	
Area for improvement 1 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the residents care plan is kept up to date and reflects the resident's current needs in relation to moving and handling equipment, repositioning needs, food and fluid intake and recording of weight. Ref: 5.2.2
	Response by registered person detailing the actions taken: All completed and updated.
Area for improvement 2 **Ref:** Standard 20.10 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure working practices are systematically audited to ensure they are consistent with the homes documented policies and procedures and action is taken when necessary. Ref: 5.2.5
	Response by registered person detailing the actions taken: Completed and audit in place.
Area for improvement 3 **Ref:** Standard 32 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the temperature range of the medicine refrigerator is monitored and recorded each day. Ref: 5.2.6
	Response by registered person detailing the actions taken: In place and audited weekly

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