Unannounced Care Inspection Report
2 July 2019

2-1-2 Old Holywood Road

Type of Service: Residential Care Home
Address: 212 Old Holywood Road, Holywood BT18 9QS
Tel no: 028 9042 5554
Inspectors: Marie-Claire Quinn & Helen Daly

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

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.0 What we look for

2.0 Profile of service

This is a residential care home which is registered to provide care for up to 14 residents living with a learning disability.

3.0 Service details

Organisation/Registered Provider: Cornerstone Care 212 Limited **Responsible Individual:** Mrs Irene McBurney	**Registered Manager and date registered:** Mrs Irene McBurney 10 July 2017
Person in charge at the time of inspection: Mrs Irene McBurney	**Number of registered places:** 14 The home is approved to provide care on a day basis only to one person.
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 13

4.0 Inspection summary

An unannounced inspection took place on 2 July 2019 from 09.30 to 14.30 hours.

This inspection was undertaken by care and pharmacist inspectors.

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

Evidence of good practice was found in relation to staffing, communication, relationships between residents and staff, the culture and ethos of the home, complaints management, management of medication changes, antibiotics, thickening agents and the management of medication related incidents.

Areas for improvement were identified in relation to the management of distressed reactions, consent records, monthly monitoring reports and audits in the home.

Residents were seen to be relaxed and comfortable in their surroundings and in their interactions with staff.

Comments received from residents and staff during the inspection, are included in the main body of this report.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	4

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Irene McBurney, Registered Manager and Ms Alison Bradford, Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 30 January 2019.

The most recent inspection of the home was an announced care inspection undertaken on 30 January 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the last care and medicines management inspection findings, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with residents, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. No responses were received within the agreed time frame.

During the inspection a sample of records was examined which included:

- care records of three residents
- recruitment and induction records for one member of staff
- competency and capability assessments for four members of staff
- minutes of relatives meeting 1 May 2019
- annual feedback questionnaires for 2019
- annual quality review report for 2019 (submitted post-inspection)

- staff training matrix
- a sample of audits of medical device cleaning, accidents and the environment in the home
- minutes of staff meeting 24 January 2019
- complaints records
- monthly monitoring reports dated 28 February, 31 March, 29 April and 30 May 2019
- records for the management of medicines on admission and medication changes
- records relating to the management of distressed reactions, pain, controlled drugs, antibiotics, time-critical medicines, thickening agents and medication related incidents
- personal medication records, medicine administration records, medicines requested, received and transferred/disposed of
- medicines management audits
- storage temperatures for medicines
- care plans regarding the management of medicines

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 outstanding areas for improvement from the last care and medicines management inspections

One area for improvement was identified at the last care inspection. This was reviewed and has now been met.

The three areas for improvement identified at the last medicines management inspection were reviewed and assessed as met.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to residents and clients from the care, treatment and support that is intended to help them.

Staffing levels on the day of inspection were adequate to meet the needs of the residents. Residents appeared content and relaxed when interacting with staff. Staff responded promptly and kindly to residents, including those presenting with distressed reactions. No concerns regarding staffing levels were raised by residents or staff. Staff commented, “I’m very happy here. Everyone helps out.”

We confirmed that staff are recruited safely, with appropriate checks completed prior to starting work in the home. The home had recently employed an activities co-ordinator who was commencing their induction on the day of inspection.

Staff mandatory training was up to date. Staff stated:

- "the training on challenging behaviours and safeguarding was very good."
- "we had good training on managing challenging behaviours."

The manager also ensured that staff were sufficiently skilled to work in the home through supervision, annual appraisal and competency and capability assessments. Management agreed to plan these dates in advance to ensure full compliance with standards.

Discussion with the registered manager prior to and during the inspection confirmed that the home adheres to adult safeguarding policy and procedures.

The home was clean, warm and tidy. Bedrooms were personalised with ample furniture. Staff wore aprons and gloves when required. We did note that a store room was unlocked, and cleaning materials were easily accessible as they had been incorrectly stored. This was highlighted to the manager, who immediately rectified this. We discussed the importance of full adherence to COSHH and the manager added this to the agenda for the staff meeting, which was being held on the day of inspection.

We observed that a piece of broken furniture was being stored in the smoking area, which also had inadequate smoking facilities. This was highlighted to the deputy manager who immediately rectified this. There were no other obvious hazards to residents' health and safety. Staff were attending their twice-yearly fire safety training on the day of inspection.

Medicines Management

Satisfactory systems for the following areas of the management of medicines were observed: staff training and competency assessment, the majority of medicine records, the management of medicines on admission and medication changes, the management of pain, controlled drugs, antibiotics, time-critical medicines, thickening agents and medication incidents.

We reviewed twelve personal medication records in detail. They were up to date and correlated with the most recent prescriptions. The date of writing had been recorded and updates had been verified and signed by two members of staff. Discontinued medicines had been cancelled. Prescribed thickening agents were recorded on the personal medication records. Obsolete personal medication records had been cancelled and archived.

We reviewed three care plans for the management of pain. Details of how the residents may express their pain and their prescribed medicines were recorded.

We reviewed the management of controlled drugs. One care assistant was responsible for the medicine and controlled drug keys during each shift. Balances were checked by two staff at the handover of responsibility.

We reviewed the management of distressed reactions for three residents. Care plans, including details of prescribed medicines, were in place for two of these residents. The deputy manager advised that this had been an oversight and that a care plan would be written before the end of the day. Stock balances were recorded following administration of these medicines. The reason for administration was recorded on the medication administration records and/or daily notes on some but not all occasions. The outcome of administration was not recorded. The

registered manager should ensure that the reason for and outcome of each administration is recorded on all occasions. An area for improvement was identified.

Medicines were observed to be stored safely and securely. However, omissions were observed in the daily record of refrigerator temperature. On those days when it was recorded it was within the accepted range and it was acknowledged that nutritional supplements were the only medicines stored in the refrigerator to make them more pleasant for residents to eat. It was agreed that staff would be reminded to monitor and record the refrigerator temperature each day and that this would be included in the auditing system.

Daily counts and monthly audits were completed on medicines which were not included in the monitored dosage system. It was agreed that nutritional supplements would be included in the audits.

Areas of good practice

Areas of good practice were identified in relation to staffing, the management of medication changes, antibiotics, thickening agents and the management of medication related incidents.

Areas for improvement

One area for improvement was identified within this domain. The management of distressed reactions should be reviewed and revised to ensure that the reason for and outcome of each administration is recorded.

	Regulations	Standards
Total number of areas for improvement	0	1

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

Residents appeared relaxed, comfortable and with personal care attended to. We observed positive and friendly interactions between residents and staff. Several staff who were not on duty, but in the home for training, were warmly greeted by residents. There was a friendly rapport between residents and staff.

Staff used a range of verbal and non-verbal communication styles with residents. We saw staff speak to and respond appropriately to residents, gently encouraging them when required. Staff presented with good knowledge and understanding of residents' individual needs, interests and communication style. Residents' bedrooms contained written and visual guides on their preferred communication methods, such as a communication dictionary or a traffic light behaviour support plan. Comments from staff included:

- "it's very relaxed here. Residents are enjoyable to work with. Like all of us, residents can change day to day, but we know their routines and how to react."
- "We know how to deescalate things and only use medication when necessary. It's all detailed in care plans."

Review of care records was satisfactory. Care plans included necessary information for staff to support residents, such as how to appropriately respond if a resident's behaviour changes. The home maintained liaison with multi-agency professionals such as G.P, district nursing, psychology, speech and language therapist and dieticians. Person centred behaviour intervention plans were in place and included strategies the staff can implement to maintain residents' comfort and health.

Written records of consent were retained in care records. We noted that they did not include consent for photographs of residents, display of photographs or information sharing arrangements such as RQIA having access to care records. An area of improvement has been made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication and the relationships between residents and staff.

Areas for improvement

One area for improvement was identified within this domain, in relation to updating written records of consent.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Residents had their own individual routine, which was supported by staff. Some residents were enjoying a lie in as they had been on an outing with the staff the night before. Those residents who declined to speak to us appeared well cared for; one resident was helping staff with their laundry as they like to maintain their independent living skills.

Staff advised that they were pleased as the home had recruited an activities co-ordinator, who works well with the residents. We saw residents in the lounge engaging in a range of activities including watching their favourite television show, completing jigsaws, playing with Lego and listening to music. One resident was eager to listen to music on their iPad and enjoyed their breakfast while staff brushed their hair, a sensory activity they find soothing. Another resident communicated their love of bus outings and playing guitar. They were particularly pleased to be getting sausages for lunch that day, one of their favourite foods.

We saw staff knock bedroom doors before entering, and seek verbal and non-verbal agreement from residents before providing care. Observation of practice, review of care records and discussion with staff confirmed that residents' independence was promoted where possible. This was tailored to the specific abilities and preferences of the resident.

Staff advocated for residents when required. For instance, one resident had been keen to attend day opportunities; there had been some difficulties sourcing an appropriate placement, however staff persisted and the resident is happy to be starting this in the next few weeks.

Care plans included consideration of residents' human rights. Deprivation of liberty assessments were retained in care plans and it was positive that these were individualised to the resident. We did note that these assessments did not explicitly reference the involvement of residents, relatives and multi-agency professionals. Evidence of this discussion and agreement was included in residents' annual care reviews. We asked the home to ensure that this was reflected in all relevant documentation, to ensure that any practices were regularly reviewed and agreed to be proportionate and necessary for resident's safety.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home.

Areas for improvement

No areas for improvement were identified within this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Staff advised that management were supportive and accessible. The manager and deputy manager outlined plans to recruit senior care staff in the home, to provide additional managerial oversight and support.

There was evidence of openness and transparency in the home. The residents guide, the home's Statement of Purpose and the home's complaints policy were visible and easily accessible in the home. Review of complaints records was satisfactory.

Review of the home's annual feedback questionnaires confirmed that residents and relatives were positive about the care provided in the home. The home had not completed their annual quality review report. The need for this was discussed with management, and the report was sent to RQIA following the inspection.

In response to requests from relatives, the home now holds regular relatives meetings. We reviewed the minutes of the last meeting, and relatives reported they were all very happy with the care provided in the home. Relatives had also made several suggestions regarding activities in the home, such as a BBQ for residents, relatives and friends, gardening and an outing to a local donkey sanctuary. Management advised there are plans to implement these suggestions over the summer.

We reviewed the home's monthly monitoring reports. Reports did not include adequate detail or evidence that sufficient efforts had been made to gather feedback from relatives if no visitors were in the home during the inspection. An area for improvement was made under regulation. An area for improvement was made under standards as there was limited evidence that action plans were reviewed and implemented in a timely manner.

An area of improvement was made in relation to audits of practice in the home. These were not regularly reviewed and we discussed how these could be improved to ensure sufficient managerial oversight. Management are aware of the need to delegate tasks in the home, and we agreed that the proposed staffing changes would be beneficial to maintain the quality of care and drive improvement in the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to complaints management.

Areas for improvement

Three areas for improvement were identified within this domain. This was in relation to monthly monitoring reports and systematic review or audits of working practices in the home.

	Regulations	Standards
Total number of areas for improvement	1	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Irene McBurney, Registered Manager and Ms Alison Bradford, Deputy Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 29. – (4) (a) **Stated:** First time **To be completed by:** 2 September 2019	The registered person shall ensure that the person carrying out the monthly monitoring visit shall interview, with their consent and in private, residents' representatives in order to form an opinion of the standard of care provided in the home. If no representatives are present in the home during the visit, attempts should be made to gather their views by other methods such as telephone or email. Ref: 6.6
	Response by registered person detailing the actions taken: Registered manager has informed the person carrying out monthly reviews of the areas for improvement as a result of this inspection. This has now been addressed and is evident in the review dated 31/7/2019 when two families have been contacted via telephone and their opinions received on the care of their loved one.
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 2 August 2019	The registered person shall review and revise the management of distressed reactions. The reason for and outcome of each administration should be recorded. Ref: 6.4
	Response by registered person detailing the actions taken: Tool box talk on distressed reactors have been documented and briefs carried out with the staff. A new form has been sourced from pharmacy which has been placed in the medicine kardex, this records the time distressed reactors have been given, the reason for its administration, and the effect of medication. All staff who administer medication have received written documentation on the above after the inspection and have dated receipt of same.
Area for improvement 2 **Ref**: Standard 7.4 **Stated:** First time **To be completed by:** 2 October 2019	The registered person shall ensure that completed written consent forms, where used, are maintained within individual consent records. These forms should include reference to the use and display of photographs of residents and information sharing arrangements, including whether the resident consents for care records to be reviewed by RQIA or others not employed in the home. Ref: 6.5

	Response by registered person detailing the actions taken: New forms have been completed for the use and display of photographs of residents also the disclosure and sharing of personal information and to whom this information may be shared. Forms have been signed and placed in the residents file.
Area for improvement 3 **Ref**: Standard 20.11 **Stated:** First time **To be completed by:** 2 September 2019	The registered person shall ensure that the monthly monitoring report includes a clear, timely plan of any actions taken by the registered person or registered manager to ensure that the organisation is being managed in accordance with minimum standards. Ref: 6.6
	Response by registered person detailing the actions taken: The registered manager has now included a section in the Regulation 29 form for documented actions by manager and the date of implementation.
Area for improvement 4 **Ref**: Standard 20.10 **Stated:** First time **To be completed by:** 2 September 2019	The registered person shall ensure that working practices are systematically audited to ensure they are consistent with the home's documented policies and procedures and action is taken when necessary. Ref: 6.6
	Response by registered person detailing the actions taken: Management will continue to audit such audits as complaints, medication and accidents within the first week of each month. A process is in place now for senior carers to be delegated the task of auditing care audits on a daily basis. Management have devised a programme detailing which audits will be carried out daily to ensure all standards of care are audited at least monthly. Senior carers will highlight to management any problems noted and management will take actions as required prior to filing the audit.

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care