Unannounced Care Inspection Report
23 May 2017

Ailsa Lodge

Type of Service: Nursing Home
Address: 6 Killaire Avenue, Carnalea, Bangor, BT19 1EW
Tel no: 028 9145 2225
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Ailsa Lodge took place on 23 May 2017 from 10:00 to 16:15.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment. Observation of the delivery of care and discussion with patents and staff evidenced that patients' needs were met by the levels and skill mix of staff on duty. A recommendation was made that the nurse given the responsibility of being in charge of the home in the absence of the registered manager should be clearly identified on the duty rota.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

A review of the home's environment was undertaken and the home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. Infection prevention and control measures were adhered to. Fire exits and corridors were observed to be clear of clutter and obstruction.

Is care effective?

A review of three patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. One area for improvement with regard to the updating of care plans was identified in the previous inspection and is stated for a second time as a result of this inspection.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Discussion with the assistant manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Is care compassionate?

Staff interaction with patients was observed to be compassionate, caring and timely. Consultation with 11 patients individually and with others in small groups confirmed that patients were afforded choice, privacy, dignity and respect. Patients stated they were involved in making choices about their own care. Staff demonstrated a detailed knowledge of patients' wishes, likes and dislikes. All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. A number of their comments are included in the report.

Ten relative questionnaires were issued; two were returned within the timescale for inclusion in this report. The relatives were very satisfied or satisfied with care provided across the four domains.

We issued ten questionnaires to nursing, care and ancillary staff; six were returned prior to the issue of this report. Staff were either very satisfied or satisfied with the care provided across the four domains.

There were no areas for improvement identified in this domain.

Is the service well led?

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required. Discussion with staff confirmed that there were good working relationships and that management were responsive to suggestions made.

Review of records evidenced that the registered manager completed a monthly report to review the quality of the services delivered. The monthly reported included discussion with patients, relatives and staff and a summary of their opinions on the service delivered. A copy of the monthly reports was available in the home.

There were no areas for improvement identified in this domain.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**2***

* One of the recommendations was made as a result of the previous inspection and is now stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ada Johnston, assistant 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.

1.2 Actions/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 14 October 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Ailsa Lodge Jacqueline Christina Mary Robinson	**Registered manager:** Jacqueline Christina Mary Robinson
Person in charge of the home at the time of inspection: Ada Johnston, assistant manager	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 41

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with eleven patients individually and with the majority in small groups, one registered nurse, two care staff, one member of housekeeping staff and the relatives of two patients.

Questionnaires were also left in the home to facilitate feedback from relatives and staff not on duty. Ten staff and relative questionnaires were left for completion.

The following information was examined during the inspection:

- Duty rota for all staff for the week of the inspection
- Records confirming registration of staff with the Nursing and Midwifery Council (NMC)and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment files
- competency and capability assessments of nurses
- four patient care records
- record of staff meetings
- patient register
- complaints and compliments record
- record of audits
- RQIA registration certificate
- certificate of public liability
- monthly monitoring reports

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 November 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 14 October 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 38.3 **Stated:** First time	It is recommended that a pre- employment health assessment is obtained as part of the recruitment process.	**Met**
	Action taken as confirmed during the inspection: A review of documentation evidenced that a healthcare questionnaire has been put in place for inclusion in the recruitment process. There has been no staff recruited since the previous care inspection. Following discussion with staff we were assured that this form would be embedded into the recruitment process. This recommendation has been met.	

Recommendation 2 **Ref**: Standard 13 **Stated:** First time	It is recommended that where a complaint has the potential to be a safeguarding issue advice is sought from the appropriate health and social care trust prior to commencing the complaints process.	**Met**
	Action taken as confirmed during the inspection: A review of the complaints record and discussion regarding potential safeguarding issues evidenced that these processes were managed appropriately. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 4 **Stated:** First time	It is recommended that when patients' needs are reassessed care plans should be reviewed and updated to accurately reflect the prescribed care.	**Partially Met**
	Action taken as confirmed during the inspection: We reviewed three care records and observed that care plans were regularly reviewed to ensure they continued to meet the needs of the patients. In one care record the patient has been reassessed by the speech and language therapist and changes made to the modification of their meals. The care plan had not been updated to reflect this significant change. This recommendation is assessed as partially met and is stated for a second time.	

4.3 Is care safe?

The assistant manager confirmed the planned daily staffing levels for the home and that staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 22 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Observation of the delivery of care and discussion with patients evidenced that their needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; six were returned following the inspection. All of the respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?".

Patients and three relative spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in timely manner. We sought relatives' opinion on staffing via questionnaires; two were returned in time for inclusion in the report. The relatives were very satisfied or satisfied that there was sufficient staff to meet the needs of their loved one.

The assistant manager confirmed that a nurse was identified to take charge of the home when the registered manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home. On the day of the inspection the nurses were unsure which one was in charge. The nurse given the responsibility of being in charge of the home in the absence of the registered manager should be clearly identified and communicated to staff. A recommendation was made.

A review of two staff recruitment records evidenced that they were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records confirmed that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the assistant manager. A review of the records of NMC registration evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The record of the checks of care staff registration included the expiry date of their registration with NISCC.

The assistant manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe.

We discussed the provision of mandatory training with staff and reviewed the training records for 2016/2017. Training records in 2016 evidenced good compliance; for example 100% of staff had completed training in safeguarding, infection prevention and fire awareness. Records evidenced that training has been arranged for 2017, for example dates for first aid and moving and handling were arranged for June. Mandatory training compliance was monitored by the registered and assistant manager.

The assistant manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Confirmation was received from the registered manager following the inspection that they were aware of the new regional operational safeguarding policy and procedure and that they were currently reviewing the safeguarding policy to ensure it was reflective of the new guidance. Following discussion we were assured that the registered manager was working towards embedding the new regional operational safeguarding policy and procedure into practice.

Review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since January 2017 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. Infection prevention and control measures were adhered to. We spoke with one member of housekeeping staff who was knowledgeable regarding the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

We discussed the management of fire safety with the assistant manager who confirmed that fire checks were completed weekly. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

The nurse given the responsibility of being in charge of the home in the absence of the registered manager should be clearly identified and communicated to staff.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

A review of four patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. As previously discussed in section 4.2 care plans were regularly reviewed to ensure they continued to meet the needs of the patients. In one care record the patient has been reassessed by the speech and language therapist and changes made to the modification of their meals. The care plan had not been updated to reflect this significant change. A recommendation made as a result of a previous inspection is now stated for a second time. Care records contained good details of patients' individual needs and preferences.

Patients who had been identified as being at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner. Records were maintained of food and fluid intake.

One identified nurse's handwriting was, at times, illegible. This was discussed with the assistant manager who confirmed that the issue had been discussed with the nurse previously and an improvement had been noted at that time. Following discussion with the assistant manager regarding the NMC standards for record keeping it was agreed that supervision would be completed with the nurse and the legibility of their handwriting monitored.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Care management reviews for patients were arranged by the relevant health and social care trust. These reviews could be held in response to a change to patient need and as a minimum annually. They could also be requested at any time by the patient, their family or the home. There was evidence within the care records of regular, ongoing communication with relatives.

Discussion with the assistant manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

The assistant manager and staff confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting held was with all staff on 5 April 2017.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

No new areas for improvement were identified during this inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

We arrived in the home at 10:00. There was a calm atmosphere and staff were busy attending to the needs of the patients. The majority of patients were in their bedrooms as was their personal preferences; some patients remained in bed, again in keeping with their personal preference and some were seated in the lounge.

Staff interaction with patients was observed to be compassionate, caring and timely. Consultation with 11 patients individually and with others in small groups confirmed that patients were afforded choice, privacy, dignity and respect. Patients stated they were involved in making choices about their own care. Patients were consulted with regarding what time they got up at and retired to bed at and where they spent their day. Patients were offered choice throughout the day with meals and drinks and snacks. Staff demonstrated a detailed knowledge of patients' wishes, likes and dislikes.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Discussion with patients individually and with others in smaller groups, confirmed that living in Ailsa Lodge was a positive experience.

All of the patients spoke highly of the staff. The following are examples of comments provided:

"The staff are great – very willing."
"The staff work very well together."
"The staff are absolutely amazing."

Patients and staff were confident that if they raised a concern or query with management, they were taken seriously and their concern/query was responded to appropriately.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. The following are examples of comments received on thank you cards:
"Thank you for the love and care you gave …during her short stay in Ailsa Lodge; a very good managed home with plenty of care and loving attention."

"Ailsa Lodge was simply not just a nursing home to us, it was an extension of our family life …your kindness and care was always in abundance."

Discussion with the assistant manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. Satisfaction questionnaires were issued monthly to a number of relatives. In addition the registered manager's working arrangements allowed her to be in the home at various times and days throughout the week and provided opportunities to meet with patients and relatives.

As previously discussed ten relative questionnaires were issued; two were returned within the timescale for inclusion in this report. The relatives were very satisfied or satisfied with care provided across the four domains.

We issued ten questionnaires to nursing, care and ancillary staff; six were returned prior to the issue of this report. Staff were either very satisfied or satisfied with the care provided across the four domains.

Any comments from relatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required. Discussion with staff confirmed that there were good working relationships and that management were responsive to suggestions made. All those spoken with described the management within the home in positive terms.

Discussion with the assistant manager and review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

A review of records evidenced that monthly audits were completed, for example care records. The records of audits evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Review of records evidenced that the registered manager completed a monthly report to review the quality of the services delivered. The monthly reported included discussion with patients, relatives and staff and a summary of their opinions on the service delivered. A copy of the monthly reports was available in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ada Johnston, assistant manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 the nursing 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements:	There were no statutory requirements made as a result of this inspection.
Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 20 June 2017	It is recommended that when patients' needs are reassessed care plans should be reviewed and updated to accurately reflect the prescribed care. **Ref section 4.2** **Response by registered provider detailing the actions taken:** All nurses have been insttructed to review patient's needs on a daily basis and care plans updated as required to reflect any changes in care.
Recommendation 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 20 June 2017	The registered provider should ensure that the nurse given the responsibility of being in charge of the home in the absence of the registered manager is clearly identified and communicated to staff. **Ref section 4.3** **Response by registered provider detailing the actions taken:** The name of the nurse in charge is now noted on the rota.

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

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