The Regulation and Quality Improvement Authority

Inspection Report

11 May 2021

Ambassador

Type of Service: Nursing Home (NH)
Address: 462-464 Antrim Road, Belfast BT15 5GE
Tel No: 028 9077 1384

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Amstecos LTD **Responsible Individual:** Mrs Emer Bevan	**Registered Manager:** Mrs Amelia Noach **Date registered:** 01 April 2005
Person in charge at the time of inspection: Mrs Amelia Noach	**Number of registered places:** 48 A maximum of 2 patients in category NH-A
Categories of care: Nursing Home (NH) A – Past or present alcohol dependence I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 36
Brief description of the accommodation/how the service operates: This is a registered Nursing Home which provides nursing care for up to 48 persons. Patient bedrooms are located over three floors. Patients have access to communal lounges, a dining room and a garden area at the rear of the home.	

2.0 Inspection summary

An unannounced inspection took place on 11 May 2021 at 9.25 am by the care inspector.

The inspection 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 environmental cleaning, teamwork and delivery of compassionate care.

Areas requiring improvement were identified in relation to infection prevention and control, management of falls, menus, initial planning of patient care and activities.

Patients spoke positively about living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients, relatives and staff are included in the main body of this report.

RQIA were assured that the delivery of care and service provided in Ambassador was safe, effective, compassionate and that the home was well led.

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.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in Ambassador. 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 patients 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.

The findings of the inspection were provided to the Registered Manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke with 10 patients and nine staff. No questionnaires were returned and we received no feedback from the staff online survey. Patients spoke highly on the care that they received and on their interactions with staff. Patients confirmed that staff treated them with dignity and respect and that they would have no issues in raising any concerns with staff. Staff acknowledged the difficulties of working through the COVID – 19 pandemic but all staff agreed that Ambassador was a good place to work. Staff were complimentary in regard to the home's management team and spoke of how much they enjoyed working with the patients.

5.0 The inspection

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

The last inspection to Ambassador was undertaken on 11 September 2020 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 How does this service ensure that staffing is safe?

Safe staffing begins at the point of recruitment. There was a robust system in place to ensure staff were recruited correctly to protect patients as far as possible. All staff were provided with a comprehensive induction programme to prepare them for working with the patients.

There were systems in place to ensure staff were trained and supported to do their job. Staff consulted with confirmed they received regular training in a range of topics such as moving and handling, infection prevention and control (IPC), adult safeguarding and fire safety. The majority of training during the COVID-19 pandemic had been completed electronically. The manager had a training planner in place for 2021 and confirmed training about fire safety, IPC and Deprivation of Liberty Safeguards (DoLS) was to be prioritised for all staff.

Staff said there was good team work and that they felt well supported in their role. They expressed no concerns with the staffing levels and the level of communication between staff and management. There was evidence that staff meetings were held and the manager agreed to plan further staff meetings for the rest of the year.

The staff duty rota accurately reflected all of 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. The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met.

Staff told us that the patients' needs and wishes were very important to them. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. Patients said staff were always available and responded promptly to call bells. One patient told us they were "very happy" with the care they received. Other patients told us the staff were "very friendly" and "lovely".

The evidence reviewed provided assurances that staffing was safe.

5.2.2 How does this service ensure patients feel safe from harm and are safe in the home?

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 Responsible Individual was identified as the appointed safeguarding champion for the home.

Review of staff training records confirmed that all staff were required to completed adult safeguarding training on an annual basis. Staff told us they were confident about reporting concerns about patients' safety and poor practice.

It was noted that patients and their relatives were provided with written information on how to raise a concern or complaint about care or any service they received in the home. Patients told us that they would have no issues in raising concerns with the home's staff. Complaints were monitored monthly in the home.

At times some patients may be required to use equipment that can be considered to be restrictive, such as bed rails or alarm mats. Review of patient records and discussion with the manager and staff confirmed that the correct procedures were followed if restrictive equipment was required. It was good to note that patients who had capacity were actively involved in the consultation process and could give informed consent. This was good practice. At present restraints used in the home are not audited on a regular basis. The manager agreed to consider implementation of a restraint audit.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs. This was evident when staff were assisting patients with mobilising and at mealtimes.

This review of processes and staff knowledge demonstrated that appropriate safeguards were in place to support patients to feel safe and be safe.

5.2.3 Is the home's environment well managed to ensure patients are comfortable and safe?

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces, the kitchen, and communal areas such as lounges and bathrooms. There was evidence that the environment was well maintained and was found to be clean, warm and tidy. Any equipment in use was clean and well maintained.

Observation of practice and discussion with staff confirmed they adhered to the national colour coding system to reduce the risk of cross infection. It was noted that disinfectant was not being used in keeping with manufacturer's guidance. The manager agreed to address this as required.

A strong odour of cigarette smoke was noted in one of lounge and dining areas. This was discussed with the manager who confirmed that the smoking room was located close to that area; they agreed to review this to ensure the nursing home is kept free of offensive odours. This will be reviewed at a future care inspection.

Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, clean and tidy. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices. The lounges and dining areas were arranged in such a way that patients could safely socially distance.

Patients spoke positively about the home and said it was clean and tidy.

Fire safety measures were in place and well managed to ensure patients, 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. Corridors and fire exits were clear of clutter and obstruction. A fire risk assessment had been completed in December 2020; any recommendations had been addressed. Review of the emergency evacuation file confirmed it was reflective of the current occupancy in the home.

During review of the environment it was noted that that food and fluid thickening agent was not stored in a locked cupboard. The potential risk this could pose to patients was discussed with the manager who agreed to remove it to a safe area immediately and address this with all staff after the inspection.

In conclusion the home's environment was safely managed and comfortable.

5.2.4 How does this service manage the risk of infection?

The manager told us 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 patients, staff and care partners and any outbreak of infection was reported to the Public Health Authority (PHA).

All visitors to the home had a temperature check completed when they arrived at the home. They were also required to wear personal protective equipment (PPE) such as aprons, masks and/or gloves. There were numerous laminated posters displayed throughout the home to remind staff of good hand washing procedures and the correct method for applying and removing of PPE. There was an adequate supply of PPE and hand sanitiser.

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

While some staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance, inconsistencies were identified in some staff's knowledge regarding the correct use of PPE and when they should take an opportunity for hand hygiene. Most staff wore their face masks correctly, although we saw some staff applying and removing PPE incorrectly. An area for improvement was identified.

One staff member was observed to be using vinyl gloves which are not recommended for use if there is a risk of contact with blood or bodily fluids. This was discussed with the manager who agreed to address the use of vinyl gloves to ensure best practice guidance is adhered to.

Visiting arrangements were managed in line with Department of Health (DoH) and IPC guidance. The manager confirmed the visiting policy was being reviewed in keeping with current DoH guidance.

It was identified that some topical creams in patients' bedrooms did not have the date of opening recorded. This was discussed with the manager and the importance of dating these items stressed as they have a limited shelf life once opened. The manager agreed to discuss this with staff and monitor this through their audit processes.

Appropriate precautions and protective measures were in place to manage the risk of infection although some improvement is required.

5.2.5 What arrangements are in place to ensure patients receive the right care at the right time? This includes how staff communicate patients' care needs, ensure patients' rights to privacy and dignity; manage skin care, falls and nutrition.

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. The majority of patient care records maintained accurately reflected the needs of the patients. This is discussed further in 5.2.6. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

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

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. Patients who required this care or who had wounds had this clearly recorded in their care records. Minor gaps in recording were identified on one patient's care records. This was discussed with the manager for action as required.

Reviews of wound management for one identified patient evidenced the wounds were dressed in keeping with care plan directions. Wound assessments were completed after each dressing and we noted some very good examples of comprehensive wound care evaluation. It was noted that photographs of the wounds had not been taken to record patient outcomes and one care plan was used for a number of wounds that required a different type of dressing and frequency of dressing renewal. In addition, daily progress notes did not make reference to the patients' skin condition. These points were discussed with the manager who agreed to address this with registered nursing staff through clinical supervision.

Examination of records and discussion with the manager and staff confirmed that the risk of falling was well managed. For example, when a patient has a fall it is good practice to complete a post fall risk assessment to determine if a patient is at increased risk of further falls and staff can recommend strategies to prevent falls and reduce the risk of injury. Such risk assessments were being completed. However, review of the management of one fall evidenced appropriate actions were not consistently taken following the falls in keeping with best practice guidance. Examination of care records confirmed that registered nursing staff did not consistently record clinical and neurological observations after a fall. An area for improvement was identified.

There was a system in place to ensure accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA. There was evidence of appropriate onward referral as a result of the post falls review. For example, patients were referred to the Occupational Therapist or their General Practitioner.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, during lunch staff wore the appropriate aprons when serving or assisting patients with meals and clothing protectors were used for patients as required. Staff told us how they were made aware of patients' nutritional needs and confirmed that patients care records were important to ensure mistakes about modified food and fluids were not made.

Lunch was observed to be supervised by staff and was a pleasant and unhurried experience for the patients. 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. It was noted that a menu showing what is available at each mealtime was not displayed in a suitable format or location; an area for improvement was identified.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily.

Patients told us they enjoyed the food in the home. One patient said, "the food is lovely; there is a good variety".

Patients' needs were clearly identified and communicated to staff. Evidence confirmed that care was being delivered effectively to meet the needs of the patients.

5.2.6 What systems are in place to ensure care records reflect the changing care needs of patients?

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans should be developed to direct staff on how to meet patients' needs; and included any advice or recommendations made by other healthcare professionals. We saw evidence of this in most of the care records examined. However, review of one identified patient's care records evidenced that initial care plans had not been fully developed in a timely manner, to guide the staff in the delivery of daily care needs. An area for improvement was identified.

Care records were generally well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Minor gaps in record keeping were discussed with the manager for action as required. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them.

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

This review of care records confirmed that on the whole they provided details of the care each patient required and were reviewed regularly to reflect the changing needs of the patients.

5.2.7 How does the service support patients to have meaning and purpose to their day?

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could go out for a walk when they wanted, remain in their bedroom or go to a communal room when they requested.

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

Patients were observed listening to music, reading newspapers and watching TV. Staff read bible passages to some of the patients during the morning. A weekly schedule of activities was displayed at the entrance to one of the large lounges. This had planned activities for three days which included hand massage, arts and crafts and movies.

Discussion with patients confirmed that they would not know what activities were planned in the home. One patient told us “we used to do bingo but that had not happened for a while”. Discussion with staff and review of records confirmed an activity co-ordinator had not been working in the home for a number of months due to the ongoing pandemic. Review of the duty rota evidenced no staff had been allocated to lead on activities on the day of the inspection. Staff told us they would assist with activities although this was not planned. In addition, activity provision was not regularly commented on in patient’s daily progress notes. An area for improvement as identified.

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

Observation of practice confirmed that staff engaged with residents on an individual and group basis throughout the day and patients were afforded choice. Some improvement is required regarding activities.

5.2.8 What management systems are in place to monitor the quality of care and services provided by the home and to drive improvement?

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 patients, care practices or the environment.

There has been no change in the management of the home since the last inspection. Mrs Amelia Noach has been the manager in this home for over 16 years.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. The manager or members of the team completed regular audit of accidents/incidents, complaints, wounds, care records, infection control and staff registrations. Some of the audits completed did not have a date and signature. The manager agreed to address this with staff as required.

There was a system in place to manage complaints. There was evidence that the manager ensured that complaints were managed correctly and that good records were maintained. The manager told us that complaints were seen as an opportunity to for the team to learn and improve. Patients said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

Staff commented positively about the manager and described her as supportive, approachable and always available for guidance. Staff said "I have good support from the manager" and "the manager is a good person. She is very professional and speaks a lot to us with good communication".

A record of compliments received about the home was kept and shared with the staff team, this is good practice. Compliments were received from patients, patients' relatives/representatives, current staff members and staff members who had left the home.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail. These are available for review by patients, their representatives, the Trust and RQIA.

The service was well led with a clear management structure and system in place to provide oversight of the delivery of care.

6.0 Conclusion

As a result of this inspection five areas for improvement were identified in respect of infection prevention and control, management of falls, menus, initial planning of patient care and activities. Details can be found in the Quality Improvement Plan included.

Evidence of good practice was found in relation to environmental cleaning, teamwork and delivery of compassionate care. There were safe systems in place to ensure staff were recruited and trained properly; and that patient's needs were met by the number and skill of the staff on duty. Systems were in place to ensure patients' safety. Patients were complimentary in relation to the environment and with the cleanliness in the home. The risk of infection was monitored during IPC audits. Patients' care records had been generally well maintained; any improvements required are detailed in the Quality Improvement Plan.

Patients chose how to spend their day in the home and in which area to spend it. The manager will review allocation of activities in the absence of an activity co-ordinator along with recording of activity delivery. Systems were in place to monitor the quality of services and drive improvements. Complaints had been managed well and compliments shared with staff. Accidents had been managed appropriately and there was good communication between the homes management and staff.

Based on the inspection findings and discussions held we are satisfied that Ambassador is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015.

	Regulations	Standards
Total number of Areas for Improvement	2	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Amelia Noach, 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the following: • donning and doffing of personal protective equipment • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene. Ref: 5.2.4
	Response by registered person detailing the actions taken: Robust IPC standards are part of the daily work practices within Ambassador NH. The Registered Manager has implemented a specific and detailed training programme on IPC which has been delivered to all Staff regularly and thoroughly during the Covid-19 pandemic. The evidence of maintaining standards was evident during the Covid pandemic. A record of the training programme has been maintained in the Home and was shown to the inspector during the inspection. Any momentary lapses of adherence to these protocols are dealt with immediately and with the individual who has deviated from the appropriate standards of which all staff have been trained. These included the shortfalls identified during the recent inspection and formed part of the supervision sessions. Inconsistencies discussed with all staff on 05/06/21. IPC training is current, ongoing and implemented regularly within the Home with particular focus on; * Do one task at a time. * Be present in the moment. * Plan out each task. * Focus on the objective.

Area for improvement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record. Ref: 5.2.5
To be completed by: Immediate action required	**Response by registered person detailing the actions taken:** The initial management practices to stabilise a resident post fall and importance of same had previously been discussed with all RGN's, SHCA and HCA's. The head injury care plan template has been revised and simplifed for RGN's to follow. Details of care plan include; * Any unwitnessed fall to be treated as potential head injury. * Neurological assessment must be undertaken following knock to the head until GCS within normal limit range, * Medical observation to accompany neurological observations for 72 hours and results strictly recorded. * BM monitoring to eliminate potential Hyperglycaemia. * Falls in vitals; BP, Respiratory rate can be indicative of ICP. One to one supervisions sessions have been held with all RGN's. In June, RGN's are participating in discussion around the importance of monitoring & recording of vital signs and auditing records of head injuries. This is being used as reflective practice sessions for some RGN's for revalidation.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure a daily menu is displayed in a suitable format and in an appropriate location, showing what is available at each mealtime. Ref: 5.2.5
To be completed by: Immediate action required	**Response by registered person detailing the actions taken:** The menu board which had been in place for several years was temporily used for allocations due to the Covid pandemic and the associated reduction of residents in the communal areas due to social distancing. A second board was installed on 14th May 2021 for menus to be displayed.

Area for improvement 2 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. Ref: 5.2.6
	Response by registered person detailing the actions taken: A plan of care is implemented within the Goldcrest system for all Residents on admission to the Home. Once the resident's individual care needs can be established over the initial days in the Home, the plan of care is ammended to be more person centred and adopts an individual holistic approach to each resident. The development of the care plan is wholly dependent on the quality of information received regarding the resident along with the resident's ability to participate in the planning of care or the family's willingness to do the same.
Area for improvement 3 **Ref**: Standard 11 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure the programme of activities is reviewed and developed following discussion with the patients. Arrangements for the provision of activities should be in place in the absence of the activity co-ordinator. Activities must be an integral part of the care process with daily progress notes reflecting activity provision. Ref: 5.2.7
	Response by registered person detailing the actions taken: The current programme of activities is in place following consultation with residents with set activities planned for Monday, Wednesday and Friday and a few additional activites included in the weekly programme. The arrangement of activities is in place in the absence of an activity co-ordinator with staff allocated to engage in the activities programme. This programme reflects the wishes of the residents in the Home. Activies are seen as an integral part of the care process in Ambassador Nursing Home and staff are reminded of the value of one to one engagement, allowing a record to be taken of resident's individual views and preferences with regards to activities. An activity log is taken reflecting participation and activity provision.

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

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