Inspection Report

2 December 2021

Carlingford Lodge Care Home

Type of Service: Nursing Home
Address: 76 Upper Dromore Road, Warrenpoint, BT34 3PN
Tel no: 028 4175 9200

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: Amore (Warrenpoint) Limited **Responsible Individual:** Sarah Elizabeth Perez - Acting	**Registered Manager:** Sara Main **Date registered:** 27 March 2018
Person in charge at the time of inspection: Paula Magee – Deputy Manager	**Number of registered places:** 58 A maximum of 25 persons in category NH-I and 33 persons in category NH-DE.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 49
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 58 persons. Patients are accommodated over two floors. Patients with a dementia are cared for on the lower ground floor and patients requiring general nursing care are cared for on the ground floor. Patients have access to communal lounges and dining areas.	

2.0 Inspection summary

An unannounced inspection took place on 2 December 2021 from 9.20am to 6.00pm by a care inspector.

This inspection sought to assess progress with issues raised on the previous quality improvement plan and focused on staffing arrangements; care delivery and record keeping, management of the environment and infection prevention and control.

Of the 14 areas for improvement identified at the previous inspection, three were met, nine remained unmet and two were carried forward for review to the next care inspection. Prior to the inspection, the Southern Health and Social Care Trust shared concerns with RQIA in relation to the management of falls in the home. This was reviewed during the inspection and an area for improvement made in this regard at the previous inspection has been stated for a second time. Additional areas stated for a second time relate to the management of pressure care and hydration, staffing arrangements, recording use of thickening agents and dating of topical preparations when opened.

Areas for improvement in relation to recording of administration of topical preparations and staff practices with infection prevention and control have each been stated for the third and final time. Inspection findings have been shared with the Southern Health and Social Care Trust.

RQIA convened a serious concerns meeting with the registered manager and acting responsible individual on 9 December 2021 to discuss the inspection findings. The regional manager and the director of quality from the Priory Group also attended this meeting. Prior to the meeting the registered manager shared an action plan with RQIA which identified how each area of concern would be brought back into compliance. Following discussion with the Priory management team, RQIA decided to accept the assurances provided along with the action plan and will carry out a further inspection to ensure compliance has been achieved.

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 patients, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires 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 daily life within the home was observed and how staff went about their work.

The findings of the inspection were discussed with the deputy manager and quality improvement lead at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke with 10 patients and seven staff. Patients spoke positively of the care that they received and on their interactions with staff. Staff acknowledged the challenges of working through the COVID – 19 pandemic but confirmed that they enjoyed working with the patients. There were no questionnaire responses or any feedback from the staff online survey received.

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 care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** Second time	The registered person shall ensure that the infection control issues identified during the inspection are managed to prevent the risk and spread of infection.	**Not met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has not been met. Please see section 5.2.3 for further information. This area for improvement has not been met and will be stated for a third and final time.	
Area for improvement 2 **Ref:** Regulation 18 (2) (n) **Stated:** Second time	The registered person shall review the provision of activities in the home to ensure that all patients, who wish to engage, are included in regular meaningful activity.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	

Area for improvement 3 **Ref:** Regulation 12 (1) (a)(b) **Stated:** First time	The registered person shall review patients' pressure management in the home to include: • Pressure management risk assessments are completed monthly • Where a risk is identified, a pressure management care plan is developed detailing the care required and to include frequency of repositioning where appropriate • Records of repositioning are maintained accurately.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement had been partially met. Please see section 5.2.2 for further information. This area for improvement has been stated for a second time.	
Area for improvement 4 **Ref:** Regulation 12 (1) (a)(b) **Stated:** First time	The registered person shall review the management of falls in the home to ensure that the appropriate actions are taken after any fall in the home to include the appropriate monitoring of the patient, notifying the appropriate persons and ensuring that the appropriate documentation has been updated.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement had been partially met. Please see section 5.2.2 for further information. This area for improvement has been stated for a second time.	

Area for improvement 5 **Ref:** Regulation 12 (1) (a)(b) **Stated:** First time	The registered person shall review the management of hydration in the home to ensure that fluid intake records are recorded accurately and that there is evidence within patients' care records of any actions taken when any deficit is identified.	**Not met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has not been met. Please see section 5.2.2 for further information. This area for improvement has not been met and will be stated for a second time.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time	The registered person shall ensure that the identified patient's care plans are written in a format which specifically directs individualised patient care and avoids the use of general terminology in accordance with professional guidance.	**Met**
	Action taken as confirmed during the inspection: The identified patient's care plans had been updated appropriately.	
Area for improvement 2 **Ref**: Standard 29 Criteria (2) **Stated:** Second time	The registered person shall ensure that TMARs are completed in full at the time of administration.	**Not met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has not been met. Please see section 5.2.2 for further information. This area for improvement has not been met and will be stated for a third and final time.	

Area for improvement 3 **Ref**: Standard 4 Criteria (9) **Stated:** Second time	The registered person shall ensure that all personal care delivered to patients is recorded to evidence actual care given.	**Met**
	Action taken as confirmed during the inspection: Personal care delivery had been evidenced within supplementary care records.	
Area for improvement 4 **Ref:** Standard 41 **Stated:** First time	The registered person shall review the staffing arrangements in the home to include the deployment of staff and morning routines to ensure the needs of patients are met.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement had been partially met. Please see section 5.2.1 for further information. This area for improvement has been stated for a second time.	
Area for improvement 5 **Ref:** Standard 28 **Stated:** First time	The registered person shall ensure that topical preparations in the home are dated on opening and disposed of in accordance with manufacturer's guidelines.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement had been partially met. Please see section 5.2.3 for further information. This area for improvement has been stated for a second time.	
Area for improvement 6 **Ref:** Standard 44 Criteria (1) **Stated:** First time	The registered person shall conduct an audit on rooms/areas in the home to ascertain which require redecoration and submit a refurbishment plan with the completed QIP.	**Met**
	Action taken as confirmed during the inspection: An audit had been conducted and a refurbishment plan had been developed.	

Area for improvement 7 **Ref:** Standard 46 Criteria (2) **Stated:** First time	The registered person shall ensure that chairs used by patients are maintained clean at all times. Any chairs in disrepair should be removed and repaired/replaced as soon as possible.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for improvement 8 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that whenever care staff administer thickeners they routinely record this activity.	**Not met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has not been met. Please see section 5.2.2 for further information. This area for improvement has not been met and will be stated for a second time.	
Area for improvement 9 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that care staff are provided with the additional necessary training in relation to the recording of the administration of topical medicines and thickeners.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement had been partially met. Please see section 5.2.2 for further information. This area for improvement has been stated for a second time.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Since the previous care inspection, the staffing levels in the home had not changed. However, the allocation and morning routine in the dementia unit had changed resulting in patients receiving breakfast earlier and staff being able to take allocated breaks during the day. Staff consulted during the inspection confirmed that they regularly worked under the planned staffing levels due to short term sick leave and/or availability of care assistants.

Staff shared concerns on the impact of reduced staffing levels and these concerns were shared with the manager for their review and actions as appropriate. Information received by RQIA alleged that patients had been nursed in bed due to low staffing levels. This was discussed at the meeting and the manager assured us that there were valid clinical reasons for these decisions. She acknowledged that these reasons may need to be better communicated to care staff to allay their concerns.

Staff confirmed that they understood their own roles in the home and the roles of others. Staff were of the opinion that, overall, teamwork was good in the home but did identify some potential barriers to effective teamwork. These were discussed with the manager for their review and actions as appropriate.

The manager confirmed that recruitment was ongoing in the home and identified at the time of inspection the home had vacancies for almost 12 care assistants and almost five registered nurses. The equivalent of four registered nurses had been block booked from nursing agencies which allowed for consistency in care but the manager was concerned that there were no care assistants available to be block booked despite efforts in trying to achieve this. During the meeting with RQIA on 9 December 2021, the management team identified measures which they have put in place to attract more staff to come and work in the home, such as, with increased rates in pay and pay bonuses.

Concerns were raised during the inspection that in the general nursing unit, the number of registered nurses working on Saturdays and Sunday mornings is reduced to one compared when two nurses are rostered to work mornings from Monday to Friday. Staff were concerned that if they had to attend to an unwell patient or a patient who suffered a fall during this time that this may impede their ability to carry out other important nursing duties such as the medicine round. The management team confirmed that there was difficulty in finding nurses to work and that they were currently reviewing this arrangement.

At the meeting senior management assured us that dependency levels of patients were regularly assessed and staffing levels were adjusted accordingly and to reflect overall occupancy. If patient occupancy is lower staffing may be reduced accordingly.

The management team acknowledged that they are reliant on agency staff at present and some of their usual measures such as daily quality walk-arounds by management and daily ‘flash meetings’ with all staff had not been applied consistently. We were assured that these measures were now in place consistently and that this would inevitably improve communication and management oversight. This is particularly important when relying on agency staff.

RQIA liaised with the Southern Health and Social Care Trust in relation to the inspection findings.

5.2.2 Care Delivery and Record Keeping

There had been a good improvement noted in relation to the recording of personal care delivery to patients. The majority of patients were presented well in their appearance, though, three patients in the general nursing unit were observed to be unshaven. This was discussed with the manager who agreed to address this with staff. Staff consulted during the inspection demonstrated knowledge on the actions to take when a patient refused assistance with personal hygiene.

Patients consulted during the inspection spoke positively on the care that they received. One told us, “I am very happy here; the staff are exceptional.” Another spoke of how they had, ‘great craic’ with the staff. Patients unable to verbalise appeared comfortable and relaxed in their surroundings. Staff were observed engaging compassionately with patients during the inspection.

Four patients’ skin care records were reviewed. A pressure management risk assessment to monitor for the potential of a patient’s skin to breakdown had been completed monthly on three of the four patients. The fourth patient had almost a four month gap when it had not been completed. Care plans were in place when a risk of skin breakdown was identified. Care plans identified frequency of repositioning where this was required. We discussed ways to further enhance the personalisation of care plans such as identifying prescribed creams and clearly stating when and where they were to be applied.

Records of repositioning had been maintained, however, there were significant gaps identified in the recordings. Gaps of seven, 10 and 12 hours during which repositioning had not been recorded were identified. When records indicated that a patient was tilted, many did not record which patients’ side they had been repositioned to. Wound care records had been maintained well. Wound care plans were in place reflective of tissue viability nurses’ recommendations and ongoing wound assessment charts monitored the progress of the wound. An area for improvement identified at the previous inspection had been partially met and has been stated for a second time.

Falls risk assessments had been completed and patients at risk of falling had a falls care plan in place. Three accident records were reviewed following falls in the home. The patients’ falls risk assessments and falls care plans had been updated following the falls. Accident records indicated that the appropriate persons had been informed of the falls. However, in each of the three accident records, the central nervous system (CNS) observations had not been monitored appropriately. An area for improvement identified at the previous inspection had been partially met and has been stated for a second time.

Four patients’ nutrition and hydration records were reviewed. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Where weight loss had been identified, there was evidence of onward referral to dieticians and/or GPs. Patients’ choking risk assessments were also completed monthly. Care plans were in place which were up-to-date and reflected patients’ nutritional requirements as indicated by speech and language therapists where appropriate. Records of food and fluid intake had been recorded, however, some patients’ food intake was recorded as ‘level 5 dinner given’ which does not capture amount or actual food consumed. One patient’s fluid intake was consistently low over two consecutive days. The patient’s daily progress evaluation records did not identify this. The utilisation of fluid targets was discussed with the manager during feedback. Following the inspection we were informed that a new supplementary record had been initiated to record food and fluid intake and this included patients’ fluid targets. Staff consulted during the inspection showed knowledge of the signs and symptoms of dehydration. An area for improvement in this regard has been stated for the second time.

Some patients require to have fluids thickened to aid in swallowing safely. Thickening agents are used to thicken the fluids. When thickening agents are used, these should be recorded on every occasion. Recording of the administration of thickening agents was identified as an area for improvement on the previous inspection report. A review of four patients’ records of administration of thickening agents during this inspection evidenced that significant gaps in

recording remained. One patient had no records completed. An area for improvement in this regard has been stated for the second time.

Gaps were also evident in the recording of the application of topical creams to patients. The person who applies the cream is the person responsible for recording this. One patient informed us that creams were applied daily, however, there was no documentation to support this. An area for improvement in relation to the use of Topical Medicine administration records (TMARS) has been stated for the third and final time.

The manager confirmed that staff competency assessments had commenced in regard to the management of topical medicines and with the use of thickening agents for modification of fluids. It is important to ensure that this training is embedded into practice.

5.2.3 Management of the Environment and Infection Prevention and Control

On entry to the home, all visitors had a temperature check and completed a declaration form to ensure that none were showing any symptoms of COVID -19. Hand hygiene and personal protective equipment (PPE) were available at the entrance. PPE was available throughout the home and there was signage available on how to don (put on) and doff (take off) PPE correctly. The home was warm, clean and tidy. A crib and Christmas tree were at the reception area.

Since the previous care inspection a refurbishment plan had been developed following an audit of the premises. It was positive to note that the actions identified for October and November 2021 had been completed as planned. An order to replace chairs in use in the dayroom of the dementia unit had been made and was in process. An area for improvement in this regard has been carried forward for review to the next care inspection.

During the inspection four staff were observed wearing wrist jewellery and one staff had nail varnish on. This would impede effective hand hygiene. One staff was not wearing the appropriate PPE when carrying out cleaning duties and three staff missed opportunities for hand hygiene on doffing PPE. This was particularly concerning given the recent outbreak of COVID-19 infection in the home. An area for improvement in this regard has been stated for a third and final time.

Remaining staff demonstrated good practices on hand hygiene and PPE use. At the meeting with the management team following the inspection assurances were provided that the home's policies and procedures on infection prevention and control would be reinforced with staff through flash meetings and registered nurses would be reminded of their accountability to enforce safe practice. We were also informed that a staff tracker would be developed to identify staff who were repeatedly not complying with the infection prevention and control policy.

At the previous care inspection, an area for improvement was identified to ensure that topical preparations in use in the home were dated on opening to ensure these were disposed of in accordance with the manufacturers' guidelines. Whilst improvements with this were observed during this inspection, many topical preparations in use did not evidence date of opening. An area for improvement in this regard has been stated for the second time.

During the meeting with RQIA on 9 December 2021, the management team acknowledged the deficits identified within this report and confirmed that there was a greater need for governance and oversight of the areas for improvement identified to ensure sustained compliance. A further unannounced inspection will be conducted to monitor the compliance in these areas.

6.0 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/or the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	5*	6*

* The total number of areas for improvement includes two that have been stated for a third time; seven that have been stated for a second time and two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Paula Magee, Deputy Manager and Rosemary Clarke, Quality Improvement Lead, 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 18 (2) (n) **Stated:** Second time	The registered person shall review the provision of activities in the home to ensure that all patients, who wish to engage, are included in regular meaningful activity. Ref: 5.1
To be completed by: 24 October 2021	**Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**

Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** Third and final time **To be completed by:** With immediate effect	The registered person shall ensure that the infection control issues identified during the inspection are managed to prevent the risk and spread of infection. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: Infection control procedures continue to be monitored through daily manager walkarounds and audits. PPE worn appropriately by staff on observation. Hand hygiene audits have been increased and any issue identified are addressed at the time of audit. Donning and doffing competencies continue to be reviewed with all grades of staff this is ongoing currently.
Area for improvement 3 **Ref:** Regulation 12 (1) (a)(b) **Stated:** Second time **To be completed by:** 2 January 2022	The registered person shall review patients' pressure management in the home to include: • Pressure management risk assessments are completed monthly • Where a risk is identified, a pressure management care plan is developed detailing the care required and to include frequency of repositioning where appropriate • Records of repositioning are maintained accurately. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Pressure management has been reviewed within the care home and discussed with nursing staff. Care plans have been reviewed monthly or as required. Supplementary documentation reviewed and additional entries added to allow for clear identification of residents position. All staff reminded daily of the importance of accurately completing supplementary records. These records are monitored through daily walkrounds and spot checks.
Area for improvement 4 **Ref:** Regulation 12 (1) (a)(b) **Stated:** Second time **To be completed by:** 2 January 2022	The registered person shall review the management of falls in the home to ensure that the appropriate actions are taken after any fall in the home to include the appropriate monitoring of the patient, notifying the appropriate persons and ensuring that the appropriate documentation has been updated. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: The management of falls continues to be a focus in the care home. Supervision with the nursing staff has been completed in relation to falls management. A monthly falls tracker remains in place to monitor and establish if there are any themes and trends and a monthly analysis is completed.

Area for improvement 5 **Ref:** Regulation 12 (1) (a)(b) **Stated:** Second time **To be completed by:** 2 January 2022	The registered person shall review the management of hydration in the home to ensure that fluid intake records are recorded accurately and that there is evidence within patients' care records of any actions taken when any deficit is identified. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Supplementary records continue to be a focus in the care home. Staff are reminded of the importance of reporting to the nursing staff when a resident is not meeting fluid targets, or declining fluids. This is monitored through daily walkarounds and spot checks. Liasion with the GP if fluids are not met for further advice and review.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 46 Criteria (2) **Stated:** First time **To be completed by:** 30 October 2021	The registered person shall ensure that chairs used by patients are maintained clean at all times. Any chairs in disrepair should be removed and repaired/replaced as soon as possible. Ref: 5.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref**: Standard 29 Criteria (2) **Stated:** Third and final time **To be completed by:** 2 January 2022	The registered person shall ensure that TMARs are completed in full at the time of administration. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: TMAR records continue to be a focus in the care home. Staff reminded of the importance of completing records when the topical medication is administered. Topical medications to be dated when opened and stored appropriately. This is monitored through spot checks. Ongoing review by GPs for prescription of topical medications.

Area for improvement 3 **Ref:** Standard 41 **Stated:** Second time **To be completed by:** 2 January 2022	The registered person shall review the staffing arrangements in the home to include the deployment of staff and morning routines to ensure the needs of patients are met. Ref: 5.1 and 5.2.1
	Response by registered person detailing the actions taken: A review has been completed of the morning routine through allocation and discussions with the staff team, this is now embedded within the unit. This will continue to be monitored and reviewed by the nurse in charge, and any concerns reported to manager.
Area for improvement 4 **Ref:** Standard 28 **Stated:** Second time **To be completed by:** 2 January 2022	The registered person shall ensure that topical preparations in the home are dated on opening and disposed of in accordance with manufacturer's guidelines. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: Topical medications are now dated when opened and stored appropriately. The topical medications are reviewed monthly along with the monthly drug cycle. Topical medication competencies continue to be reviewed with care staff. This is monitored through spot checks.
Area for improvement 5 **Ref**: Standard 29 **Stated:** Second time **To be completed by:** 2 January 2022	The registered person shall ensure that whenever care staff administer thickeners they routinely record this activity. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Dysphagia, modified diets and thickening agent competencies continue to be reveiwed with care staff. Staff reminded of the importance of accurately recording this on the appropriate documentation.
Area for improvement 6 **Ref**: Standard 28 **Stated:** Second time **To be completed by:** 2 January 2022	The registered person shall ensure that care staff are provided with the additional necessary training in relation to the recording of the administration of topical medicines and thickeners. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Topical medication and thickening agent competencies continue to be reviewed and updated as required.

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