The Regulation and Quality Improvement Authority

Inspection Report

28 September 2023

St James Lodge Care Home

Type of service: Nursing Home
Address: 15-17 Coleraine Road, Ballymoney, BT53 6BP
Telephone number: 028 2766 8212

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

1.0 Service information

Registered Provider: St James' Lodge Limited **Responsible Individual:** Mrs Mary Frances Gibson	**Registered Manager:** Miss Bronagh Barker **Date registered:** 4 October 2013
Person in charge at the time of inspection: Miss Bronagh Barker	**Number of registered places:** 44 A maximum of 20 patients in category NH-DE accommodated on the Ground Floor, A maximum of 21 patients in category NH-I and a maximum of 3 patients in NH-PH accommodated on the First Floor.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 43
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 44 patients. The home is divided in two units, over two floors. The ground floor unit provides care for people living with dementia and the first floor unit provides general nursing care. Patients have access to communal lounges, dining rooms and garden space.	

2.0 Inspection summary

An unannounced inspection took place on 28 September 2023 from 9.40 am to 4.40 pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home 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.

It was evident that staff promoted the dignity and well-being of patients by respecting their personal preferences and choices throughout the day. Discussion with staff identified that they

had a good knowledge of patients' needs and had relevant training to deliver safe and effective care. Staff provided care in a compassionate manner and were sensitive to patients' wishes.

Patients were happy to engage with the inspector and share their experiences of living in the home. Patients expressed positive opinions about the home and the care provided. Patients said that staff members were helpful and pleasant in their interactions with them.

Patients who could not verbally communicate were well presented in their appearance and appeared to be comfortable and settled in their surroundings.

We found that there was safe, effective and compassionate care delivered in the home and the home was well led by the Manager.

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

3.0 How we inspect

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

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

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the management team at the conclusion of the inspection.

4.0 What people told us about the service

Patients, staff and relatives were consulted during the inspection. Staff spoken with said that St James Lodge was a good place to work. Staff were satisfied with the staffing levels and the

training provided. Staff told us how they love coming to work and how supportive and approachable the Manager is.

Patients spoken with told us they had good experiences living in the home and they liked the meals provided. Patients told us "the staff are very good and kind". Patients who could not verbally communicate were well presented in their appearance and appeared to be comfortable and settled in their surroundings.

Relatives spoke positively regarding the care provided to their loved ones, a relative told us; "the home is excellent".

Four questionnaires were returned from relatives all with a very satisfied response to the questions regarding the care and other services provided by the home. The following additional comments were included; "I feel the care the staff provide my mum is excellent, they keep me informed about any changes in mum's health. I feel this is a very well run home and everyone is very friendly and helpful", "I have experience of several care homes and find this one to be the best in the causeway coast and glens area" and "I am so glad my wife is being well looked after".

No staff survey responses were received within the allocated timeframe.

5.0 The inspection

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

Areas for improvement from the last inspection on 31 May 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 12 (1) (a) **Stated:** First time	The registered person shall ensure the following in regards to the repositioning of patients: • that patients are repositioned in keeping with their prescribed care • that repositioning records are accurately and comprehensively maintained at all times • the type of mattress and correct setting must be documented correctly in patients care plan.	**Partially met**

	Action taken as confirmed during the inspection: Review of care records confirmed that the type and correct setting of mattresses was documented in patients' care plans. However, the review of repositioning records did not provide evidence that the patients were repositioned regualrly. This area for improvement has been partially met and will be stated for a second time.	
Area for Improvement 2 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time	The registered person shall ensure care documentation for the management of wounds accurately reflect the assessed needs of the patient. • The frequency of dressing change should reflect the assessed need of the wound • The wound care plan accurately details the frequency of dressing changes and the type of dressings required • wound assessment charts are completed at each dressing change • a wound care audit is implemented by the Manager to regularly review this aspect of care delivery.	**Partially met**
	Action taken as confirmed during the inspection: Review of wound care records confirmed that patient wounds were dressed as prescribed in their care plans and a monthly wound audit is conducted by the Manager. However, the wound assessment chart was not always completed at each wound dressing change. This area for improvement has been partially met and will be stated for a second time.	

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		Validation of compliance
Area for Improvement 1 **Ref:** Standard 4.1 **Stated:** Second time	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. The care plans should be further developed within five days of admission, reviewed and updated in response to the changing needs of the patient.	**Carried forward to the next inspection**
	Action taken as confirmed during the inspection: Only one new patient care records were reviewed and these had been developed timely. This area for improvement will be carried forward for review at the next care inspection so more than one record can be inspected.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

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

There were systems in place to ensure staff were trained and supported to do their job. The Manager retained good oversight of staff compliance with their training requirements.

A matrix system was in place for staff supervision and appraisals to record staff names and the date that the supervision/appraisal had taken place.

There was a system in place to monitor that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC).

Staff who take charge in the home in the absence of the Manager had completed relevant competency and capability assessments.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the Manager was not on duty.

Staff told us that 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. It was clear through these interactions that the staff and patients knew one another well.

Staff said that they felt well supported in their role and found the Manager very approachable. Staff spoke positively on staffing levels and teamwork in the home.

5.2.2 Care Delivery and Record Keeping

Staff said they met for a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff demonstrated their knowledge of individual patient's needs, preferred daily routines, likes and dislikes.

It was observed that staff provided care in a caring and compassionate manner and the patients were well presented in their appearance.

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 may 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.

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' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Only one new patient's care records were examined on inspection, therefore, an area for improvement was carried forward for review at the next inspection to ensure more than one record can be reviewed. Generally, care records were well maintained, reviewed and updated to ensure they continued to meet the patients' needs. Patients' individual likes and preferences were well reflected throughout the records. Care plans were detailed and contained specific information on each patient's care needs and what or who was important to them.

However, the review of care records for patients who required wound care, evidenced that the wound observation charts were not consistently recorded at each wound dressing. An area for improvement was stated for a second time.

Daily records were kept of how each patient spent their day and the care and support provided by staff.

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

Patients who were less able to mobilise were assisted by staff to change their position. A review of repositioning records evidenced a number of deficits for example; a number of patients' care plans did not evidence a repositioning time frame and there were gaps in the timing of patient repositioning. An area for improvement was stated for a second time.

Discussion with the Manager and a review of records confirmed that the risk of falling and falls were well managed. The home participates in an anticipatory model of care whereby the local GP's visit the home at least weekly to review the care of the patients; this includes the care of patients following a fall. Review of records confirmed that staff took appropriate

action in the event of a fall, for example, they completed neurological observations and sought medical assistance if required. The appropriate care records were reviewed and updated after fall. Staff also completed a post fall review to determine if anything more could have been done to prevent the fall.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. The home was warm, clean and comfortable. Patients' bedrooms were clean, tidy and personalised with items of importance to each patient, such as family photos and sentimental items.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible and the staff had taken part in regular fire drills in the home. The home's most recent fire safety risk assessment was completed on 26 April 2023.

Staff members were observed to carry out hand hygiene at appropriate times and to use personal protective equipment (PPE) in accordance with the regional guidance.

5.2.4 Quality of Life for Patients

The atmosphere in the home was relaxed and homely with patients seen to be comfortable, content and at ease in their environment and interactions with staff.

There was a range of activities provided for patients by activity staff. The monthly planned activities were displayed. The range of activities included for the patients included social, community, cultural, religious, spiritual and creative events.

Patients' needs were met through a range of individual and group activities. Activity records were maintained which included patient engagement with the activity sessions.

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

Patients appeared to be content and settled in their surroundings and in their interactions with staff.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection.

Staff members 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 was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. It was observed that the care record audits had not been completed regularly, this was discussed with the Manager. After the inspection written assurance in the form of an action plan was provided by the Manager on how the auditing of all the care records would be prioritised over the next three months.

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

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

The Manager maintained records of regular staff and departmental meetings. The records contained an attendance list and the agenda items discussed. Meeting minutes were available for those staff who could not attend.

Messages of thanks including any thank-you cards were kept and shared with staff.

A review of records in regard to complaints management established that these were well managed and used as a learning opportunity to improve practices and/or the quality of services provided by the home.

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; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

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 the Care Standards for Nursing Homes (December 2022).**

	Regulations	Standards
Total number of Areas for Improvement	2*	1*

*the total number of areas for improvement includes two Regulations that have been stated for a second time and one standard that is carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team, 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 12 (1) (a) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure the following in regards to the repositioning of patients: • that patients are repositioned in keeping with their prescribed care • that repositioning records are accurately and comprehensively maintained at all times • the type of mattress and correct setting must be documented correctly in patients care plan. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: This was fully discussed with Staff Nurses & Care Assistants at a staff meeting held on the 11/10/23 at which it was emphasised the importance of accurate recording of resident's repositioning. Care Plans for all residents have been reviewed and updated where necessary to reflect the residents abilities/needs re repositioning. Care staff were also reminded that they must read care plans and familiarise themselves with each residents individual needs.
Area for improvement 2 **Ref:** Regulation 12 (1) (a) (b) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure care documentation for the management of wounds accurately reflect the assessed needs of the patient. • The frequency of dressing change should reflect the assessed need of the wound • The wound care plan accurately details the frequency of dressing changes and the type of dressings required • wound assessment charts are completed at each dressing change • a wound care audit is implemented by the Manager to regularly review this aspect of care delivery. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: This was fully discussed with the home's Staff Nurses at a Staff Nurse meeting held on the 11/10/23. Nurses post wound

	change record has been implemented to ensure that all steps are completed at each dressing change. The Nurse Manager will review and audit this area moving forward.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 4.1 **Stated:** Second time **To be completed by:** With immediate effect	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. The care plans should be further developed within five days of admission, reviewed and updated in response to the changing needs of the patient. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: This area of improvement has been carried forward to the next inspection as a review only took place of one new resident on the day of the inspection. A reminder has been given to all Staff Nurses at the meeting held on the 11/10/23 re the importance of timely completion of care plans & assessments for new residents to the home.

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

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

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