Inspection Report

14 November 2023

Oakmont Lodge Care Home Nursing Unit

Type of Service: Nursing Home
Address: 267 - 271 Old Belfast Road,
Bangor BT19 1LU
Tel no: 028 9146 5822

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: Dunluce Healthcare Bangor Ltd **Responsible Individual:** Mr Ryan Smith	**Registered Manager:** Mrs Emma Kerrigan – not registered
Person in charge at the time of inspection: Mrs Emma Kerrigan – Manager	**Number of registered places:** 41 There shall be a maximum of 12 residents in Category NH-DE.
Categories of care: Nursing Home (NH) 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 DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 41
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 41 patients. The home is divided in two units; the McKee unit located on the first floor in which patients receive general nursing care; and a 12 bedded unit which provides care to people living with dementia. There is also a registered Residential Care Home located within the same building.	

2.0 Inspection summary

An unannounced inspection took place on 14 November 2023 from 9.15 am to 5.05 pm by two care inspectors. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Areas requiring improvement were identified during this inspection and are discussed within the main body of the report and Section 6.0.

Patients were happy to engage with the inspectors 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.

RQIA were assured that the delivery of care and service provided in Oakmont Lodge Care Home Nursing Unit was provided in a compassionate manner by staff that knew and understood the needs of the patients.

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.

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

Throughout the inspection patients, relatives, staff and a visiting professional were asked for their opinion on the quality of the care and their experience of living, visiting or working in Oakmont Lodge Care Home Nursing Unit. 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 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 manager at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about the care that they received and about 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. One patient said, "staff are very good, attentive and kind. I'm well looked after," while another patient said, "It's a good house. Staff are helpful and there's enough staff about. If I need someone, they come to me pretty quickly." A further patient said, "My room is comfortable and clean."

Relatives spoken with were complimentary of the care provided in the home. Two relatives said, "Thank you for everything that you do." And "I come in at different times of the day and the staff are always approachable and kind. My husband is well cared for and safe here.''

Staff spoken with said that Oakmont Lodge Care Home Nursing Unit was a good place to work. Staff commented positively about the manager and described her as supportive and approachable. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

A visiting professional commented: "Staff are friendly and helpful. If I need anything, they will get it for me. I have no issues at all."

No questionnaires were returned by patients or relatives and no responses were received from the staff online survey.

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 Oakmont Lodge Care Home Nursing Unit was undertaken on 15 June 2023 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

A review of staff selection and recruitment records evidenced that staff members were recruited safely ensuring that pre-employment checks had been completed prior to each staff member commencing in post. Enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

Staff members, including agency staff, were provided with a comprehensive induction programme to prepare them for providing care to patients. It was noted that induction records were not available for student nurses who were on placement in the home. This was discussed with the manager who confirmed an induction had been completed and that records of induction had been completed retrospectively.

Checks were made to ensure that staff maintained their registrations with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

The staff duty rota accurately reflected the staff working in the home on a daily basis. This rota identified the person in charge when the manager was not on duty. Review of records confirmed all of the staff who takes charge of the home in the absence of the manager had completed a competency and capability assessment to be able to do so.

There were systems in place to ensure that staff were trained and supported to do their job. Staff consulted with confirmed that they received regular training in a range of topics such as moving and handling, infection prevention and control (IPC) and fire safety.

Review of staff training records confirmed that all staff members were required to complete adult safeguarding training on an annual basis. Staff members were able to correctly describe their roles and responsibilities regarding adult safeguarding.

Staff said they felt well supported in their role and were satisfied with the level of communication between staff and management. Staff reported good teamwork and had no concerns regarding the staffing levels.

Patients spoke positively about the care that they received and confirmed that staff attended to them in a timely manner; patients also said that they would have no issue with raising any concerns to staff. It was observed that staff responded to patients' requests for assistance in a prompt, caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff members were knowledgeable of patients' needs, their daily routine, wishes and preferences. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

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. Staff members 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 members were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

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. Examination of the recording of repositioning evidenced these were well completed.

Management of wound care was examined. Review of a selection of patient's care records confirmed that wound care was managed in keeping with best practice guidance.

Falls in the home were monitored monthly to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring. There was a system in place to ensure that accidents and incidents were notified to patients' next of kin, their care manager and to RQIA, as required.

Review of the management of two falls evidenced appropriate actions were not consistently taken following these falls in keeping with best practice guidance. This was discussed with the manager who agreed to audit all falls until improvements are sustained. An area for improvement was identified.

At times, some patients may be required to use equipment that can be considered to be restrictive, for example, bed rails. Review of patients' records and discussion with the manager and staff confirmed that the correct procedures were followed if restrictive equipment was used.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Lunch was a pleasant and unhurried experience for the patients. The food served was attractively presented and smelled appetising and portions were generous. A variety of drinks were served with the meal. Patients may need support with meals ranging from simple encouragement to full assistance from staff. Staff attended to patients' dining needs in a caring and compassionate manner while maintaining written records of what patients had to eat and drink, as necessary. Patients spoke positively in relation to the quality of the meals provided.

It was noted that a menu was not displayed in a suitable format in the dementia unit. This was discussed with the manager who confirmed in an email received following the inspection that a pictorial menu had been ordered.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of food and fluids. Care plans detailing how the patient should be supported with their food and fluid intake were in place to direct staff. However, examination of records for one identified patient confirmed their care plan had not been updated to reflect the Speech and Language Therapists (SALT) recommendations. While a choking risk assessment was in place, this was not recorded in the patient's care plan. An area for improvement was identified.

Review of records regarding weight showed that nutritional risk assessments were carried out monthly using the Malnutrition Universal Screening Tool (MUST) to monitor for weight loss and weight gain.

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. Review of a selection of patient's care records evidenced that care plans had been developed within a timely manner to accurately reflect their assessed needs. Minor shortfalls in record keeping were discussed with staff and addressed satisfactorily before the end of the inspection.

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

Examination of daily and monthly evaluations of care confirmed that while some entries were person centred, there was evidence that some registered nursing staff were using repetitive statements which were not sufficiently person centred. This was discussed with the manager who confirmed this had been highlighted during recent audit activity as an area for review and was being addressed by senior management. Given these assurances and to allow time for evaluations of care to be reviewed, additional areas for improvement were not identified on this occasion. This will be reviewed at a future care inspection.

Daily progress notes reviewed evidenced that staff were not consistently recording the 24-hour fluid intake for patients who were having their fluid intake monitored. This was discussed with the manager who agreed to meet with nursing staff and monitor through ongoing care record audits. An area for improvement was identified.

While supplementary care records were generally well completed, shortfalls were identified in completion of personal care records. The manager agreed to review the system currently in use to ensure an accurate record is maintained. Care staff should record when care has been offered but refused and evidence any further attempts that were made for care delivery.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment evidenced the home was warm, clean, tidy and fresh smelling. Many patients' bedrooms were personalised with items important to them.

Minor shortfalls in the cleaning of the environment were noted. These issues were discussed with the deputy manager who arranged for the deficits to be addressed before the end of the inspection. The manager confirmed supervisions had been completed with identified staff. Some beds had been 'made up' with bed linen that required changing. This was discussed with the deputy manager who confirmed that there was sufficient clean bed linen in the home and arranged for the identified bed linen to be changed immediately. The manager advised that they would review current systems to actively monitor the use of clean linen in the home. An area for improvement was identified.

Fire safety measures were in place to ensure that patients, staff and visitors to the home were safe. Staff members were aware of their training in these areas and how to respond to any concerns or risks. A fire risk assessment had been completed on 10 November 2023. In an email received following the inspection, the manager confirmed all immediate actions identified by the fire risk assessor had been addressed.

There were laminated posters displayed throughout the home to remind staff of good hand washing procedures and the correct method for applying and removing of personal protective equipment (PPE). There was an adequate supply of PPE and hand sanitisers were always readily available throughout the home.

Discussion with staff confirmed that training on IPC measures and the use of PPE had been provided. Most staff members were observed to carry out hand hygiene at appropriate times and to use PPE correctly. A small number of deficits in individual staff practice were discussed with the manager who agreed to address this through supervision.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. Some patients preferred the privacy of their bedroom but would enjoy going to the dining room for meals.

Patients were observed listening to music and watching TV, while others enjoyed doing arts and crafts or a visit from relatives.

There was evidence that planned activities were being delivered for patients within the home. An activity planner displayed in the home confirmed varied activities were planned for which included a magic table, boccia ball, memory box, church services, exercise classes, arts and crafts and movies. Visits were also planned from children who attend a local primary school.

Although there was evidence of planned activities, examination of activity records confirmed that further work was required to evidence delivery of activities on a consistent basis to all patients. The activity planner was not in a suitable format to meet the needs of all patients. Examination of records evidenced that individual activity assessments with associated person centred activity care plans were not consistently in place and evaluations of activity delivery was not consistently recorded. This was identified as an area for improvement.

5.2.5 Management and Governance Arrangements

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 has been no change in the management of the home since the last inspection. Mrs Emma Kerrigan has been the manager since 24 January 2023.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. The manager or delegated staff members completed regular audits to quality assure care delivery and service provision within the home. The quality of the audits was generally good and the manager was responsive to suggestions made to improve action plan oversight.

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 was identified as the appointed 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.

Review of records confirmed that systems were in place for staff appraisal and supervision.

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 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.

Review of records evidenced that patient, patient representative and staff meetings were held on a regular basis. Minutes of these meetings were available.

Staff commented positively about the manager and described her as supportive, approachable and always available for guidance. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

A review of the records of accidents and incidents which had occurred in the home found that these were generally well managed and reported appropriately. Review of records identified two notifiable events which had not been reported. These were submitted retrospectively.

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. It was noted that no visit had been completed for August 2023 due to unforeseen circumstances. This was discussed with the responsible individual who agreed to review arrangements for completion of monthly monitoring visits in the event of unforeseen circumstances and seek advice from 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	3	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Emma Kerrigan, manager, Mr Ryan Smith, responsible individual, and 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 13 (1) (a) (b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that nursing staff manage falls in keeping with best practice. All actions taken post fall should be appropriately recorded in the patient's care record. Ref: 5.2.2
	Response by registered person detailing the actions taken: Supervision completed with all nursing staff. Audit on the documentation post falls continues to identify any errors or discrepancies with an appropriate action plan developed after same.
Area for improvement 2 **Ref:** Regulation 16 (2) (b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that the patient's plan is kept under review and reflective of their assessed needs. This area for improvement is made with specific reference to nutrition and choking risk. Ref: 5.2.2
	Response by registered person detailing the actions taken: Nursing staff have completed further training in dysphagia. There is a clear procedure for referrals to Speech and Language Therapy and supervision completed with all nursing staff regarding the importance of the correct diet and choking risk documented in careplan.
Area for improvement 3 **Ref:** Regulation 18 (2) (c) (e) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure clean bedding is used at all times suitable to the needs of patients. Arrangements must be in place for the regular laundering of bed linen. Ref: 5.2.3
	Response by registered person detailing the actions taken: Supervision completed with staff re checks of bed linen. Daily walk around audit amended to include daily checks of bed linen. Additional bed linen purchased as required.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 37.4 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that patients' fluid intake over a 24-hour period is reviewed by a registered nurse where appropriate and accurate records are maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: Nurses to ensure fluid intake is recorded and reviewed after 24hrs. Morning and afternoon huddles have been commenced with all staff to identify residents with low fluids and ensure action is taken in a timely manner. Care records audited to maintain accurate records.
Area for improvement 2 **Ref:** Standard 11 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure activities are planned and delivered to provide structure to the patient's day. These should be developed in consultation with the patients and reviewed at least twice yearly to ensure it meets patients changing needs. The programme of activities should be displayed in a suitable format so that patients know what is scheduled. Individual activity assessments should be completed and reviewed as required to inform and compliment patient centred care plans. A contemporaneous record of activities delivered must be retained. Ref: 5.2.4
	Response by registered person detailing the actions taken: New pictorial activity planner now in use in Dementia Unit. All patients have had their activities care plan reviewed since the RQIA inspection, additionally meetings have commenced monthly with management and activity staff to address seasonal and additional activities and furthermore address any specific resident requests. Importance of record keeping addressed at staff meeting particularly with reference to the record keeping of activities with the addition regular reviews of the records by management.

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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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