

# Inspection Report

4 May 2021



## Carrickfergus Manor

Type of service: Nursing Home  
Address: 76 Dunluskin Gardens,  
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[www.rqia.org.uk](http://www.rqia.org.uk)

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Assurance, Challenge and Improvement in Health and Social Care

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## 1.0 Service information

<b>Organisation/Registered Provider:</b> Kathryn Homes Ltd  <b>Responsible Individual:</b> Mr Dermot Parsons	<b>Registered Manager:</b> Ms Joanne Elizabeth Alderdice  <b>Date registered:</b> 17 December 2014
<b>Person in charge at the time of inspection:</b> Ms Joanne Elizabeth Alderdice	<b>Number of registered places:</b> 47
<b>Categories of care:</b> 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.	<b>Number of patients accommodated in the nursing home on the day of this inspection:</b> 43
<b>Brief description of the accommodation/how the service operates:</b>  This home is a registered Nursing Home which provides nursing care for up to 47 persons. The Nursing Home is on the first floor and is divided into two units, Loughview and Knockagh. There is also a registered Residential Care Home under the same roof on the ground floor.	

## 2.0 Inspection summary

An unannounced inspection took place on 4 May 2021 from 10.05 a.m. until 6.00 p.m. The inspection was undertaken by the care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and 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 care delivery, the environment and maintaining good working relationships.

It was positive to note that the existing areas for improvement had been met and no new areas requiring improvement were identified.

Patients said that living in the home was a good experience. 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 Carrickfergus Manor was safe, effective, and compassionate and that the home was well led.

The findings of this report will provide the management team 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 patients, their relatives and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. 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, the Responsible Individual and the Deputy Manager at the conclusion of the inspection.

### **4.0 What people told us about the service**

During the inspection we spoke with 18 patients, both individually and in small groups, three patients' relatives and eight staff. Patients told us that they felt well cared for, enjoyed the food and that staff were helpful and friendly. Relatives said that communication was good and their loved ones were well looked. One relative felt that staffing levels could perhaps be improved on occasions. Staff said that, whilst short notice sick leave could affect staffing levels at times, efforts were made to provide cover for shifts, the manager was very approachable, teamwork was great and that they felt well supported in their role.

Following the inspection we received five completed questionnaires. One patient indicated that they were satisfied/very satisfied that the care provided was safe, effective, compassionate and well led. Another patient and three relatives indicated that they were very satisfied across all four domains.

## 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 2 June 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 14 (1) (b)  <b>Stated:</b> First time	The registered person shall ensure that there is a robust system in place to refer patients to the GP in order that timely treatment or advice is provided where necessary.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> Accurate and up to date contact details for GP's were readily available in both nurses' stations. Nurses demonstrated their knowledge of when and how to make timely referrals to a GP. Referrals to the GP were clearly recorded in the patients' care records. Information regarding referrals to the GP and the reason for referral was shared with the team during the daily handover and daily 'flash meetings'.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		Validation of compliance
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 4 (9)  <b>Stated:</b> First time	The registered person shall ensure that wound care plans are developed in a timely manner, regularly evaluated and discontinued once a wound has healed.  The system in place to monitor and review wound care delivery should be robust.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> Review of wound care plans and wound charts evidenced that these were maintained accurately and were up to date. There was evidence of regular evaluation of wounds and wound care delivery. Where a wound was	

	healed the care plan had been discontinued.	
<b>Area for improvement 2</b> <b>Ref:</b> Standard 21 (1) <b>Stated:</b> First time	The registered person shall ensure that referrals to health care professionals, such as the GP, are timely and that records maintained in relation to this are meaningful, informative and contemporaneous.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> Review of patients' care records evidenced that when a referral had been made to a GP or other health care professional this was clearly and contemporaneously recorded. The records described the reason for the referral and when it was made.	

## 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, this also included agency or temporary staff.

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics including moving and handling, fire safety and dysphagia awareness. Staff said that they were provided with relevant training to enable them to carry out their roles and responsibilities effectively. Regular staff meetings were held; as a result of the COVID-19 pandemic these were currently attended via Zoom.

Staff said teamwork was good, the manager was approachable and that they felt well supported in their role. Staff also said that, whilst they were kept busy, staffing levels were generally satisfactory apart from when there was an unavoidable absence. As previously discussed in Section 4.0 staff said that management did attempt to provide cover in those circumstances.

The manager told us that the number of staff on duty was reviewed on at least a monthly basis to ensure the needs of the patients were met. The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the manager was not on duty. It was noted that there were enough staff in the home to respond to the needs of the patients in a timely way. Call bells were answered promptly by staff who were observed to respond to requests for assistance in a caring and compassionate manner.

Patients said that they felt well looked after and that staff were attentive. Patients' relatives said they felt their loved ones were well looked after and that staff were mostly helpful. As previously discussed in Section 4.0, one relative said they felt staffing levels could be better on occasions but had no concerns about the care provided.

There were safe systems in place to ensure staff were recruited and trained properly and also to ensure that patients' needs were met by the number and skill mix of the staff on duty.

### **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 manager was identified as the appointed adult safeguarding champion for the home.

Review of staff training records confirmed that all staff were required to complete adult safeguarding training on a three yearly basis. Staff told us they were confident about reporting concerns regarding, for example, patients' safety or poor practice.

On occasions some patients may be required to use equipment that can be considered to be restrictive, for example, bed rails and 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 positive to note that patients and/or their relatives were involved in the consultation process and could give informed consent. Risk assessments and care plans were in place regarding the use of restrictive practices where required.

Staff confirmed they had attended specialised training to ensure they were aware of deprivation of liberty safeguards (DoLS) and restrictive practices. Staff were aware of how to ensure that, if restrictive practices could not be avoided, best interest decisions were made safely for all patients but particularly those who were unable to make their own decisions. Staff knew where to access information regarding DoLS and demonstrated their knowledge of what constituted a restrictive practice.

Staff were seen to communicate effectively with patients; they were kind, respectful and sensitive to their needs. For example, staff told us that a particular patient wouldn't always accept assistance with their personal care at traditional times; they recognised the importance of ensuring that assistance was given when the patient was in a more relaxed and receptive frame of mind.

Patients' relatives spoken with said that they felt listened to if they raised any issues or concerns.

There were systems in place to ensure that patients were safely looked after in the home and to ensure that staff were adequately trained for their role in keeping patients 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, ensuites, treatment rooms, storage spaces and communal areas such as lounges and bathrooms. There was evidence that the environment was clean, tidy and well maintained. The manager said that all the required safety checks and measures were in place and regularly monitored.

Patients' bedrooms were personalised with items that were important to them. Bedrooms and communal areas were well decorated, suitably furnished and comfortable. Patients said that the home was kept clean and tidy.

There was evidence throughout the home of 'homely' touches such as magazines, books and DVD's for patients to enjoy. Jugs of juice were available in lounges and bedrooms and patients were offered suitable drinks and snacks between their main meals. The home was attractively decorated and pictures that would be of interest to patients were on display in the corridors. Staff were seen to ask patients in the communal lounges if they preferred to watch TV or listen to music; it was positive to see that patients opinions were sought and taken into account.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors and fire exits were clear from clutter and obstruction. A valid fire risk assessment was available for review.

Equipment was well maintained and in good condition. Staff were seen to clean hoists between patient use; this was good practice.

There were systems in place to ensure that the home was kept clean, tidy and well maintained in order that patients were comfortable and safe in their environment.

### **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 and completed a health declaration on arrival. They were also required to wear personal protective equipment (PPE) such as aprons, masks and/or gloves.

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

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by management and records were maintained. PPE stations were observed to be well stocked throughout the home.

The manager said that cleaning schedules included frequent touch point cleaning and this was carried out by both domestic and care staff on a regular basis over the 24 hour period. The manager also said that any issues observed regarding IPC measures or the use of PPE were immediately addressed.

Visiting and care partner arrangements were managed in line with DoH and IPC guidance. Policies regarding visiting and the care partner initiative had been developed. Relatives were provided with guidance regarding visiting and the care partner role and provided with training on the use of PPE and effective hand hygiene.

Patients' relatives, who were in the home in their capacity as care partners, said that they had been well informed about the current guidelines regarding visiting and the care partner initiative.

There were systems were in place to manage the risk of infection and to ensure that guidelines regarding the current COVID-19 pandemic were adhered to.

**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 received a handover at the beginning of each shift to discuss any changes in the needs of the patients. Nursing staff also attended a daily 'flash meeting' with the manager or nurse-in-charge to share relevant patient information, for example, if a patient had become unwell and required a General Practitioner (GP) visit. In addition, patient care records were maintained which accurately reflected the needs of the patients. Staff were knowledgeable about individual patients' needs including, for example, dietary recommendations and their daily routine preferences. Staff respected patients' privacy and spoke to them with respect. Staff were seen to knock on doors before entering bedrooms and bathrooms.

Patients who were less able to mobilise require special attention to their skin care. These patients were assisted by staff to change their position regularly. Care records relating to repositioning were accurately maintained.

Patients who had wounds had this clearly recorded in their care records. There was evidence that nursing staff had consulted with the Tissue Viability Specialist Nurse (TVN) and were following any recommendations they had made. Care records relating to wound care were accurately maintained.

Where a patient was at risk of falling, measures to reduce this risk were put in place, for example, call bells were accessible, aids such as floor alarm mats were in use if recommended and staff carried out regular checks on patients as per the recommendations in individual care records.

Examination of records and discussion with the manager and staff confirmed that the risk of falling and falls were well managed. Review of records showed that staff took appropriate action in the event of a fall, for example, they completed neurological observations and sought medical assistance if required. Staff also completed a post fall review to determine if anything more could have been done to prevent the fall.



Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was seen to be a pleasant opportunity for patients to socialise, music was playing, and the atmosphere was calm and relaxed. Staff had made an effort to ensure patients were comfortably seated. There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, staff recognised that patients may need a range of support with meals and were seen to helpfully encourage and assist patients as required.

There was choice of meals offered, the food was attractively presented and smelled appetising. Staff knew which patients preferred a smaller portion and demonstrated their knowledge of individual patient's likes and dislikes. There was a variety of drinks available. Patients told us they very much enjoyed the food provided in the home.

Staff told us how they were made aware of patients' nutritional needs and confirmed that patients' care records were kept up to date to ensure they received the correct diet. There was a system in place to ensure that all staff were aware of individual patients' nutritional needs and any modified dietary recommendations made by the Speech and Language Therapist (SALT). There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. Up to date records were kept of what patients had to eat and drink daily.

There were systems were in place to ensure that patients' needs, including any changes, were communicated to all staff in a timely manner. Patients' privacy and dignity was maintained and their needs regarding management of falls, skin care, wounds and nutrition were met.

#### **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 were developed to direct staff on how to meet patients' needs; these included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. 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 preferences were 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.

Daily records were kept of how each patient spent their day and the care and support provided by staff. Referrals to, or visits from, any healthcare professional was recorded, along with the outcome, for example, if staff contacted the GP regarding a patient.

Patients' relatives said that communication was good and they felt that they were kept well informed about any change in care needs.

There were systems in place to ensure that care records were regularly evaluated, updated to reflect any changes in patients' needs and to ensure that staff were aware of any changes.

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

It was observed that staff offered choices to patients throughout the day which included, for example, preferences for what clothes they wanted to wear and food and drink options. Patients told us that they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of their time in their room and staff were observed supporting patients to make these choices.

There was a range of activities provided for patients by the wellbeing leads and staff. The range of activities included social, community, cultural, religious, spiritual and creative events.

The activity schedule was on display and planned sessions included, for example, current affairs, gentle exercises, pamper time, fun with food, reminiscence, church on-line, arts and crafts and a tea party.

Patients told us that they were aware of the activities provided in the home and offered the choice of whether to join in or not, one patient said "there is plenty to do if you want to join in".

The manager said that patients' views and opinions were sought via surveys.

Review of records showed that patients had the opportunity to participate in regular meetings to give them an opportunity to comment on the running of the home and make suggestions as to how things could be improved further. Relatives' meetings had also been held via Zoom. The manager recognised the importance of keeping relatives up to date and seeking their opinions whilst ensuring the current guidelines regarding COVID-19 were followed.

Staff recognised the importance of maintaining good communication between patients and their relatives, 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. Staff also maintained good communication links directly with relatives via email, telephone calls and the home's newsletter.

The three relatives we spoke to were all in the home in their capacity as care partners; all agreed that this had had a positive impact on both their loved one and themselves.

There were suitable systems in place to support patients to have meaning and purpose to their day and to allow them the opportunity to make their views and opinions known.

### **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?**

There had been a change in the registered provider and responsible individual arrangements for the home since the last inspection and RQIA had been appropriately notified. The management arrangements had not changed. The manager said they felt well supported by the responsible individual and their organisation.

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. Staff said that the manager was approachable and accessible.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. Regular audits were completed to review, for example, IPC measures, wounds, restrictive practices, falls and care records. The audits contained clear action plans where required.

There was a system in place to manage complaints. There was evidence that the manager ensured that complaints were managed correctly, a complaints record was maintained which included relevant details and the outcome. The manager told us that complaints were seen as an opportunity for learning and to improve the service provided. Patients and their relatives said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

A record of compliments and thank you cards received about the home was kept and shared with the staff team; this is good practice.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately to patients' next of kin, their care manager and to RQIA if required.

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.

There were systems in place to monitor the quality of care and services provided and to drive improvement in the home.

## **6.0 Conclusion**

Patients looked well cared for and were seen to be content and settled in the home. Staff treated patients with respect and kindness. The home was clean, tidy and well maintained.

The outcome of this inspection concluded that all areas for improvement identified at the last care inspection had been met and no new areas for improvement were identified.

Thank you to the patients, relatives and staff for their assistance and input during the inspection and also to those who returned completed questionnaires following the inspection.

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

## **7.0 Quality Improvement Plan/Areas for Improvement**

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Joanne Alderdice, Registered Manager, Mr Dermot Parsons, Responsible Individual, and Ms Elizabeth Jeffrey, Deputy Manager, as part of the inspection process and can be found in the main body of the report.



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