The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Ladyhill Private Nursing Home**

Provider: **Town & Country Care Homes Limited**

Date of Inspection: **23 January 2025**

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:	Town & Country Care Homes Limited
Responsible Individual:	Mr Christopher Philip Arnold
Registered Manager:	Miss Faye McDonnell – Not registered

Service Profile –
This home is a registered nursing home which provides nursing care for up to 31 patients who have a learning disability. Patients' bedrooms are located over one floor and patients have access to communal dining and lounge spaces in the home. Patients also have access to a garden area around the home.

2.0 Inspection summary

An unannounced inspection took place on 23 January 2025 from 9.15am to 4.00pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards and to assess progress with the area for improvement identified, by RQIA, during the last care inspection on 29 April 2024.

As a result of this inspection the previous area for improvement was assessed as having been addressed by the provider and one new area for improvement was identified. Details can be found in the main body of this report.

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. Refer to Section 3.2 for more details.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the 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 process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "Staff are good," and, "I like it here".

Patients told us that staff offered choices to 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.

Relatives consulted during the inspection were complimentary in regards to the care their loved one was receiving. One told us,"The care is fantastic here; they (the staff) genuinely care".

We received no questionnaire responses from patients or their visitors/relatives and no responses from the staff online survey.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Patients raised no concerns in relation to the staffing arrangements. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs. A relative commented, "They really bring xxx to life. They go above and beyond".

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 were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

Nursing and care staff received a handover at the commencement of their shift. However, examples were shared with the manager where these handovers had not been effective. This included the handovers of patients who required one to one care. An area for improvement was identified.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Patients were safely positioned for their meals and the mealtimes were well supervised. Food served appeared appetising and nutritious. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Where a patient had a wound, care plans were in place to guide staff in how to manage the wound and evaluation records monitered the progress of the treatment. When patients required to be repositioned to maintain skin integrity, records of repositioning had been kept.

When patients' needs changed, such as, mobility or dietary needs, all of the necessary care records were amended to reflect the change.

A monthly activities planner was available for review. Activities were conducted in groups and/or on a one to one basis depending on patients' preferences. Records of activity engagements were recorded. Ways of enhancing the activity provision was discussed with the manager.

Relatives told us that staff always kept them up to date with their loved one's care. One told us, "xxx is very settled here and knows the staff very well". Relatives confirmed that they could visit when they wanted.

Patients spoken with told us they enjoyed living in the home and that staff were friendly.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse 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. Patients care records were held confidentially.

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

Nursing staff recorded regular evaluations about the delivery of care. 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.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy and patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, warm and comfortable.

Fire safety measures were in place to protect patients, visitors and staff in the home. Actions required from the most recent fire risk assessment had been completed in a timely manner.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been a change to the Responsible Individual of the home since the last inspection. Mr Chris Arnold became the Responsible Individual on 5 November 2024. Ms Faye McDonnell continues as manager of the home.

It was good to note that the management team in the home had prepared well for an approaching storm to ensure the safety and well-being of the patients.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place.

There was a system in place to manage any complaints received. A compliments log was maintained and any compliments received were shared with staff.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further. Patients and their relatives spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1	0

The area for improvement and details of the Quality Improvement Plan was discussed with Faye McDonnell, Manager and Linda Graham, Regional Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (1) (a) **Stated:** First time	The registered person shall ensure that all nursing and care staff coming on duty receive a detailed handover on the patient/s that they will be caring for. Ref: 3.3.2
To be completed by: With immediate effect (23 January 2025)	**Response by registered person detailing the actions taken:** Acting Nurse Manager can confirm that all staff receive a handover in relation to residents in their care and specifically any staff covering 1-1 care. To further enhance the handover, a new process has been developed and actioned with immediate effect to ensure sufficient delivery of same following identification of area for improvement. - New profile summaries developed for all 1:1 residents and placed at the beginning of their folders. Details of care and support required are included within same to be utilised when providing handover to oncoming staff ensuring suifficent detail is provided.

	- New weekly handover summary provided at the end of every week and placed into Care Assistant Communication file for staff to review on return from period off or annual leave. - SOP for Providing and receiving handovers reviewed and updated before being shared amongst staff team. Acting Nurse Manager continues to monitor and ensure detailed oversight of handovers are provided and effective, actioning any short falls as soon as identified.

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