The Regulation and Quality Improvement Authority

Inspection Report

29 April 2024

Ladyhill Private Nursing Home

Type of service: Nursing Home
Address: 40 Creevery Road, Antrim, BT41 2LQ
Telephone number: 028 9446 6905

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

1.0 Service information

Organisation: Town & Country Care Homes Limited **Responsible Individual:** Dr Marina Lupari	**Registered Manager:** Ms Faye McDonnell – not registered
Person in charge at the time of inspection: Ms Faye McDonnell	**Number of registered places:** 31
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 24
Brief description of the accommodation/how the service operates: 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 29 April 2024 from 9.50am to 4.30pm by two care inspectors.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and determined if the home was delivering safe, effective and compassionate care and if the service was well led.

Patients were well presented in their appearance and spoke positively when describing their experiences of living in the home. Comments received from patients and staff are included in the main body of this report.

We found that there was safe, effective and compassionate care delivered in the home and the home was well led by the manger/management team.

One area for improvement was identified and details can be found in the Quality Improvement Plan (QIP) at the end of this report.

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 manager and the responsible individual at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with patients and staff. Patients told us that they were happy living in the home and were offered choice in how they spent their day. One patient said, "The staff are good; I can't say anything bad about them."

Staff told us that there were enough staff on duty to provide good care and that there were good working relationships between staff and the home's management team.

There were no questionnaire responses received from patients or relatives and we received no feedback from the 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?

Areas for improvement from the last inspection on 13 July 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Third time	The registered person shall ensure that the maximum and minimum refrigerator temperature is monitored and recorded each day. Corrective action must be taken if temperatures outside the accepted range are observed. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Area for improvement 2 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time	The registered person shall ensure that wound care is recorded in line with best practice guidance. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Area for improvement 3 **Ref:** Regulation 14 (2) (a) and (c) **Stated:** First time	The registered person shall ensure that patients are not exposed to hazards to their health. This is in relation to access to medicines in the treatment room. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 12 Criteria (27)	The registered person shall ensure that food and fluid intake records are reflective of the actual food and fluids consumed by patients.	**Met**

Stated: Second time		
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure that repositioning charts are consistently recorded accurately in accordance with their care plan.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Patients raised no concerns in regards to the staffing arrangements in the home. Staff confirmed that the number and skill mix of staff on duty met the needs of the patients. The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked. Staff felt that they worked well together and that the teamwork was good. They shared comments, such as, “We have a good team here and we work hard” and, “We all enjoy working together”. Observation of care delivery during the inspection raised no concerns with the staffing arrangements in place.

A comprehensive pre-determined list of pre-employment checks had been completed and verified prior to any new employee commencing work in the home. All staff completed a two-week induction to become more familiar with the homes policies and procedures. A booklet was completed to record the topics of induction completed. A list of training was identified for completion as part of the induction process.

Staff had a suite of mandatory training topics to complete annually to maintain their knowledge and skills in order to provide safe and effective care. Training topics included patient moving and handling, adult safeguarding, deprivation of liberty safeguards (DoLS) and fire safety training. A system was in place to ensure staff completed their training.

Staff confirmed that they received an annual appraisal to review their performance and, where appropriate, identify any training needs. Staff also confirmed that they received recorded supervisions on a range of topics.

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

Staff were observed to work well and communicate well with one another during the inspection. Care was delivered in a caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

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. Patients' care records were held confidentially.

All staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles. The duty rota identified the individual tasks and responsibilities for each staff member during their shift and at what time.

Supplementary care records were recorded to capture the care provided to patients. This included any assistance with personal care, activity involvement, food and fluid intake and any checks made on patients. Several patients required one to one care. One to one care plans identified when the one to one care was to begin and finish and the reasoning for the one to one care. The person providing one to one care maintained accurate supplementary care notes. Nursing staff completed daily progress notes to evaluate the daily care delivery.

All patients had a pressure management risk assessment completed monthly. Where a risk of skin breakdown was identified; a care plan was developed to guide staff in how to manage this risk. However, when a plan of care changed, such as the need to no longer reposition a patient, the main pressure management care plan was amended to reflect the change, but, the associated care plans where not updated. Gaps in the recording of patients' skin checks was also observed. This was discussed with the manager and identified as an area for improvement.

Incident forms were completed by staff to record any accidents or incidents which occurred in the home. Falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented. Accident records evidenced that the appropriate actions had been taken following a fall in the home and the appropriate persons notified.

A 'Safety Pause' was conducted with staff before each meal in the home to ensure that patients were receiving the correct modified levels of food and fluids. Patients had good access to food and fluids throughout the day and night. The manager reported no significant weight loss in the home. Meal timings were well spaced out during the day. On the day of inspection patients were looking forward to a Birthday party with party food.

5.2.3 Management of the Environment and Infection Prevention and Control

During the inspection we reviewed the home's environment including a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. Patients' bedrooms were personalised with items important to them. Appropriate doors leading to rooms which contained hazards to patients had been locked. The home was warm, clean and comfortable. There were no malodours detected in the home.

It was evident that fire safety was important in the home. Staff had received training in fire safety and the manager confirmed fire safety checks including fire door checks and fire alarm checks were conducted regularly. Corridors in the home were free from clutter and obstruction as were the fire exits should patients have to be evacuated. Fire extinguishers were easily accessible.

Patients had access to the garden. Seating was available for patients here to enjoy the outdoors when they wished.

Infection prevention and control (IPC) audits and environmental audits were conducted monthly and contained action plans to address any deficits found. Minor IPC issues identified during the inspection were managed during the inspection. There was evidence of managerial oversight of the audits.

5.2.4 Quality of Life for Patients

Patients appeared comfortable and settled in their environment. There was a pleasant atmosphere throughout the home. It was observed that staff provided care in a caring and compassionate manner. It was clear through patient and staff interactions that they knew one another well and were comfortable in each other's company.

A socialisation lead was employed in the home to promote socialisation and activity provision. Care staff were also involved in activity provision. An activities calendar was available for review. Activities were conducted on a group basis or on a one to one basis where this was preferred. Activities included cooking, dancing, singing and arts and crafts. Patients were taken outside for walks and outings. Individual records of activity engagements were recorded. These included activities which had been offered but refused.

Patients spoken with told us they enjoyed living in the home and that staff were friendly. One patient told us, "I like it here." Another patient told us how they were looking forward to the planned shopping trip in the afternoon.

Visiting had returned to pre-covid arrangements in line with Department of Health guidelines. Patients were free to leave the home with family members if they wished.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been a change to the management arrangements. Faye McDonnell has been managing the home since 29 January 2024. An application to register as manager with RQIA was in process. Discussion with the manager and staff confirmed that there were good working relationships between staff and the manager. Staff told us that they found the manager and management team to be 'approachable'.

In the absence of the manager, the registered nurse would take charge of the home. Nurses first completed a competency and capability assessment on taking charge of the home prior to commencing this role. Staff confirmed that the management team were contactable at all times should they require assistance.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff had a good understanding of the home's organisational structure should they need to escalate their concern and were aware of the departmental authorities that they could contact should they need to escalate further.

The manager confirmed their own internal governance practices in order to monitor the quality of care and other services provided to patients. Audits were conducted on, for example, patients' care records, restrictive practice, medicines management, staff training and the environment. A DoLS register was maintained to confirm patients' capacity levels, mobility and date of authorisations.

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. It was positive to note that progress with the RQIA QIP was reviewed as part of the visit. The reports of these visits were completed and completed reports were available for review by patients, their representatives, the Trust and RQIA. Where improvement actions were required, an action plan was included within the report. The action plan would be reviewed at the subsequent monthly monitoring visit to ensure completion.

A complaint's file was maintained and records kept to include the nature of any complaint and any actions taken in response to the complaint. The number of complaints made to the home was low. A compliment's log was also completed to record any verbal compliments, cards of thanks or gifts received. The manager confirmed that all compliments received would be shared with the staff.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	0	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Faye McDonnell, Manager and Dr Marina Lupari, Responsible Individual, 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 Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 29 May 2024	The registered person shall ensure that when a plan of care changes, all associated care plans must also be updated to reflect the current need. Records should evidence daily skin checks. Ref: 5.2.2
	Response by registered person detailing the actions taken: Comprehensive review was undertaken by the Acting Nurse Manager and determined that all systems are in place and of a high standard to overview the need for updating care plans to reflect current need. All Registered Nurses were however, reminded of their responsibility and requirement to update all relevant care plans if any change to plan of care should arise. All members of the care team were reminded of their responsibility to ensure completion of daily skin care bundle checks are completed accurately and with no gaps in records for applicable residents. Registered Nurse and Care Assistants checklists reviewed and updated accordingly to reflect the same as of 29.04.2024. Audit amended to capture area of practice reviewed monthly to ensure compliance with recording of daily skin care checks and monitoring of care plans. Same communicated to the responsible provider through R29 monthly audit.

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