Inspection Report

30 and 31 August 2021

Larne Care Centre

Type of service: Nursing (NH)
Address: 46-48 Coastguard Road, Larne, BT40 1AU
Telephone number: 028 2827 7979

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: Larne Care Centre Limited **Responsible Individual :** Mr Colin Nimmon	**Registered Manager:** Mr Leslie Stephens **Date registered:** 3 October 2014
Person in charge at the time of inspection: Mr Leslie Stephens – Registered Manager	**Number of registered places:** 87 40 – NH- I A maximum of 31 patients accommodated within category -NH-DE A maximum of 25 patients accommodated within category -LD/LD(E). 3 named residents receiving residential care in category in RC-I. 5 persons (3 general nursing and 2 in LD/LD(E).
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. TI – Terminally ill. DE – Dementia. LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 66
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 87 patients. The home is divided in four units over two floors. The Carnlough and Olderfleet units on the ground floor and first floor provide care for people with learning and physical disabilities. The Ballygally unit on the first floor provides general nursing care and the Glenarm unit which is on the first floor provides care for people with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 30 August 2021 from 9.20 am to 4.30 pm and on 31 August 2021 from 9.20 am to 11.20 am by a care inspector.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Five new areas requiring improvement were identified during this inspection and this is discussed within the main body of the report and Section 7.0.

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 were helpful and pleasant in their interactions with them.

RQIA were assured that the delivery of care and service provided in Larne Care Centre was provided in a safe and compassionate manner.

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, staff and relatives were asked for their opinion on the quality of the care and their experience of living, visiting or working in Larne Care Centre. 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 at the conclusion of the inspection.

4.0 What people told us about the service

We spoke with 19 patients, one relative and 10 staff. No questionnaires were returned and we received no feedback from the staff online survey within the timeframe for inclusion in this report.

Patients spoke highly of 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.

Staff acknowledged the challenges of working through the COVID – 19 pandemic but all staff agreed that Larne Care Centre was a good place to work. Staff were complimentary in regard to the home's management team and spoke of how much they enjoyed working with the patients.

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 15 September 2020		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 46.1 **Stated:** First time	The registered person shall ensure that accurate and consistent records are being maintained to evidence the monitoring of staffs' temperatures in accordance with regional guidance.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that any plan of care for a patient accurately reflects their assessed needs and that fluid intake records are maintained in a consistent manner.	**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

A review of staff selection and recruitment records evidenced that staff were recruited safely ensuring that all pre-employment checks had been completed prior to each staff member commencing in post. All staff were provided with a comprehensive induction programme to prepare them for providing care to patients. 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 take 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. The majority of training during the COVID-19 pandemic had been completed electronically. The manager said there had been challenges in delivering training during the recent pandemic although records reviewed evidenced training had been delivered with further training planned between September 2021 and December 2021.

Review of staff training records confirmed that all staff were required to complete adult safeguarding training on an annual basis. Staff were able to correctly describe their roles and responsibilities regarding adult safeguarding although some staff confirmed they had not completed training with regards to Deprivation of Liberty Safeguards (DoLS). This was discussed with the regional manager who confirmed this training was ongoing.

Staff said they felt well supported in their role and were satisfied with the level of communication between staff and management. Staff reported good team work and said when planned staffing levels were adhered to they had no concerns regarding the staffing levels. However, some staff consulted were not satisfied that there were sufficient staff numbers on occasions when staff sickness was not covered at short notice. The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met and discussed the ongoing staffing challenges within the care home sector. They confirmed ongoing recruitment for nursing and care assistant positions within the home.

Patients spoke highly 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. Relatives spoken with expressed no concerns regarding staffing arrangements in the home.

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 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 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 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 generally well completed.

Where a patient was at risk of falling, measures to reduce that risk were put in place, for example, through use of an alarm mat. 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 in keeping with best practice guidance. Examination of care records confirmed that registered nursing staff did not consistently update the patient's care plan after their fall to reflect their assessed need and daily evaluation records did not consistently comment on the patient's neurological status. 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. It was good to note that, where possible, patients were actively involved in the consultation process associated with the use of restrictive interventions and their informed consent was obtained.

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.

Plastic tumblers were used at mealtimes for serving drinks to patients; glassware was not available. Some patients spoken with said they would prefer to drink from a glass. The manager agreed to arrange dining audits for each unit and review the use of plastic tumblers to ensure patients who prefer to use glass are facilitated.

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. Care plans detailing how the patient should be supported with their food and fluid intake were in place to direct staff. However, review of one care record evidenced an appropriate choking risk assessment was not in place despite the patient being on a modified diet. An area for improvement was made.

Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of food and fluids. Thickening agents were administered by care assistants; however they did not record administration. This was discussed with the manager and regional manager who agreed to review current practices to ensure that records for delegated tasks such as the administration of thickening agents and topical medicine administration are accurately maintained. This will be reviewed at a future inspection.

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 one identified patient's care records evidenced that most of their care plans had been developed within a timely manner to accurately reflect most of the patient's assessed needs. It was pleasing to note that many of the care plans reviewed were patient centred and evidenced involvement of the patient and/or their family. However, examination of continence management evidenced that the risk assessment and care plan did not accurately reflect the patients assessed needs. An area for improvement was identified.

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. However, deficits in record keeping with regard to personal care were identified. 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. An area for improvement was identified.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from and consultations with any healthcare professional was also recorded.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment evidenced the home was warm, clean and comfortable. There were no malodours detected in the home. One armchair was found to be damaged. This was discussed with the manager who advised this was the patient's own personal armchair and agreed to follow up with their family with a view to having it replaced.

Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, clean and tidy. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices. The lounges were arranged in such a way that patients could safely socially distance; although the dining areas were not. This was discussed with the manager who agreed to reconfigure the dining areas to facilitate social distancing.

Fire safety measures were in place to ensure that patients, staff and visitors to the home were safe. Staff 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 11 December 2020. The manager agreed to review staff participation in fire drills to ensure all staff have attended at least one fire drill this year.

It was noted that the door exiting the Ballygally unit had a keypad on it. This could be considered a restrictive practice if not used appropriately. This was discussed with the manager and regional manager and advice was given on how this could be managed, including discussion with their aligned estates inspector. They agreed to review its use and risk assess as appropriate. Appropriate care plans should be in place. This will be reviewed at a future care inspection.

The manager said that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. The home was participating 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 when they arrived. They were also required to wear personal protective equipment (PPE).

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 PPE. There was an adequate supply of PPE although hand sanitiser was not always readily available in some areas of the home, particularly in dining rooms. This was discussed with the manager who agreed to review this.

Discussion with staff confirmed that training on IPC measures and the use of PPE had been provided. Most staff were observed to carry out hand hygiene at appropriate times and to use PPE correctly; although one staff member did not. This was discussed with the manager who agreed to support this staff member through clinical supervision.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, some patients told us they liked the privacy of their bedrooms, but enjoyed going to the dining room for meals and choosing where to sit with their friends. Other patients preferred to enjoy their meals and socialise in the lounge.

Patients were observed enjoying listening to music, reading newspapers/magazines and watching TV, while others enjoyed a visit from relatives or did arts and crafts. Patients spoke fondly about the activity co-ordinator. One patient told us they enjoyed bingo and the entertainment while another said there was a live band at the home recently which they enjoyed. Other patients told us they potted plants for the garden. Examples of the plants were seen outside the home in the patio areas and arts and crafts made by the patients were displayed in the home.

A schedule of activities was displayed for patients; these included pool competitions, cinema, ball games and board games. The activity co-ordinator said they did a variety of one to one and group activities to ensure all patients had some level of activity. It was pleasing to note that

registered nursing staff reflected on activity and meaningful engagement in daily progress notes. This is good practice.

Staff recognised the importance of maintaining good communication with families, 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.

5.2.5 Management and Governance Arrangements

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.

There has been no change in the management of the home since the last inspection. Mr Leslie Stephens has been the registered manager in this home since 3 October 2014**.**

Discussions were held with management in relation to the current registration and categories of care and a variation was submitted post inspection.

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. Given the deficits identified in the care records regarding recording of personal care delivery, choking risk assessment, falls and continence management, the manager agreed to increase audit activity around care records.

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 regional 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.

Staff commented positively about the manager and the management team and described them 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.

Examination of the annual quality report from February 2021 confirmed it did not integrate the views of all key stakeholders. An area for improvement was identified.

A review of the records of accidents and incidents which had occurred in the home found that these were well managed correctly and reported appropriately.

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.

6.0 Conclusion

Patients were observed to be comfortable in their surroundings and were attended to by staff in a timely and effective manner. Patients' dignity was maintained throughout the inspection and staff were observed to be polite and respectful to patients and each other.

New areas requiring improvement were identified in relation to falls and continence management, choking risk, record keeping and the annual quality report.

Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing care in a compassionate manner.

7.0 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 (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	2	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Leslie Stephens, Registered 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) (b) **Stated:** First time **To be completed by:** From the date of the inspection onwards	The registered person shall ensure that nursing staff consistently comment on the patient's neurological status in their daily evaluations following a head injury/unwitnessed fall. Patient's care plans should be updated to reflect their assessed needs following a fall. Ref: 5.2.2
	Response by registered person detailing the actions taken: All nurses signed a reminder re recording of neurological status in daily evaluations post head injury / unwitnessed fall. This reminder included the need to update care plans to reflect assessed needs following a fall. Both areas will be followed up with an audit by management.
Area for improvement 2 **Ref:** Regulation 16 (1) **Stated:** First time **To be completed by:** From the date of the inspection onwards	The registered person shall ensure that continence care plans and risk assessments are reflective of the patients assessed needs. Ref: 5.2.2
	Response by registered person detailing the actions taken: Nurses reminded continence care plans and risk assessments must reflect the clients assessed need and any medication that can relate to urinary or bowel output. This will be audited by management.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 4.7 **Stated:** First time **To be completed by:** From the date of the inspection onwards	The registered person shall ensure that choking risk assessments are completed in keeping with the assessed needs of the patient. Ref: 5.2.2
	Response by registered person detailing the actions taken: All nurses to ensure care plans / risk assessments reflect those clients who are at risk of choking i.e. all clients on a modified diet. This will be audited by management.

Area for improvement 2 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** From the date of the inspection onwards	The registered person shall ensure that personal care records are accurately maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: Nurses to ensure personal care records reflect how many staff are required to assist with bath / shower and if client refused. Nurses must also document in daily evaluations. Care plans must reflect if client is bedbathed only or prefer bath / shower.
Area for improvement 3 **Ref:** Standard 35.16 **Stated:** First time **To be completed by:** 28 February 2022	The registered person shall ensure that the annual quality report integrates the views of residents, their relatives and staff into the evaluation and review of the quality of care. Ref: 5.2.5
	Response by registered person detailing the actions taken: The annual quality report for 2022 will reflect the views from relatives, clients and staff and will be completed in January 2022.

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

The Regulation and Quality Improvement Authority

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