The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Ambassador**

Provider: **Amstecos Ltd**

Date of Inspection: **21 & 25 February 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:	Amstecos Ltd
Responsible Individual:	Mrs Emer Bevan
Registered Manager:	Mrs Amelia Noach
This is a registered Nursing Home which provides general nursing care for up to 48 persons, including patients with a terminal illness. Ambassador also provides care for patients living with a physical disability other than sensory impairment over and under the age of 65 years and for patients with past/present alcohol dependence. Patients' bedrooms are located over three floors. Patients have access to communal lounges with dining areas and a garden area at the rear of the home.	

2.0 Inspection summary

An unannounced inspection took place on 21 February 2025, from 09.40 am to 5.20 pm by a care inspector and on 25 February 2025, from 10.40 am to 1.30 pm, by a finance 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 areas for improvement identified by RQIA, during the last care inspection on 22 February 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

Evidence of good practice was found throughout the inspection in relation to the environment, the patient dining experience and the management of care records. There were examples of good practice found in relation to the culture and ethos of the home in maintaining the dignity and privacy of patients and maintaining good working relationships.

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.

As a result of this inspection, two areas for improvement were assessed as having been addressed by the provider. This inspection resulted in one new area for improvement being identified by the care inspector. No new finance related areas for improvement were identified during the inspection on 25 February 2025.

Full details can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4

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 patient's, 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 commented positively about staff. They confirmed that staff offered them choices throughout the day which included preferences for what clothes they wanted to wear and where and how they wished to spend their time. They told us that they could have a lie in or stay up late to watch TV if they wished and they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of the time in their room and staff were observed supporting patients to make these choices.

Relatives spoke with said, "Dad's well cared for. I couldn't fault the care or staff as it's a weight lifted off, giving me peace of mind. The manager is great. Everything's good but if I had any issues I could discuss them and be confident they would be addressed" and "The staff are great and communication is good. They let us know if there are any changes to my husband's care or health".

Relatives commented positively about the provision of activities and told us that a recent visit from an outside entertainer and a patient's birthday party was enjoyed by everyone.

Following the inspection, we received no patient, patient representative or staff questionnaires within the timescale specified.

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 told us that they felt well cared for; they enjoyed the food and that staff were nice. They said that the manager and staff are approachable and they felt if they had any issues that they could discuss them and were confident any concerns would be addressed accordingly.

Staff spoken with said there was good teamwork and that they felt supported in their role. Staff also said that, whilst they were kept busy, staffing levels were satisfactory apart from when there was an unavoidable absence. Patient call systems were noted to be answered promptly by staff.

Staff told us they were aware of individual patient's wishes, likes and dislikes. It was observed that staff responded to requests for assistance promptly in an unhurried, caring and compassionate manner. Patients were given choice, privacy, dignity and respect.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss patients' care, to ensure good communication across the team about any changes in patients' needs. Staff were knowledgeable about individual patient's needs, their daily routine, wishes and preferences; and 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.

It was observed that staff respected patients' privacy and dignity by offering personal care to patients discreetly and discussing patients' care in a confidential manner. Staff were also observed offering patients choice on how and where they spent their day or how they wanted to engage socially with others.

The dining experience was an opportunity for patients to socialise. The menu was displayed on white boards, outlining what was available at each meal time for patients and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. Staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

Staff demonstrated their knowledge of patients' individual needs, likes and dislikes regarding food and drinks. They were able to describe the various international dysphagia diet standardisation initiative (IDDSI) levels of modified foods and demonstrated how to modify the consistency of drinks. Adequate numbers of staff were observed assisting patients with their meal appropriately, in an unhurried manner

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. The programme of activities was

displayed on the noticeboard, advising patients of forthcoming events. Patients told us that they were aware of the activities provided in the home and that they were offered the choice of whether to join in or not.

Activities for patients were provided which involved both group and one to one activities such as quizzes, puzzles, games, knitting club and arts and crafts.

The manager confirmed the home facilitates a patients' forum which gives patients the opportunity to offer suggestions and views on the service.

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.

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.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. A variety of methods was used to promote orientation. There were clocks and photographs throughout the home to remind patients' of the date, time and place.

Equipment used by patients such as hoists, shower chairs and wheelchairs were noted to be effectively cleaned.

The kitchen and cleaning stores were observed to be appropriately locked. However, it was observed that the treatment room door was unlocked and unsupervised. It was concerning that a cupboard and the medicine refrigerator was not locked and patients' prescribed medicines could be easily accessed. This was discussed with the manager and the registered nurse on duty who ensured the door was locked immediately. An area for improvement was identified.

Fire safety measures were in place to ensure patients, staff and visitors to the home were safe. Corridors and fire exits were clear from clutter and obstruction. Records reviewed and discussion with the manager confirmed environmental and safety checks were carried out, as required on a regular basis.

Review of records evidenced that a Fire Risk Assessment had been carried out on 17 December 2024.

Personal protective equipment, for example, face masks, gloves and aprons were available throughout the home. Dispensers containing hand sanitiser were seen to be full and in good working order. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Amelia Noach has managed the home since 1 April 2005.

Patients and staff commented positively about the manager and described her as supportive, approachable and able to provide guidance. Staff confirmed that there were good working relationships.

Review of a sample of records evidenced that the manager had processes in place to monitor the quality of care and other services provided to patients. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and the quality of services provided by the home.

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.

Staff meetings were held on a regular basis. Minutes were available.

Cards and letters of compliment and thanks were received by the home. Comments were shared with staff. This is good practice.

3.3.6 Management of patients' finances and property

A safe place was provided within the home for the retention of patients' monies and valuables. There were satisfactory controls around the physical location of the safe place and the members of staff with access to it. A review of a sample of records of patients' monies and valuables confirmed that the records were up to date at the time of the inspection on 25 February 2025.

The inspector was informed during the inspection on 25 February 2025 that a new system had recently been implemented for recording valuables held on behalf of patients. The system also included the recording of reconciliations (checks) of monies and valuables held on behalf of patients. The revised system will be reviewed at the next RQIA inspection.

A bank account was in place to retain patients' personal monies. A review of a sample of statements from the bank account evidenced that the account only contained patients' monies. A sample of records of withdrawals from the bank account was reviewed; the amounts withdrawn reflected the amounts recorded as lodged at the home.

A sample of records evidenced that reconciliations of the patients' bank account were undertaken on a monthly basis. The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

A review of one patient's written agreement evidenced that the weekly fee paid by, or on behalf of, the patient was included in the agreement. A list of services provided to the patient as part of their weekly fee was also included. The agreement reviewed was signed by the patient and their representative, and a representative from the home.

Discussion with staff confirmed that no patient was paying an additional amount towards their fee over and above the amount agreed with the Health and Social Care Trusts.

A review of a sample of records of payments to both the hairdresser and podiatrist evidenced that the records were up to date. Receipts from the transactions were retained for inspection. Good practice was observed as the hairdresser and podiatrist had signed the records, along with a member of staff, to confirm that the treatments took place.

A review of two patients' files evidenced that property records were in place for the patients. The records were updated with additional items brought into the patients' rooms and when items were disposed of. Staff advised the inspector that the process for recording patients' property was in the process of being updated in order to ensure that the full details of the items were recorded, for example, type and make of television owned by the patient. A record will also be retained to evidence that patients' personal possessions were checked, at least quarterly. The records will be signed by two members of staff. This will be reviewed at the next RQIA inspection.

Discussion with staff confirmed that no transport scheme was in place at the time of the inspection on 25 February 2025.

No new finance related areas for improvement were identified during the inspection on 25 February 2025.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Amelia Noach, 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 (4) (a) **Stated:** First time **To be completed:** From the date of inspection 21 February 2025	The registered person shall ensure that any medication which is kept in the nursing home is stored in a secure place in order to make proper provision for the nursing, health and welfare of patients. Ref: 3.3.4
	Response by registered person detailing the actions taken: Medication is stored within a locked medicine trolley secured within the building with metal wiring. Suppements and overflow stock are stored in the treatment room with a keypad on the treatment room door to further safeguard medication storage. The mechanism on the treatment room door had slackened with use, necessitating staff to ensure the door closed tightly on exiting the room. This was adjusted on the day of the inspection to ensure the door closes fully so the keypad system can fully engage.

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