The Regulation and Quality Improvement Authority

Inspection Report

9 April 2024

Lecale Lodge

Type of service: Nursing Home
Address: 26 Strangford Road, Downpatrick, BT30 6SL
Telephone number: 028 4461 6487

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

1.0 Service information

Organisation: Ann's Care Homes **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Miss Louise Mackle **Date registered:** 8 June 2023
Person in charge at the time of inspection: Miss Louise Mackle	**Number of registered places:** 41 A maximum of 39 patients in category NH-MP/MP(E) and a maximum number of 2 patients in Category NH-I.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 40
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 41 patients. Patients' bedrooms are located over two floors within three units. The Quoile and Slieve Patrick Units are on the ground floor and the Nendrum Unit is located on the first floor. Patients have access to communal dining and lounge areas.	

2.0 Inspection summary

An unannounced inspection took place on 9 April 2024 from 9.30am to 4.50pm by a care inspector.

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.

Areas requiring improvement were 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 regional manager 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. 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 four questionnaire responses received from patients which were all positive in regards to their experience of living in the home. One commented, "I can't think of anything that could be done better because they do a good job". Another commented, "I think the work is very hard and it is the best". 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 25th April 2023		
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that when a patient has more than one wound, each wound will have a separate care plan in place which can be reviewed and evaluated accordingly.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref:** Standard 35 **Stated:** First time	The registered person shall ensure that audit action plans are reviewed to make sure that the deficits identified have been addressed.	**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. Respondents of the questionnaires confirmed that staff made them feel safe in the home. All patients consulted confirmed that they were happy with the care provision 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 strong team here at the minute", "Everybody works well together" and, "We have the perfect team". Staff confirmed that they assisted one another in other units when this was required. 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, including agency staff on their first shift, completed an induction to the home. Non-agency 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 mental health awareness, adult safeguarding, deprivation of liberty and crisis prevention and intervention (CPI) training. Staff could request additional training, pertinent to their role, from the manager. A system was in place to ensure staff completed their training and evidenced that 95 percent of staff were compliant with mandatory training requirements.

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. Following the handover, a delegation sheet identified tasks to be completed and which staff were responsible for the completion of the identified tasks.

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, where a patient was required to be repositioned to maintain skin integrity in accordance with their care plan; records of the repositioning had not been recorded to evidence the position the patient was repositioned to and from. This was discussed with the manager and identified as an area for improvement.

Where a patient had a wound, a care plan was in place to direct staff on how to manage the wound and wound evaluations were completed at the time of wound dressing to monitor the progress of the treatment. When a patient had more than one wound, each wound had a separate care plan and evaluation.

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. Each unit was reviewed separately. Any learning from the review was shared with staff.

There was a four week rolling menu served in the home. The menu offered a good range and variety of foods. Patients confirmed that they had a choice of meals at mealtimes. A daily record of meal choices included the nutritional requirements of patients, such as, the levels of modification for safe swallowing.

The nutritional records for a patient who had significant weight loss over the preceding months was reviewed. A nutritional assessment had identified the risk of weight loss and the patient was referred to the dietician. However, the care records evidenced that the patient's food intake was not being monitored. Records of fluid intake had been recorded well and included liquid supplements which the patient was taking. This was discussed with the manager and identified as an area for improvement.

One aspect of care that can lead to poor dietary intake is poor oral hygiene. Where staff are directed to provide assistance/encouragement with this within care plans; there should be evidence of the assistance provided within the personal care records. We reviewed the records of one patient where this was required and there was no evidence of oral care. This was discussed with the manager and identified as an area for improvement.

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. One patient commented, "It's very good; I am very happy to be here. Staff are very caring". Another told us, "The staff are lovely. I have no complaints here at all".

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. Bedrooms were suitably furnished and decorated. 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.

There was access to the garden area through the lounge. Seating was available for patients here to enjoy the outdoors when they wished.

Infection prevention and control audits were conducted monthly and included action plans which were reviewed to ensure actions had been completed. There was evidence of managerial oversight of the audits. However, three staff on duty were observed to be not bare below the elbow; wearing watches or bracelets. This would impede on effective hand hygiene. This was discussed with the manager and an area for improvement was identified.

5.2.4 Quality of Life for Patients

Patients confirmed that they were offered choices in how and where they spent their days in the home. A patient told us, "I love it here. I pick my own clothes to wear every day and you get a good choice of food. You can do what you want during the day".

An activity timetable was displayed on communal walls within the home. There were four activity therapists employed to assist with the provision of activities. Activities included music, bingo, beauty care, arts and crafts, religious services and exercises. The home had its own hairdressing/nail bar room. Patients were taken out for coffee trips or walks. There were raised beds in the garden for planting when the warmer weather comes. Patients could avail of online shopping or those, who could, could go to the shops when they wanted.

Activities were conducted on a group basis or on a one to one basis where this was preferred. Records of activity provision were maintained. Patients told us that they enjoyed engaging in activities and that these were carried out regularly.

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 no change to the management arrangements. Louise Mackle has been the Registered Manager of the home since 8 June 2023. 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'.

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, wound care, restrictive practice, medicines management, staff training and the environment.

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 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.

Patient and relatives' surveys were in the process of completion to seek their views on the service provision in the home. Results will be analysed and the findings from the surveys will be included within the home's Annual Quality Report.

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 Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	1	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Louise Mackle, Registered Manager and Lorraine Thompson, 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 12 (1) (a) and (b) **Stated:** First time **To be completed by:** 9 April 2024	The registered person shall ensure that when a patients plan of care requires repositioning; records of repositioning are maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: The importance of repositioning charts has been discussed with all staff at flash meetings and will continue as an agenda point on all staff meetings. Repositioning will be monitored by Home Manager/Deputy Manager.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 6 Criteria (14) **Stated:** First time **To be completed by:** 9 May 2024	The registered person shall ensure that patients' oral care needs are included within care planning and evidenced within supplementary care records. Ref: 5.2.2
	Response by registered person detailing the actions taken: Oral care has been discussed at staff meetings. Nurses and carers are all aware of the importance of oral care and documenting when this is completed or refused on Goldcrest.
Area for improvement 2 **Ref:** Standard 12 Criteria (12) **Stated:** First time **To be completed by:** 9 April 2024	The registered person shall ensure that when a patient has lost a significant amount of weight, records are maintained of food intake. Ref: 5.2.2
	Response by registered person detailing the actions taken: Nurses are aware of the importance of checking weights over a number of months rather that just one month at a time. Food charts are in place for those residents identified as having weight loss. This will be monitored via the monthly weight audit, and from reports from Goldcrest.

Area for improvement 3 **Ref:** Standard 46 Criteria (2) **Stated:** First time **To be completed by:** 9 April 2024	The registered person shall ensure that training of infection prevention and control is embedded into practice in that staff remain bare below the elbow in all care areas. Ref: 5.2.3
	Response by registered person detailing the actions taken: Infection Control has been disccussed at all staff meetings. This is monitored by the Home Manager during daily walk arounds and all nurses have been reminded to monitor on a daily and during the hand hygiene and PPE audits..

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