The Regulation and Quality Improvement Authority

Inspection Report

9 July 2024

Carlingford Lodge Care Home

Type of Service: Nursing Home
Address: 76 Upper Dromore Road, Warrenpoint, BT34 3PN
Tel no: 028 4175 9200

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: Healthcare Ireland (No. 4) Limited **Responsible Individual:** Ms Amanda Mitchell	**Registered Manager:** Mrs Erminia Suciu – Not registered
Person in charge at the time of inspection: Mrs Erminia Suciu, Manager	**Number of registered places:** 58 A maximum of 25 persons in category NH-I and 33 persons in category NH-DE.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 41
Brief description of the accommodation/how the service operates: Carlingford Lodge is a nursing home registered to provide nursing care for up to 58 patients. Patients are accommodated over two floors. Patients with dementia are cared for on the lower ground floor and patients requiring general nursing care are cared for on the ground floor. Patients have access to communal lounges, dining areas and outside space. A residential care home occupies a corridor of the ground floor and the manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 9 July 2024 from 9.20 am to 4.40 pm by care inspectors.

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

Evidence of good practice was found in relation to patient care and maintaining good working relationships. There were examples of good practice in relation to the culture and the ethos of the home in maintaining the privacy and dignity of patients and valuing patients and their representatives.

Four new areas requiring improvement were identified during the inspection; one area for improvement has been stated for a second time and two areas for improvement in relation to medicines management have been carried forward for review at the next inspection. These are discussed in the main body of the report.

The home was found to be clean, tidy, well-lit, comfortably warm and free from malodour.

Staffing arrangements were found to be satisfactory and reviewed regularly by the manager in order to meet the assessed needs of the patients. Staff were seen to be professional and polite as they conducted their duties and told us they were supported in their role with training and resources.

Patients were observed to be well looked after regarding attention to personal care and appearance and were seen to be content and settled in the home. Staff treated patients with respect and kindness. The lunchtime meal was served to patients by staff in an unhurried, relaxed manner.

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.

Comments received from patients, patients' representatives and staff are included in the main body of this report.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience. Addressing the areas for improvement will further enhance the quality of care and service in the home.

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 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 Mrs Erminia Suciu, Manager and the management team at the conclusion of the inspection.

4.0 What people told us about the service

Patients, patients' relatives and staff provided positive feedback about Carlingford Lodge Care Home. Patients told us that they felt well cared for, enjoyed the food and that staff were caring and kind. Staff said that the manager was approachable and that they felt supported in their role.

Patients' spoken with said: "The staff are great. I couldn't fault them. If I had an issue I'd tell them straight and I would be confident it would be sorted out" and "I have everything I need. The staff are good, I'm comfortable and well looked after".

Relatives spoken with said "there is really good communication with family" and "I can address any issues I have with staff".

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

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

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

An unannounced inspection took place on 20 June 2024. This inspection was completed by two pharmacist inspectors and focused on the management of medicines in the home.

Areas for improvement from the last inspection on 20 June 2024		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 20 (1) (a) **Stated:** First time	The registered person shall review the staffing arrangements in the home to include the deployment of staff and working practices to ensure the needs of patients are met.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 2 **Ref:** Regulation 12 (1) (a) **Stated:** First time	The registered person shall review oral care delivery in the home and demonstrate where oral care plans direct twice daily care; the supplementary care records evidence when this has been delivered or offered.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 3 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time	The registered person shall ensure that daily evaluations of care are recorded at appropriate times and meaningfully evaluate the care delivery of the shift period worked identifying actions taken in response to any discrepancies.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 4 **Ref:** Regulation 14 (2) (a) and (c) **Stated:** First time	The registered person shall ensure that cleaning products and staffs' personal belongings are not accessible to patients, in any part of the home when not in use.	**Not met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was not met; see section 5.2.3 for details. This area for improvement is stated for the second time.	

Area for Improvement 5 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the infection control issues identified during the inspection are managed to prevent the risk and spread of infection.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
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 patients' care plans give clear directions to staff on actions to take should any of the following happen: • Patients' bowels do not open as normal. • Fluid targets have not been met.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 2 **Ref:** Standard 47 Criteria (3) **Stated:** First time	The registered person shall ensure that all items stored within storage areas are stored in a safe manner and in accordance with safe working practices.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 3 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that care plans (for distressed reactions and adding medicines to food/drinks) are reviewed and updated to ensure that they are patient-centred and provide sufficient detail to direct the required care.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	

Area for improvement 4 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that prescribed medicines are stored securely including external preparations and thickening agents. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. The manager confirmed that a robust system was in place to ensure staff were recruited correctly to protect patients, in accordance with relevant statutory employment legislation and mandatory requirements.

Staff said that they worked well together and that they supported each other in their roles. Staff also said that, whilst they were kept busy, staffing levels were generally satisfactory apart from when there was an unavoidable absence.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Examination of the staff duty rota confirmed this.

The provision of mandatory training was discussed with staff. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Review of the staff training and development plan for 2024 evidenced that staff had attended training regarding adult safeguarding, deprivation of liberty safeguards (DoLS), dysphagia awareness, moving and handling, first aid, control of substances hazardous to health (COSHH), medicines management and fire safety. The manager confirmed that staff training is kept under review.

We discussed the Mental Health Capacity Act – Deprivation of Liberty Safeguards (DoLS). Staff were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. Ms Mary Stevenson, Regional Area Manager, was identified as the appointed safeguarding champion for the home.

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.

5.2.2 Care Delivery and Record Keeping

Staff attended a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable about individual patient's needs including, for example, their daily routine preferences. Staff respected patients' privacy and dignity by offering personal care to patients discreetly. It was also observed that staff discussed patients' care in a confidential manner.

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' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patient's care needs and what or who was important to them.

Care records regarding oral hygiene were reviewed and evidenced that they were clearly documented and well maintained to direct the care required and reflect the assessed needs of the patient. Appropriate oral assessments and evaluations had been completed. Supplementary records regarding the delivery of oral care were noted to be well documented.

Supplementary care records were completed to record care delivery such as personal care, food and fluid intake and continence management. Review of a number of patients' care plans gave clear directions to staff on actions to be taken if required.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example bed rails and alarm mats. Care plans were in place for the management of bed rails.

Repositioning records evidenced the assessed frequency of repositioning for patients who require assistance to change their position to relieve pressure was adhered to.

Nutritional risk assessments were carried out monthly using the Malnutrition Universal Screening Tool (MUST) to monitor for weight loss and weight gain.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, general practitioners (GPs), the speech and language therapist (SALT) and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), SALT or the dietician.

Daily records were kept of how each patient spent their day and the care and support provided by staff. Review of patients' care was noted to be meaningfully evaluated and recorded at appropriate times.

We observed the serving of the lunchtime meal in the dining room on the ground floor. Staff had made an effort to ensure patients were comfortable throughout their meal. A choice of meal was offered and the food was attractively presented and smelled appetising. The food appeared nutritious and was covered on transfer whilst being taken to patients' rooms. There was a variety of drinks available. Patients wore clothing protectors if required and staff wore aprons when serving or assisting with meals. Staff demonstrated their knowledge of patients'

likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Adequate numbers of staff were observed assisting patients with their meal appropriately, in an unhurried manner. The daily menu displayed did not reflect the meal choices for that day. The daily menu is required to be displayed in a suitable format including pictorial where necessary, in a suitable location showing what is available at each mealtime. This was discussed with the manager and an area of improvement was identified.

Patients able to communicate indicated that they enjoyed their meal.

5.2.3 Management of the Environment and Infection Prevention and Control

We observed the internal environment of the home and noted that the home was comfortably warm and clean throughout. Items within storage areas were noted to be stored in a safe manner and in accordance with safe working practices.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were suitably furnished 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. Patient call systems were noted to be answered promptly by staff.

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

In one unit cleaning products and staffs' personal belongings were observed to be accessible to patients due to a door keypad that had not been activated and a broken lock. This was discussed with the management team. This area for improvement is stated for the second time.

On review of the home's environment, it was noted that a number of products used for personal care were stored in unlocked ensuite bathroom cabinets which could potentially pose a risk to some patients. An identified store cupboard was observed to be unlocked. This allowed for unsupervised access to cleaning materials. It was observed that identified communal bathrooms had no waste bins in place. Observation of the environment identified concerns that had the potential to impact on patient safety; fluids and food items were observed unsecured in the dementia unit. This was discussed with the manager and an area for improvement was identified.

The nurses' stations and treatment rooms were observed to be appropriately locked.

While infection control issues identified during the previous care inspection were noted to be managed to prevent the risk and spread of infection; it was noted that identified sluice rooms were unlocked and untidy. In one sluice room a waste bag was observed on the floor. This was discussed with the management team and an area for improvement was identified.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors and fire exits were clear from clutter and obstruction. However, records reviewed evidenced that regular fire drills had not been undertaken. This was discussed with the management team and an area for improvement was identified.

Personal protective equipment (PPE), 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.

5.2.4 Quality of Life for Patients

It was observed that staff offered choices to patients throughout the day which included, for example, preferences for what clothes they wanted to wear and food and drink options. Patients 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.

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 notice board advising patients of forthcoming events. Patients' needs were met through a range of individual and group activities.

Patients spoken with said they enjoyed the activities they attended.

Visiting arrangements were in place and staff reported positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

Since the last inspection there has been no change in the management arrangements. Discussion with staff, patients and their representatives evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the manager.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

The manager confirmed that a process was in place to monitor the registration status of registered nurses with the Nursing and Midwifery Council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC).

Arrangements were in place to ensure that all staff members have regular supervision and an appraisal completed this year.

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding incidents/accidents.

It is required that the home is visited each month by a representative of the registered provider to consult with patients, their representatives and staff and to examine all areas of the running of the home. These reports were made available for review by patients, their representatives, the Trust and RQIA. The reports of these visits showed that where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed.

Records reviewed confirmed that systems were in place to ensure that complaints were managed appropriately. Patients said that they knew who to approach if they had a complaint.

Review of records evidenced that patient, patient representative and staff meetings were held on a regular basis. Minutes of these meetings were available.

Staff confirmed that there were good working relationships and commented positively about the manager and described her as supportive and approachable.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where 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	3*	4*

* the total number of areas for improvement includes one that has been stated for a second time and two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Erminia Suciu, Manager and the management team 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 14 (2) (a) and (c) **Stated:** Second time **To be completed by:** Immediate and ongoing (9 July 2024)	The registered person shall ensure that cleaning products and staffs' personal belongings are not accessible to patients, in any part of the home when not in use. Ref: 5.1 & 5.2.3
	Response by registered person detailing the actions taken: This has been addressed at clinical governance meeting in relation to health and safety issues. This has also been discussed in safe care huddles and supervision has been undertaken with all staff. Lock to life café was immediately repaired following inspection feedback.Staff locker facilities available.
Area for improvement 2 **Ref:** Regulation 14 (2) (c) **Stated:** First time **To be completed by:** Immediate and ongoing (9 July 2024)	The registered person shall ensure that unnecessary risks to the health and safety of patients are identified and so far as possible eliminated. This relates specifically to issues identified regarding COSHH and the environment which should be closely monitored. Staff should be made aware of their responsibilities regarding COSHH. Ref: 5.2.3
	Response by registered person detailing the actions taken: This has been addressed . All staff have been advised of COSHH and Health and Safety Policy. A memorandum has been issued in relation to mandatory compliance to ensure residents safety. Supervision has been undertaken with all staff following inspection feedback.
Area for improvement 3 **Ref:** Regulation 27 (4) (F) **Stated:** First time **To be completed by:** 16 September 2024	The registered person shall ensure that staff undertake regular fire drills and that an up to date record is maintained. Ref: 5.2.3
	Response by registered person detailing the actions taken: Fire drill matrix implemented for all staff . Fire drills commenced and remain ongoing. This will be monitored by Home manager and during monthly provider Reg 29 visits.

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:** Immediate and ongoing (20 June 2024)	The registered person shall ensure that care plans (for distressed reactions and adding medicines to food/drinks) are reviewed and updated to ensure that they are patient-centred and provide sufficient detail to direct the required care. Ref: 5.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** Immediate and ongoing (20 June 2024)	The registered person shall ensure that prescribed medicines are stored securely including external preparations and thickening agents. Ref: 5.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed:** Immediate and ongoing (9 July 2024)	The registered person shall ensure that the daily menu displayed reflects the meals served and is displayed in a suitable format and location. Ref: 5.2.2
	Response by registered person detailing the actions taken: Memo issued to kitchen department and care staff . New template has been added to the meal distribution folder to record any changes to the planned menu, the rationale and how changes to planned menu has been communicated to the residents.Pictorial menus have been implemented and displayed within the dining rooms.

Area for improvement 4 **Ref:** Standard 46 **Stated:** First time **To be completed by:** Immediate and ongoing (9 July 2024)	The registered person shall ensure that sluice rooms are closely monitored to ensure that they remain tidy and clutter free in order to adhere to best IPC practice and to minimise the risk of infection for staff, patients and visitors. Ref: 5.2.3
	Response by registered person detailing the actions taken: This has been addressed in clinical governance meeting in relation to Infection, prevention and control. Monthly and quarterly IPC audits in place. Supervision has been undertaken with care and domestic staff. Manager monitors compliance during daily walk arounds. This will also be montiored during monthly provider Reg 29 visits.

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