The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Carlingford Lodge Care Home

Provider: Healthcare Ireland (No 4) Limited

Date of Inspection: 11&12 June 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:	Healthcare Ireland (No 4) Limited
Responsible Individual:	Ms Amanda Mitchell
Registered Manager:	Mrs Amanda Lacey – not registered
This home is a registered nursing home which provides general nursing care for up to 58 patients under and over 65 years of age, including patients living with dementia. 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 11 June 2025 from 10.05 am to 5.05 pm and on 12 June 2025 from 09.50 am to 5.30 pm by care inspectors.

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 19 November 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

Significant concerns were identified regarding the delivery of care to patients in the general nursing unit and the failure to meet patients' needs in relation to personal care, mealtime supervision, the management of risk and care records.

The findings of this inspection raised concerns that the quality of care and service within Carlingford Lodge falls below the standards expected.

Enforcement action resulted from the findings of this inspection.

A Serious Concerns meeting was held with the Registered Person on 23 June 2025. An action plan was presented with details of the completed/planned actions to drive improvement and to ensure concerns raised at the inspection were addressed. RQIA were satisfied with the

assurances from the provider and decided to take no further enforcement action. RQIA will continue to monitor and review the management of patient care and the quality of services provided in the home.

This inspection resulted in nine new areas for improvement being identified. As a result of this inspection one area for improvement regarding medicines management was not reviewed and has been carried forward for review at a future inspection and one area for improvement was not met and is stated for a second time. 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 patients, 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. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

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 confirmed that generally 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. Patients said, "I'm more than happy with staff. They're great and I'm well looked after. The food is good and I'm offered the choice of going to the dining room for meals and they invite me to the activities. I don't go to anything as I like to stay in my room and plan my own time" and "Staff are more than good to me. I have no issues at all".

One patient spoken with enquired if there were issues with staffing levels as they had noticed the home was short staffed and staff appeared rushed. The patient said, "I noticed at breakfast. When there's a change you notice".

Relatives spoken with confirmed that they were happy with the care provided and that they found staff kind and attentive.

However, other patients, relatives and staff spoken with raised concerns about staffing levels and stated that there were not enough staff on duty to meet patients' needs.

Staff spoken with advised that the number of staff on duty was impacting on care delivery.

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

One staff questionnaire received indicated that the care provided was safe, effective, compassionate and well led. However, comments included concerns regarding staffing levels especially in the mornings when patients were being assisted with personal care and breakfast. All of the comments were discussed with the manager for review.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. Review of records evidenced that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work and that a structured orientation and induction programme was undertaken at the commencement of their employment.

We discussed the provision of mandatory training 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 staff training records for 2025 evidenced that staff had attended training regarding induction, personal care, dementia awareness, dysphagia awareness, catheter care, diet/nutrition, Deprivation of Liberty Safeguards (DoLS) and fire safety.

Concerns were identified on the first day of the inspection in relation to the timely delivery of care to patients in the general nursing unit. The manager explained that the planned staffing had not been achieved due to unplanned short notice absence. Despite efforts to replace these staff, the home had been unable to arrange replacement cover. Throughout the morning the routine was disorganised with nurse call bells ringing at times in excess of 15 minutes without being responded to. There was no evidence of any contingency planning to prioritise patient care and mitigate against the staff shortages; an area for improvement was identified. The impact of staff shortages on care resulted in delayed care for a number of patients.

On the second day of the inspection the planned staffing levels were achieved, however, the routine continued to be disorganised with nurse call bells again ringing for significant lengths of time without being responded to. We discussed the planned staffing with the manager who advised that a dependency tool was in place to determine the number of staff required to meet the needs of the patients. However, it was unclear from the most recent review if the tool was being used accurately to identify staffing levels. This was discussed at the meeting on 23 June 2025 and assurances provided that a new tool was being introduced to more accurately identify the required staffing.

Staff in the dementia unit shared concerns regarding a drop in staffing levels between 2.00pm and 4.00pm. Staffs' concerns were shared with the manager for their review and action as appropriate.

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.

As previously discussed the unplanned staff shortages on the first day of the inspection resulted in delayed care for a number of patients. For example, there was a significant delay in staff response to answer call bells and the delivery of care. On one occasion the inspector intervened to answer a call bell that had been ringing for a significant period of time.

Issues were also identified with the lack of attention to detail to patients' personal care and appearance prior to the inspection. We spoke with one family who advised that their relative had not received a shower for a number of weeks. Patient's records did not evidence when the patient had last received a shower. This was brought to the attention of the manager. An area for improvement was identified.

Patients in the dementia unit were well presented in their appearance. Personal care records captured when patients were offered but refused assistance with their care needs. Staff were aware of the actions to take when this occurred.

Observation of the lunchtime meal on 11 June 2025 in the dining room of the general nursing unit raised further concerns regarding the delivery of care. One care assistant was overseeing lunch for seven patients; one patient, assessed as requiring direct supervision with their meal, did not receive the appropriate level of supervision. Patients were not assisted with their meals in a timely manner; one patient was observed to be asleep at the table and their meal was cold. One patient, who preferred to have lunch in their bedroom, enquired if they had been forgotten about as they had not received lunch. The tables had not been set and the menu was not appropriately displayed and was not reflective of the food served. An area for improvement was identified.

Improvement was noted on the second day of inspection. A catering assistant served the meals from the heated trolley which allowed the care staff to focus on assisting the patients; it was unclear why this arrangement had not been in place on the previous day. Tables had been nicely set with flowers and condiments and the menu was reflective of the food being served.

The lunchtime meal in the dementia unit was well organised. A safety pause was held to ensure that patients received their correct meals and fluids in accordance with their nutritional requirements. The mealtime was well supervised and staff were seen encouraging patients with their meals. Food was only served when the patients were ready to eat their meals. Staff were aware of the actions to take should a patient repeatedly refuse their meals.

On both days of inspection, the servery in the general nursing unit beside the dining room was noted to be unlocked and unattended. A cupboard containing two tins of agents used to thicken fluids was unlocked and another unlocked cupboard contained a tub of alcohol wipes. This was identified as an area for improvement. The storage of thickening agents was included in an area for improvement as a result of the previous medicine management inspection and is now stated for second time.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The weekly 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 such as movie club, reminiscence therapy, embroidery, cross stitch, jewellery making and arts and crafts.

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. Patients care records were held confidentially.

Review of records evidenced that care planning was not always reflective of patient needs and the multidisciplinary team recommendations were not always being adhered to. Areas for improvement were identified.

Nutritional risk assessments were carried out monthly using the Malnutrition Universal Screening Tool (MUST) to monitor for weight loss and weight gain. On review, four MUST calculations had been incorrectly scored; this resulted in an opportunity to seek advice from the relevant healthcare professionals being missed. An area for improvement was identified.

A new electronic recording system was introduced to the home on 3 June 2025. There was no written implementation plan for the introduction of the system to ensure the completion of contemporaneous records during the implementation and migration stage of records to the new system. A review of records evidenced gaps in the recording of care delivery and that care was not always contemporaneously recorded with the accurate time of when the care was delivered. This was discussed at the meeting on 23 June 2025 and assurances provided that a documented contingency plan, including a baseline audit of current care records was now in place. Additional training for staff had also been arranged.

3.3.4 Quality and Management of Patients' Environment

The home was clean and well maintained. Patients' bedrooms were personalised with items important 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 and shower chairs were noted to be effectively cleaned.

In relation to infection prevention and control, on both days of inspection of the general nursing unit, two bins in the sluice room were not regularly changed creating a malodour. An area for improvement was identified.

Review of the environment evidenced that corridors and fire exits were clear from clutter and obstruction. The manager confirmed environmental and safety checks were carried out, as required on a regular basis, to ensure the home was safe to live in, work in and visit.

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 a change in the management of the home since the last inspection. Mrs Amanda Lacey has been the manager in this home since 7 April 2025. An application to register as manager has been received by RQIA.

Patients, relatives 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. However, observation of care, review of records and discussion with the manager raised concerns regarding the effectiveness of these processes given the inspection findings.

The manager advised that they complete a daily walk around of the home but records were not kept to ensure any improvements required were actioned. An area for improvement was identified.

Patients' relatives said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well. Review of complaints from May to June 2025 evidenced that relatives had raised concerns regarding the provision of personal care. These were being addressed by the manager.

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

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	6	5*

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

This inspection resulted in nine new areas for improvement being identified. Findings of the inspection were discussed with Mrs Amanda Lacey, Manager and Ms Karen Agnew, Regional Area Manager, as part of the inspection process and can be found in the main body of the report.

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) **Stated:** First time **To be completed by:** Immediate and ongoing (11&12 June 2025)	The registered person shall ensure that a contingency plan is put in place to prioritise patient care and ensure their needs and request for assistant are met in a timely manner at times of unplanned staff shortages. Ref 3.3.1
	Response by registered person detailing the actions taken: .On the first day of the inspection 50% of the planned staffing for the general nursing unit failed to attend work. Neither the providing agency nor the individual staff members had not contacted the home to alert them to the planned absence. This was addressed directly with the agencies in question as the lack of communication impacted on resident care on that day. The agencies could not provide replacement staff to the home. A formal contingency plan was developed and has been cascaded across all HCI facilities
Area for improvement 2 **Ref:** Regulation 13.- (1) (a) **Stated:** First time **To be completed by:** Immediate and ongoing (11&12 June 2025)	The register person shall ensure that the nursing home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. Staff must ensure that care is delivered to maintain patients personal care and appearance in accordance with their individual needs. Ref: 3.3.2
	Response by registered person detailing the actions taken: The issue of shaving and nail care has been discussed with the team post inspection and the importance of this empathised in safe care huddles. Reporting of refusal for nail care and shaving with some of the residents was also discussed and care staff were shown how to record this on the new PCS handsets.

	Compliance is being monitored daily by the manager and deputy managers and during monitoring visits by the Senior Management Team. The issue of the resident not having hair washed was recorded as a complaint / investigated and responded to as per HCI complaints policy. Remedial action was taken and is being monitored
Area for improvement 3 **Ref:** Regulation 13.- (1) (b) **Stated:** First time **To be completed by:** Immediate and ongoing (11&12 June 2025)	The registered person shall ensure that patients are appropriately supervised at mealtimes in accordance with SALT recommendations and their assessed need. Ref: 3.3.2
	Response by registered person detailing the actions taken: Meal service routine was reviewed. In addition to the mealtime co coordinator a nurse is present in the dining room to oversee and direct the service of meals and the assistance and supervision of the residents.
Area for improvement 4 **Ref:** Regulation 14.- (2) (c) **Stated:** First time **To be completed by:** Immediate and ongoing (11&12 June 2025)	The registered person shall ensure the servery in the general nursing unit is securely locked when unattended. Ref: 3.3.2
	Response by registered person detailing the actions taken: Both doors to the servery as now locked by a keypad and relatives have been advised to ensure that doors are securely locked when they exit the servery
Area for improvement 5 **Ref:** Regulation 16.- (1) **Stated:** First time **To be completed by:** Immediate and ongoing (11&12 June 2025)	The registered person shall ensure that care plans are reflective of the individual needs of the patients. Ref 3.3.3
	Response by registered person detailing the actions taken: Carlingford Care Home implemented a new computerised care record system on 02.06.25. Following the inspection and with the support of the Regional Support Manager and deputy manager of another HCI facility a review of the care plans and risk assessments was completed to ensure that the information captured in the older paper versions were entered fully onto the computerised system. A comprehensive action plan was developed and is now complete

Area for improvement 6 **Ref:** Regulation 10.- (1) **Stated:** First time	The registered person will review the home's governance systems to ensure they are sufficiently robust to identify, drive and to sustain improvements required. Ref 3.3.5
To be completed by: Immediate and ongoing (11&12 June 2025)	**Response by registered person detailing the actions taken**: A debrief meeting post inspection was completed with the team within the home who complete the audits. The audit cycle was discussed and the importance of development and review of action plans clarified. A review of the auditing schedule was completed to allow for cross auditing across the units.
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: 2.0
	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:** Second time	The registered person shall ensure that prescribed medicines are stored securely including external preparations and thickening agents. Ref: 2.0 & 3.3.2
To be completed by: Immediate and ongoing (11&12 June 2025)	**Response by registered person detailing the actions taken:** Key code locks are now on both servery doors on Marina Unit to ensure that thickening agents are secure and not available to residents.Adherence to the securing of thickening agents is monitored during managers walkaround and during visits by senior managemnt team
Area for improvement 3 **Ref:** Standard 12.3 **Stated:** First time	The registered person must ensure that recommendations regarding the frequency patients must be weighed are adhered to. Ref 3.3.3
To be completed by: Immediate and ongoing (11&12 June 2025)	**Response by registered person detailing the actions taken:** The care plan for the identfied resident on the PCS system was reviewed to ensure it reflected the content of the previous paper record which included the dietican direction to weigh two weekly.

Area for improvement 4 **Ref:** Standard 12.4 **Stated:** First time **To be completed by:** Immediate and ongoing (11&12 June 2025)	The registered person shall ensure that MUST tools are accurately calculated and appropriate actions taken if a weight loss is identified. Ref: 3.3.3 **Response by registered person detailing the actions taken:** Following on from inspection a review of the Must scores was completed . All nursing staff have completed MUST training
Area for improvement 5 **Ref:** Standard 46 **Stated:** First time **To be completed by:** Immediate and ongoing (11&12 June 2025)	The registered person shall ensure that bins in the identified sluice room are changed regularly to prevent malodours occurring. Ref: 3.3.4 **Response by registered person detailing the actions taken:** The allocation of duties sheet was reviewed to include the emptying of bins in the sluice room at identified times. This is working well .

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews