Inspection Report

Name of Service: **Lecale Lodge**

Provider: **Ann's Care Homes**

Date of Inspection: **27 August 2026**

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:	Ann's Care Homes
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Mrs Kelly Kilpatrick

Service Profile –
This home is a registered nursing home which provides nursing care for up to 40 patients who have a mental disorder and includes one patient under the elderly and infirm category of care. 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.

There is a residential care home located within the same building and the manager for this home manages both services.

2.0 Inspection summary

An unannounced inspection took place on 27 August 2026 from 9.10am to 4.35pm by a care 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 15 August 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and the service was well led. Patients spoke positively when describing their experiences of living in the home. Refer to Section 3.2 for more details.

As a result of this inspection, all areas for improvement from the care inspection on 15 August 2025 were assessed as having been addressed by the provider and no new areas for improvement were identified. Two areas for improvement identified at a medicines management inspection on 9 June 2026 were carried forward for review at the next inspection.

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 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 were well presented in their appearance and were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. One told us, "I'm very happy here. The staff are excellent and we can make our own choices in what we do". Another simply described living in the home as, "Lovely".

We received four questionnaire responses from patients who complimented the care they received. One said," Staff are good to me; I feel at home and comfortable around residents and staff". Another commented, "I am looked after well. Staff always have my back and always have my best interests at heart".

Relatives were complimentary on the care their loved one was receiving. During the inspection a relative told us, "Everything is brilliant here. We are very happy with their care. All the staff are so attentive and we are always kept well informed of what's going on". We received one relative questionnaire return. They described the care as 'excellent' and confirmed that they were informed on a regular basis of their loved one's care.

Staff told us that they were happy working in the home and enjoyed engaging with the patients. They felt that they worked well together and were supported by management to do so. There was one response from the staff survey. The respondent confirmed that they felt care in the home was safe and compassionate and that patients' choices were listened to and patients were treated with dignity and respect.

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.

All appropriate recruitment safety checks had been verified prior to staff commencing in post. Newly employed staff completed a structured induction at the commencement of their employment which included mandatory training. A robust system was in place to ensure that all staff were compliant with pre-determined mandatory training requirements.

Staff told us that they were satisfied that the number and skill mix of staff on duty met the needs of the patients. Some concerns raised by staff which could potentially affect staffing arrangements were shared with the managers for their review and action as appropriate.

Patients raised no concerns in relation to the staffing arrangements. Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty and that staff responded to requests for assistance promptly in a caring and compassionate manner.

Minutes of staff meetings were available to all staff to aid in the communication within the home.

Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council, and care staff with the Northern Ireland Social Care Council.

3.3.2 Quality of Life and Care Delivery

Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Interactions between staff and patients were noted to be caring and compassionate. Patients spoke fondly about the staff.

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. Patients told us that they had choice in where and how they spent their day, what they wore and what they had to eat.

Staff confirmed that they received a detailed handover at the commencement of their shift and the information shared included important aspects of patients' needs, especially changes to care. All staff received a handover sheet to be used as an aide memoire.

Pressure management risk assessments were completed and reviewed monthly. Patients who required special attention with skin care were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs. Staff recorded checks on patient equipment in use, such as, mattress settings.

Assessments had been carried out to determine the level of need required to assist with personal and oral hygiene needs. Care plans were in place to guide staff on the level of care needed. Any assistance given, or refusals of offers made, were documented. Staff were aware of the actions to take when a patient refused oral care. Patients had access to call bells to summon staff when required.

Patients' weights were monitored monthly, or more frequently if required, for weight loss or weight gain. Nutritional care plans were in line with the recommendations from dieticians and/or speech and language therapists. Food and fluid intakes had been monitored. A way to enhance this recording was discussed with the manager.

Patients had good access to food and fluids throughout the day and night. Patients were safely positioned for their meals and the mealtimes were appropriately supervised. Staff communicated well to ensure that every patient received their meals in accordance with their assessed needs. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. Staff sat with patients when helping with their meal and assistance was given in an unhurried manner. One patient, not satisfied with their meal, was immediately provided with an alternative. Patients enjoyed their meal and spoke positively on the quality of their meal.

Hourly checks were maintained on patients to ensure their safety. Some patients required more frequent checks in place which were also recorded. Care staff reported any concerns to the registered nurses on duty.

Activities for patients were provided incorporating both group and one to one engagement. A programme of planned activities was available for review on communal corridors and orientation boards were displayed keeping patients orientated to the date, day, month and weather. Activities included arts and crafts, beauty therapy, exercises, bingo, movies, shop, games and Sunday services. Birthdays and annual holidays were celebrated. Records were kept of all activity engagements with patients.

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 the patients' needs. 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. Risk assessments and care plans were reviewed regularly to ensure that they remained reflective of patient need. Care records were stored securely.

Supplementary care records were maintained to evidence the care delivered to patients. The records included personal care delivery, food and fluid intake, repositioning, checks made on patients and continence care.

Nurses completed daily progress notes to monitor and evaluate the care delivered to the patients in their care.

3.3.4 Quality and Management of Patients' Environment

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. Storage and communal rooms were maintained clean and tidy. A painting programme was in progress throughout the home. There were no malodours in the home.

The internal smoking area had been deep cleaned and maintained clean. Furniture had been replaced in this room. An area for improvement in this regard has now been met. Planned works to move the smoking area were in progress. The communal corridors in Nendrum Unit will be refurbished once these works are completed.

Externally the home was well maintained. There were enclosed garden areas where patients could sit outside.

Corridors and fire exits were clear of clutter and obstruction should the need to evacuate occur and fire extinguishers were easily accessible. Staff had attended fire safety training and fire safety checks were regularly conducted. A recent fire risk assessment had taken place and any actions identified were managed in a timely manner. There were no doors propped open and a record of visitors to the home had been maintained.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. Personal protective equipment and hand hygiene facilities were readily available throughout the home.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Kelly Kilpatrick has been managing the home since 23 June 2025 and was registered as manager with RQIA on 4 December 2025. Staff commented positively about the manager and described her as supportive and approachable.

In the absence of the manager there was a nominated nurse-in-charge (NIC) to provide guidance and leadership. The NIC completed a competency and capability assessment on taking charge prior to taking on the role and was clearly identified on the duty rota.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. The manager had a suite of audits to complete. Accidents were reviewed monthly for any patterns or trends in an effort to prevent any future falls from occurring.

A deprivation of liberty register was maintained to ensure that any patient deprived of their liberty, for their own wellbeing, were legally permitted to be. The manager maintained an oversight on the use of restrictive practices to ensure that consent or best interest decisions had been made and the practices assessed and care planned for each of the patients where this had been applied.

There were no recent or ongoing complaints relating to the home. There was a system in place to manage any complaints received. All compliments received were shared with staff.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mr Daniel Maxim, Clinical Lead Nurse and Mrs Barbara Armstrong, Regional Manager, as part of the inspection process and can be found in the main body of the report.

	Regulations	Standards
Total number of Areas for Improvement	0	2*

*The total number of areas for improvement includes two which are carried forward for review at the next inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 45 **Stated:** First time **To be completed by:** 9 June 2026	The registered person shall ensure that inhaler spacer devices are labelled to denote ownership and cleaned and replaced in line with the manufacturer's recommendations. 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 29 **Stated:** First time **To be completed by:** 9 June 2026	The registered person shall review the management of thickening agents to ensure that the recommended consistency level is recorded on both personal medication records and administration records. 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.

The **Regulation** and **Quality Improvement** Authority

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