Unannounced Follow Up Care Inspection Report
31 July and 1 August 2019

Wood Green Nursing Home

Type of Service: Nursing Home (NH)
Address: Wood Green, Circular Road, Jordanstown, BT37 0RJ
Tel no: 028 9036 9901
Inspectors: Julie Palmer and Paul Nixon

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.0 What we look for

2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 32 persons.

3.0 Service details

Organisation/Registered Provider: Wood Green Management Company (NI) Ltd **Responsible Individual:** Yvonne Diamond	**Registered Manager and date registered:** Debby Ann Gibson 21 September 2018
Person in charge at the time of inspection: Debby Ann Gibson	**Number of registered places:** 32
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:** 30 A maximum of 19 patients in category NH-DE and a maximum of 13 patients in category NH-I.

4.0 Inspection summary

An unannounced inspection was carried out by the care inspector on 31 July 2019 from 07.55 hours to 18.15 hours. An unannounced medicines management inspection was also carried out by the pharmacy inspector on 1 August 2019 from 09:45 hours to 13:55 hours.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

The inspection sought to assess progress with issues raised during and since the previous care inspection. The inspection was also undertaken following information received by RQIA from the Belfast Health and Social Care Trust safeguarding team. It is not the remit of RQIA to investigate adult safeguarding concerns made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, if RQIA is notified of a potential breach of regulations or minimum standards, it will review the matter and take appropriate action as required; this may include an inspection of the home.

Evidence of good practice was found in relation to staffing, training, supervision and appraisal, safeguarding, the home's environment, medicines management, communication between staff and patients, maintaining good working relationships and reporting notifiable events.

Areas requiring improvement were identified in relation to keeping repositioning records up to date, the mealtime experience for patients and ensuring up to date wound care plans are in place.

Patients described living in the home in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	*3

*The total numbers of area for improvement include two which have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Debby Gibson, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection on 14 May 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 14 May 2019. Other than those actions detailed in the QIP no further actions were required to be taken following this most recent inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection we met with 15 patients, six patients' relatives and six staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten patients' questionnaires and ten patients' relatives/representatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

A poster informing visitors to the home that an inspection was being conducted was displayed at the entrance to the Oak Unit.

The following records were examined during the inspection:

- duty rota for all staff from 29 July to 11 August 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- incident and accident records
- three patient care records including food and fluid intake and repositioning charts
- a sample of governance audits
- complaints and compliments records
- a sample of monthly quality monitoring reports from May 2019
- staff supervision and appraisal schedule
- staff training records
- adult safeguarding annual position report
- RQIA registration certificate
- medicines management records
- medicine management audits.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 14 May 2019

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from previous inspection(s)

Areas for improvement from the last care inspection dated 14 May 2019		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 23 **Stated:** First time	The registered person shall ensure that recording on repositioning charts is reflective of individual patients' care plans and is contemporaneous.	**Partially met**

	Action taken as confirmed during the inspection: Review of three patients' care records evidenced that recording on repositioning charts was not reflective of the repositioning schedules directed in the care plans for two of the patients. This area for improvement has been stated for a second time.	
Area for improvement 2 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure mealtimes are a positive experience for patients; menus on display should be up to date, patients should be offered condiments and a selection of drinks and sufficient clothing protectors should be provided for all patients who require them in order to respect their dignity and protect their clothing.	**Partially met**
	Action taken as confirmed during the inspection: Observation of the mealtime experience evidenced that an up to date menu was on display, patients were offered a selection of drinks and there were sufficient clothing protectors. However, condiments were not on the tables nor were they offered and food taken to patients in their rooms at breakfast time was not covered in order to keep it warm. This area for improvement has been stated for a second time.	

Areas for improvement from the last medicines management inspection dated 14 February 2019		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the management of new patients' medicines to ensure the relevant records are in place.	**Met**
	Action taken as confirmed during the inspection: For a new patient, the medicine regime was confirmed with the prescriber. Medicines received were recorded appropriately and handwritten entries on the medicine administration records were signed by two registered nurses.	

Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	The registered person shall review the management of in use insulin pen devices as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The in-use insulin pens were labelled and marked with the date of opening.	
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that two staff are involved in the disposal of medicines and transcribing of medicines information on handwritten medication administration records.	**Met**
	Action taken as confirmed during the inspection: Two staff were involved in the disposal of medicines and the transcribing of medicines information on handwritten medication administration records.	
Area for improvement 4 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that patients' care plans reflect their healthcare needs and these are kept up to date.	**Met**
	Action taken as confirmed during the inspection: A sample of care plans relating to the management of distressed reactions, diabetes, dysphagia and pain were examined. They reflected the healthcare needs of the patients and were reviewed at monthly intervals or more frequently if needed.	

6.3 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to monthly review to ensure the assessed needs of the patients were met. A review of the staffing rota from 29 July to 11 August 2019 evidenced that the planned daily staffing levels were adhered to.

Staff spoken with were satisfied with staffing levels, they stated there were occasional issues with short notice leave but that this was unavoidable and shifts were generally 'covered'. Comments included:

- "Staff levels are good, hardly any agency staff used now."
- "I love it here, it's great."
- "Teamwork is fairly good."
- "Younger staff are keen and willing to learn."
- "I'm enjoying it here."

We also sought staff opinion on staffing via the online survey; no responses were received.

Patients spoken with indicated they were satisfied there were enough staff on duty to meet their needs. Patients' visitors spoken with were also satisfied that there were enough staff on duty although one did comment that she felt "staff were under pressure".

We also sought the opinion of patients and patients' visitors on staffing levels via questionnaires; no responses were received.

The registered manager told us that there were no current staff vacancies and use of agency staff was minimal. The registered manager continues to notify RQIA appropriately of any instances of short notice leave as agreed at a previous inspection.

Review of records confirmed there was a system in place to monitor the registration status of registered nurses with the NMC and care staff with NISCC and this clearly identified the registration status of all staff.

We reviewed the supervision and appraisal schedule in operation in the home; staff spoken with confirmed they received regular supervision and a yearly appraisal.

Discussion with staff confirmed they were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Staff spoken with also confirmed they were aware of the home's whistleblowing policy. Review of records and discussion with the registered manager confirmed that in the event of a safeguarding issue arising regional protocols were followed and the relevant authorities were notified. An adult safeguarding annual position report had been compiled to reflect on adult safeguarding referrals and the outcome of investigations made throughout the previous year.

We observed that staff adhered to infection prevention and control (IPC) measures in the home. Personal protective equipment (PPE), for example aprons and gloves, were readily available and appropriately used by staff. Staff were also observed to carry out hand hygiene at appropriate times.

One staff member was not wearing a uniform although they were neatly dressed and observed to use PPE appropriately. The staff member informed us that they were recently employed and the uniforms provided on commencement of work in the home had not fitted. We discussed this with the registered manager who confirmed that uniforms had been ordered, however, there had been a supply problem and they were still awaiting delivery. The registered manager agreed that uniforms should be available for and worn by all staff. The registered manager contacted RQIA the day after the inspection to inform us that uniforms had been obtained from a stock supply for the staff member. We were satisfied that action had been taken to resolve this matter.

A review of the home's environment was carried out and included observations of a sample of bedrooms, bathrooms, shower rooms, lounges, storage areas, sluices, treatment rooms and the dining room. The home was found to be warm, well decorated, fresh smelling and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction. Review of records confirmed staff had received mandatory training in fire safety.

Review of care records evidenced that a range of validated risk assessments were completed and informed the care planning process for patients. Where practices were in use, for example bedrails, that could potentially restrict a patient's choice and control, validated risk assessments and care plans were in place, consent was obtained where appropriate and care plans were reviewed regularly.

On at least a monthly basis, falls occurring in the home were analysed to identify if any patterns or trends were emerging and an action plan was devised if necessary.

Medicines Management

The sample of medicines examined showed that patients were receiving their prescribed medicines.

Medicines were managed in compliance with legislative requirements, professional standards and guidelines. Medicines were managed by staff who had been trained and deemed competent to do so. There were procedures in place to ensure the safe management of medicines during a patient's admission or readmission to the home. Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. There were satisfactory arrangements in place to manage changes to prescribed medicines. Audits which cover all areas of medicines management were performed regularly, discrepancies investigated and records maintained. There were robust arrangements in place for the management of medicine related incidents.

Medicines records complied with legislative requirements, professional standards and guidelines.

Medicines were safely and securely stored in compliance with legislative requirements, professional standards and guidelines. Medicines were stored in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened.

The management of controlled drugs was in compliance with legislative requirements, professional standards and guidelines. Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, infection prevention and control measures, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

We observed care delivery and the daily routine in the home and this evidenced that patients' care needs were met. Patients unable to voice their opinions appeared to be comfortable and content in their surroundings. Patients able to express their opinions commented positively about the care they received.

Patients' visitors spoken with were also satisfied with the care provided, comments included:

- "Treatment is excellent."
- "Second to none, staff are really good."
- "It's fairly good."
- "It's good here, no complaints."
- ''We've no complaints about anything."

Review of three patients' care records evidenced that patients' nutritional needs had been identified and validated risk assessments were completed to inform care planning. Patients' weights were monitored on at least a monthly basis. There was evidence of referral to, and recommendations from, the dietician and the speech and language therapist (SALT) where required. Review of supplemental care records evidenced that patients' daily food and fluid intake was recorded and that these records were up to date.

Staff spoken with demonstrated their knowledge of how to care for a patient who had a fall. In the care records reviewed we saw that, where a fall had occurred, the appropriate risk assessments and care plans had been updated as necessary.

We spoke to a visiting healthcare professional from the Northern Trust Dementia Team who told us that they carried out regular visits to the home and were involved in information gathering and assessment for patients with dementia. The team made recommendations to assist and direct staff with individualised care planning for patients living with dementia. These recommendations would be implemented by staff in the home and reviewed by the team. They told us that staff were generally responsive to recommendations, however, on the day of the inspection, review of one patient evidenced that the recommendations made had not been put in place; the team had brought this to the attention of staff to ensure action was taken. We also discussed this with staff who confirmed that they had received the recommendations and would implement them.

We looked at the management of wounds and observed that in one of the three care records reviewed a wound care plan had not been developed for the individual patient, although a wound chart was in place and had been completed contemporaneously. In the two other records reviewed there was evidence of referral to other healthcare professionals such as the tissue viability nurse (TVN) and care plans for wound care were in place, although, we noted that one care plan had not been updated to reflect a recommended change to the dressing in use by the TVN. An area for improvement was made in relation to ensuring wound care plans were developed and updated as necessary.

Validated risk assessments and care plans were also in place to direct care for the prevention of pressure ulcers and pressure relieving equipment was in use if directed. Review of three patients' care records evidenced that recording on repositioning charts was not reflective of the repositioning schedules directed in the care plans for two of the patients. However, we did not observe any 'gaps' in recording on the repositioning charts and staff assured us that patients' skin condition was checked regularly. This area for improvement was partially met and will be stated for a second time.

We arrived in the home at 07.55 hours in order to observe the early morning routine. Staff received a handover and proceeded to attend to their allocated patients. We saw that staff treated patients with respect; they knocked on doors before entering rooms and ensured doors were closed to maintain patients' privacy. Staff were helpful and attentive to patients, the routine was unhurried and calm.

We observed that cooked breakfasts, delivered to those patients who were eating in their rooms, had not been covered with a protective lid in order to keep the food warm. Food served should be appealing and kept warm or reheated if necessary. Observation of the serving of lunch evidenced that meals taken to patients in their rooms at that time were covered with a protective lid. An up to date menu was on display in the dining room, patients were offered a selection of drinks and there were sufficient clothing protectors. The food on offer was well presented and smelled appetising. However, patients were not offered condiments nor were these readily available in the dining room. We also observed that a staff member stood over a patient they were assisting rather than sitting down beside them to help them eat their meal. Mealtimes should be a positive experience for patients; this area for improvement was only partially met and will be stated for a second time.

Patients spoken with said that they had enjoyed their lunch, comments included:

- "The food is good, I like plenty to eat."
- "I'm a bit of a fuss pot when it comes to food and that isn't a problem."
- "Breakfast is great."

Staff demonstrated effective communication skills with patients and obviously knew them well; they were observed to be pleasant and friendly towards the patients at all times.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management of falls, risk assessing and care planning, communication between staff and patients and the daily routine.

Areas for improvement

An additional area for improvement was identified in this domain in relation to ensuring wound care plans were developed and updated as necessary.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

During the inspection we spoke with 15 patients about their experience of living in Wood Green. Patients spoke positively about the staff and the care they received. Patients who were unable to voice their opinions appeared to be content and settled both in their surroundings and in their interactions with staff. One patient told us that "the staff are just lovely and really helpful".

Patients' visitors spoken with were satisfied that the care provided was compassionate and caring, they commented:

- "It's just like their own home."
- "We're quite happy."
- "There are a lot of activities which is lovely."

The weekly activity planner was displayed throughout the home. In the morning two activity co-ordinators distributed the 'Daily Sparkle' newsletter to patients and offered them the opportunity to join in with 'knit and natter' and armchair aerobics sessions. Patients who took part in the sessions appeared to enjoy them and the activity co-ordinators were helpful, friendly and encouraging. A pet therapy session was planned for the afternoon and patients told us that this was one of their favourite activities. One to one activities, such as hand massage, and room visits were also arranged for those patients who preferred not to, or were unable to, join in group sessions. Patients' spiritual needs were taken into account; there was a weekly prayer group and 'Songs of Praise' on a Sunday.

Thank you cards were on display throughout the home and we were pleased to see that the registered manager had introduced a system to record compliments and thank you cards received. Comments made included:

- "Your care and professionalism everyday made all the difference."
- "Thank you very much for the care and attention shown to my husband."

Review of records confirmed a relatives' meeting had been held in May 2019. A resident's comfort fund meeting had also been held in May 2019; this gave patients the opportunity to say what they would like comfort monies spent on in order to improve and enhance their experience of living in the home. Patients spoken with said that they felt staff listened to them and took their views on board.

The atmosphere within the home was friendly and relaxed; patients were seen to be treated with kindness and compassion. The culture and ethos within the home appeared to be positive.

We observed that staff communicated effectively both with patients and with each other. Staff spoken with were knowledgeable regarding their roles and responsibilities and the importance of maintaining confidentiality for the patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, the activities on offer and listening to and valuing patients.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was displayed in the entrance hall of the home. There had been no change in management arrangements since the last inspection. A review of the duty rota for the nursing unit evidenced that the registered manager's hours and the capacity in which these were worked was recorded. Discussions with staff and observations within the home confirmed that it was operating within the categories of care registered.

Staff spoken with commented positively about working in the home. They were on first name terms with the registered manager; staff said that "they can go to Debby" and that they felt supported by her. Staff also said that they did not always feel that they were kept informed of action taken to resolve issues they raised; these comments were relayed to the registered manager for her consideration.

Patients' visitors confirmed that they knew who to speak to about a concern and were aware of the management arrangements in the home.

We observed that there was a system in place for recording complaints received. The complaints procedure was displayed in the entrance of the home. Patients' visitors spoken with were aware of the procedure although none of them had had any cause to raise a complaint.

Patients' visitors spoken with were satisfied with the level of communication they received from staff about their relative and with consultation about all aspects of care planning.

We reviewed a sample of monthly monitoring reports from May 2019; these were comprehensive, detailed and informative, they contained an action plan and a scheduled date of completion for the actions required.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Review of records confirmed the home provided mandatory training to ensure staff were adequately trained for their roles and responsibilities. Discussion with staff confirmed that they felt there were good training opportunities within the home and that they were readily able to access training.

The registered manager completed a number of monthly audits to assure the quality of care and services provided in the home. Audits were completed, for example, regarding accidents/incidents, care records, use of restrictive practices, wounds, falls and infection prevention and control practices. An action plan was developed where shortfalls were identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication and consultation, management of complaints, training, quality improvement and governance arrangements

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Debby Gibson, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The DHSSPS Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 23 **Stated:** Second time **To be completed by:** 7 August 2019	The registered person shall ensure that recording on repositioning charts is reflective of individual patients' care plans and is contemporaneous. Ref: 6.2
	Response by registered person detailing the actions taken: A new repositioning chart has been implemented and staff have received supervision in relation to the completion of them. A review of the patients care plans was completed and subsequently they have been updated to reflect the current needs of the patients.
Area for improvement 2 **Ref**: Standard 12 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure mealtimes are a positive experience for patients; patients should be offered condiments. Ref: 6.4
	Response by registered person detailing the actions taken: New condiment sets have been purchased and available on both nursing units. Staff have received supervision in relation to offering condiments at mealtimes.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that were there is a wound care plans are developed and updated as necessary. Ref: 6.4
	Response by registered person detailing the actions taken: A full wound care audit has been completed. Following this all wound care plans were reviewed and updated to reflect the current care regime of the individual patient.

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

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