Pine Lodge
RQIA ID: 1013
186 Belmont Road
Belfast
BT4 2AS

Inspector: Priscilla Clayton
Inspection ID: IN022301

Tel: 02895043170
Email: annew.doherty@belfasttrust.hscni.net

Unannounced Care Inspection
of
Pine Lodge

9 March 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of inspection

An unannounced care inspection took place on 09 March 2016 from 11.00 to 15.00. On the day of the inspection the home was found to be delivering safe, effective and compassionate care. The standard inspected were assessed as being met. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) appended to this report.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005, the DHSSPS Residential Care Homes Minimum Standards (2011), NICE guidelines on the management of urinary incontinence in women (September 2013), NICE guidelines on the management of faecal incontinence (June 2007) and Guidance and Audit Implementation Network (GAIN) guidelines available for palliative care.

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1.1 Actions/enforcement taken following the last inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last inspection.

1.2 Actions/enforcement resulting from this inspection

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

1.3 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**1**	**1**

The details of the QIP within this report were discussed with the Ann Woods Doherty, registered manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service details

Registered Organisation/Registered Person: Belfast Health and Social Care Trust	**Registered Manager:** Anne Woods Doherty
Person in charge of the home at the time of inspection: Ann Woods Doherty, Registered Manager	**Date manager registered:** 1 April 2005
Categories of care: RC-E, RC-MP(E), RC-PH, RC-PH(E), RC-I	**Number of registered places:** 40
Number of residents accommodated on day of inspection: 17	**Weekly tariff at time of inspection:** BHSCT Trust facility.

3. Inspection focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standard and theme has been met:

Standard 1. Residents' views and comments shape the quality and facilities provided by the home.

4. Methods/processes

Prior to inspection the following records were reviewed:

- Previous care inspection report.
- Notifications of accidents/incidents since the date of the previous inspection.

During the inspection the inspector met with eight residents, three care staff, two visiting professional and two visitors.

The following records were examined during the inspection:

- Three care files
- Accidents records,
- Complaints records,
- Residents' guide
- Statement of purpose
- Monthly quality monitoring visits
- Policies / procedures
- Complaints record

5. The inspection

5.1 Review of requirements and recommendations from previous inspection

The previous inspection of the home was an unannounced care inspection dated 13 August 2015

5.2 Review of requirements and recommendations from the last Care inspection:

No requirements or recommendations were made as a result of the last care inspection.

5.3 Standard 1: Residents' involvement

Is care safe?

Residents were observed to be comfortably settled in various areas of the home. Residents spoke positively about the care they received and confirmed that staff actively sought their views and preferences each day in matters affecting them.

Residents' meetings are held every two weeks in each Zone. Minutes recorded where retained. An examination of the minutes of the meetings evidenced that residents' views were sought on a range of issues.

Four care records were inspected. Records included needs assessments which were complemented with risk assessments; care plans; evaluations of care and care review including annual care management review. Resident participation in the care planning process was evidenced by their signatures in place on the care plans and the review minutes.

Discussion with the manager regarding the care plan of one resident took place. The manager readily agreed to make a referral to the district nurse regarding the availability of a comprehensive holistic nursing care plan so that staff are very clear about the care required to meet the actual and potential nursing needs of the resident. One recommendation was made in this regard.

Is care effective?

There were a range of methods and processes in place where residents' and their representatives' views and opinions were sought. These included a key worker scheme, an active complaints policy, monthly visits made on behalf of the registered provider and residents meetings. The record of complaints showed that any expression of dissatisfaction made by a resident is taken seriously and acted on. Monthly audits of complaints are undertaken to identify ant trends or patterns where improvement is required.
One requirement was made in regard to the availability of monthly monitoring reports as the manager had not received reports of the visits undertaken during November 2015 and January 2016. Reports were subsequently submitted and received in RQIA on 9 March 2016.

Is care compassionate?

Discussion with staff demonstrated that they were knowledgeable about residents' needs and that a person centred approach is taken in the care provision.

Discussion with two relatives provided positive responses in regard to the provision of care in the home. No issues or concerns were raised or indicated.

Staff interactions with residents confirmed that residents were treated with dignity and respect. Care duties were observed to be conducted at an unhurried pace with time afforded to residents in a polite, friendly and supportive manner.

Areas for improvement

There were two areas identified for improvement. One recommendation related to liaison with the district nurse regarding availability of a nursing care plan and one recommendation regarding the retention of monthly monitoring reports in the home.

Number of requirements:	**1**	**Number of recommendations**:	**1**

5.4 Additional areas examined

5.4.1 Residents

Residents stated they were very happy in the home and that they were well cared for by excellent staff who were always very attentive and promptly responded to their calls for assistance when required. A selection of comments was:

- "The staff are all great, very kind"
- "It's not the same as my own home but it's the next best thing"
- "This is a very good place and staff listens to what we have to say."

5.4.3 Visiting Professionals

Two community nurses who visited the home stated that the care provided to their patients was good. The nurses confirmed that the home works well with community nursing team and any instructions left regarding a resident are carried out as prescribed. Discussion took place regarding the necessity for a written district nursing care plan to be available in the home so that care staff, both day and night staff are aware of the care to be provided meet the actual and potential nursing needs of the resident.

5.4.4 Staffing levels

On the day the following care staff were on duty:

AM
- Manager x 1
- Senior care staff x 3
- Care staff X 3

PM
- Manager X1
- Senior care staff X 2
- Care staff X 3

In addition ancillary staff were employed for domestic duties.
A staff duty roster was being maintained.

The manager confirmed that the level of staff on duty was satisfactory to meet the needs and numbers of residents accommodated.

5.4.5 Accidents / incidents

Inspection of the accident / incident records showed that these had been responded to and recorded appropriately within the home's records. Notifications forwarded to RQIA were discussed with the manager as several received had not been correctly completed within identified sections. The manager agreed to remind staff in this regard and to only submit appropriate notifications in accordance with guidance received from RQIA.

5.4.6 Environment

Inspection of the internal environment was undertaken. The home was clean, organised, comfortably heated and fresh smelling throughout. Fire doors were closed and exits unobstructed. There were no visible fire safety hazards.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ann Woods Doherty, registered manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Residential Care Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The DHSSPS Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions taken by the Registered Manager/Registered Person

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to care.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation 29 5 (a) **Stated:** First time **To be completed by:** 30 April 2016	The registered provider shall maintain a copy of the monthly monitoring report in the home and make it available on request to RQIA.
	Response by Registered Person(s) detailing the actions taken: Monthly monitoring reports are generally received promptly but due to administrative difficulites there was a delay at the beginning of the year. The delayed reports were received and forwarded to the inspector on the same day as the inspection.
Recommendations	
Recommendation 1 **Ref**: Standard 6.1 **Stated:** First time **To be completed by:** 10 April 2016	The registered manager to liaise with the district nursing sister regarding the necessity for a holistic nursing care plan for one resident so that staff are very clear about the care required to meet the actual and potential nursing needs of the resident.
	Response by Registered Person(s) detailing the actions taken: One resident had become palliative care very quickly after admission and the decision with the district nursing services, GP, community rehabilitation team and the care staff in the home was to provide the care needed. An intensive care plan was available within the home for care staff and the patient held nursing records were also available. However the manager will ensure that where any resident has complex nursing needs and where the community nursing team is involved in the care provided they will input directly into the care plan with clear directions for the care staff.

Registered Manager completing QIP	ANNE W DOHERTY	**Date completed**	15.04 16
Registered Person approving QIP	Martin Dillon	**Date approved**	05/04/16
RQIA Inspector assessing response	Priscilla Clayton	**Date approved**	13/05/2016

Please ensure this document is completed in full and returned to care.team@rqia.org.uk from the authorised email address