Cedarhurst Lodge
RQIA ID: 1070
Beech Suite
Cedarhurst Road
Belfast
BT8 4RH

Inspector: Heather Sleator
Inspection ID: IN021688

Tel: 028 9049 2722
Email: cedarhurst.lodge@fshc.co.uk

Unannounced Care Inspection
of
Cedarhurst Lodge

5 January 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 5 January 2016 from 10.00 to 15.45.

The focus of this inspection was continence management which was underpinned by selected criteria from:
Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Heath care and Standard 39: Staff Training and Development.

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 28 July 2015.

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	0	6

The details of the Quality Improvement Plan (QIP) within this report were discussed with Lavina Harris, 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: Four Seasons Dr Maureen Claire Royston	**Registered Manager:** Lavina Harris
Person in Charge of the Home at the Time of Inspection: Lavina Harris	**Date Manager Registered:** 1 April 2005.
Categories of Care: NH-DE NH-MP	**Number of Registered Places:** 28 – DE 15 - MP
Number of Patients Accommodated on Day of Inspection: 27 – DE 5 - MP	**Weekly Tariff at Time of Inspection:** DE - £593 - £618 per week MP - £1126.46 per week

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the selected criteria from the following standards have been met:

Standard 4: **Individualised Care and Support, criterion 8**
Standard 6: **Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8and 15**
Standard 21: **Heath Care, criteria 6, 7 and 11**
Standard 39: **Staff Training and Development, criterion 4**

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the registered manager
- discussion with patients
- discussion with staff on duty during the inspection
- review of care records
- observation during a tour of the premises
- evaluation and feedback

Prior to inspection the following records were analysed:

- inspection report and quality improvement plan (QIP) from the previous care inspection on 28 July 2015
- incident reports submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005

During the inspection, the inspector met with approximately 15 patients, four care staff, ancillary staff and four registered nurses.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection focus
- staffing arrangements
- three patient care records
- staff training records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced estates inspection dated 29 October 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the last care inspection dated 28 July 2015

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 32.1 **Stated:** First time	A system should be implemented to evidence and validate staffs' knowledge of the policies and procedures, newly issued by the organisation, in respect of communicating effectively and palliative and end of life care.	**Met**
	Action taken as confirmed during the inspection: A system had been put in place and was reviewed at inspection, to evidence staff had read the newly published policy documentation in respect of communicating effectively and palliative and end of life care.	
Recommendation 2 **Ref:** Standard 32.6 **Stated:** First time	Pain management should be discussed with nursing staff. Nursing staff should be informed and made aware of their responsibility regarding anticipatory prescribing to ensure that medication is available in a timely manner.	**Met**
	Action taken as confirmed during the inspection: Pain management was discussed with nursing staff at a meeting and the registered nurses were made aware of their responsibility regarding effective pain management.	

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies and procedures were in place to guide staff regarding the management of continence.

A resource file on the management of continence/incontinence had been developed and was available for staff. The file included regional and national guidelines for the management of urinary catheters), constipation (RCN and NICE) and improving continence care (RCN)

Discussion with staff and the registered manager confirmed that training relating to the management of the urinary and bowel incontinence had been completed by 15 staff in July 2015 and further training was scheduled for 21 January 2016. The registered manager also informed the inspector that there was support, and training opportunities from the local health and social care trust, if staff required an update in their training of catheterisation and/or the management of stomas.

Staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.

Is Care Effective? (Quality of Management)

Review of three patients' care records evidenced that a continence assessment was in place in one of the three care records. The assessment which was reviewed identified the patient's individual continence needs. A care plan was in place to direct the care to meet the needs of the patients. A recommendation has been made that a continence assessment is completed for each patient. A further recommendation has been made that the continence assessment and corresponding care plan identifies the specific type of continence aid required as this was only present in one of the three care plans which were reviewed.

There was evidence in the patients' care records that the assessment and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate.

The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Care plans referred to patients normal bowel patterns and care staff maintained a record using the Bristol Stool chart of bowel movements. However, there was no evidence in patients progress records that nursing staff were monitoring and evaluating patients' bowel function. A recommendation has been made.

Urinalysis was undertaken as required and patients were referred to their GPs appropriately.

The management of urinary catheters was reviewed. Registered nurses (RNs) spoken with were knowledgeable regarding the management of urinary catheters and the rationale for the use of urinary catheters. Urinary catheters were only inserted on the instructions of the patient's GP or consultant

Care plans relating to the management of urinary catheters did contain information regarding the frequency of changing the catheter in accordance with the type and evidenced based practice and that 'catheter care' was to be provided.

Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken in one of the three records reviewed. This was discussed with the nurse in charge of the unit who provided evidence from the archived care records that patients and or their representatives had been informed/consulted. However, as discussed with the registered manager the process for evidencing patient/representative involvement should be reviewed to ensure the information is accurate and up to date. A recommendation has been made.

Is Care Compassionate? (Quality of Care)

Discussion with the registered manager confirmed where patients, or their families, have a personal preference for the gender of the staff providing intimate care their wishes would be respected, as far as possible. Arrangements were in place for the deployment of staff, if required, to ensure that patients' wishes were adhered to.

Staff were observed to attend to patient's continence needs in a dignified and personal manner.

Patients spoken with confirmed that they were treated with dignity and respect, that staff were polite and respectful and that their needs were met in a timely manner. Good relationships were evident between patients and staff.

Areas for Improvement

It is recommended an up to date continence assessment is present in patients' care records

It is recommended that the continence assessment and corresponding care plan identifies the type of continence aid required.

It is recommended that registered nurses evidence in care records that they are monitoring patients' bowel function.

It is recommended management implement a system to evidence patients and/or their representatives have been consulted regarding the planning of care.

Number of Requirements:	**0**	**Number of Recommendations**:	**4**

5.4 Additional Areas Examined

5.4.1. Records and record keeping

The review of patient care records did not evidence a consistent approach to care planning was being undertaken by registered nurses. Two of the three care records reviewed did not have a continence assessment in place. Discussion took place with the nurse in charge of Beech unit in respect of the auditing of care records. An audit was present in one care record. The audit identified shortfalls within the care record however evidence was not present that remedial action had been taken in respect of the shortfalls. The effective auditing of care records should also have identified the absence of the two continence assessments. In discussion with the nurse in charge it was agreed the system of auditing care records would be revised to evidence that remedial action had been taken, where necessary. Any audit of a care record would also be signed off by the nurse in charge to verify all required action has been taken within the requested timescale. A recommendation has been made.

5.4.2. Environment

The nursing home was found to be clean, comfortable and well decorated throughout.
In November 2015 a new 15 bedded unit for adults with mental health issues (Sycamore) was opened. As a result of this unit the dementia unit (Beech) has reduced in patient numbers from 45 to 28. The home has benefitted from this in terms of being redecorated and some new furnishing purchased for Beech unit as well as Sycamore.

However, areas for improvement were identified in relation to the laundry. In general, storage space was limited in the home and particularly in the laundry. Due to the limited availability of storage items of unnamed patients' clothing were being stored in the corridor and slippers on the window sill. Due to this the flow of laundry going into and out of the laundry was disrupted i.e. there was no entry for laundry in need of washing and an exit for clean laundry. This was discussed with the registered manager who agreed to have additional shelving put up in the laundry and both the entrance and the exit doors in the laundry would be used in future, in accordance with infection prevention and control guidelines.

Storage of bed linen was also limited. The bed linen viewed during a tour of the home was observed to be well worn. This was discussed with the registered manager who stated new bed linen was available however storage of the linen was an issue. It was agreed the new shelving in the laundry would accommodate bed linen in future and the new supply of bed sheets would be put into use. A recommendation has been made in relation to ensuring the operation of the laundry facilities is in accordance with infection prevention and control measures.

Areas for Improvement

It is recommended that management ensure that the auditing of care records is robust, regular and signed off by the nurse in charge when all actions are completed.

It is recommended the operation of the laundry facilities is in accordance with infection prevention and control measures.

Number of Requirements:	**0**	**Number of Recommendations:**	**2**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Lavina Harris, 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 Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. 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 must be completed by the registered person/registered manager to 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 nursing.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	
Recommendations	
Recommendation 1 **Ref:** Standard 21.6 **Stated:** First time **To be Completed by:** 8 February 2016	The registered person shall ensure a continence assessment has been completed for patients where a care plan for elimination needs has been written. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: This has been addressed-a continence assessment has been completed for patients where a care plan for elimination needs has been written.Completion of continence assessments and Care Plans will be monitored through the internal auditng system.
Recommendation 2 **Ref:** Standard 4.8 **Stated:** First time **To be Completed by:** 8 February 2016	The registered person shall ensure the continence assessment and corresponding plan of care identifies the type of continence aid required and the level of support the patient requires. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: This has been addressed.The registered manager has checked the continence assessments and corresponding plans of care to ensure it identifies the type of continence aid required and the level of support the patient requires. The completion of accurate care plans will be montiroted through the internal auditing system.
Recommendation 3 **Ref:** Standard 4.5 **Stated:** First time **To be Completed by:** 15 February 2016	The registered person shall ensure a system is implemented to evidence patients and/or their representative have been consulted regarding the planning of care and informed of any changes to the care plan. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: This has been addressed.The registered manager has implemented a system to evidence that patients and/or their representative have been consulted regarding the planning of care and informed of any changes to the care plan.

Recommendation 4 **Ref:** Standard 4.9 **Stated:** First time **To be Completed by:** 8 February 2016	The registered person shall ensure registered nurses evidence the monitoring of patients bowel function in care records. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: This has been addressed.The registered manager is checking the monitoring of patients bowel function in care records by registered nurses.
Recommendation 5 **Ref:** Standard 35.6 **Stated:** First time **To be Completed by:** 15 February 2016	The registered person shall ensure the system of auditing of care records is robust and evidences that where shortfalls have been identified remedial action had been taken and signed off by the registered person or nurse in charge. **Ref: Section 5.4.1**
	Response by Registered Person(s) Detailing the Actions Taken: This has been addressed.There is a robust system of auditing of care records and there is evidence that where shortfalls have been identified remedial action has been taken and signed off by the registered manager or nurse in charge.
Recommendation 6 **Ref:** Standard 46.1 **Stated:** First time **To be Completed by:** 8 February 2016	The registered person shall ensure the operation of the laundry facilities is in accordance with infection prevention and control guidelines. **Ref: Section 5.4.2**
	Response by Registered Person(s) Detailing the Actions Taken: This has been addressed.The registered manager has upgraded the operation of the laundry facilities to ensure it is in accordance with infection prevention and control guidelines.

Registered Manager Completing QIP	Lavina Harris	**Date Completed**	4.4.16
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	04.04.16
RQIA Inspector Assessing Response	Heather Sleator	**Date Approved**	06.04.16

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