Unannounced Follow-up Care Inspection Report 5 March 2020

Cedarhurst Lodge

Type of Service: Nursing Home (NH)
Address: Cedarhurst Road, Belfast, BT8 7RH
Tel no: 028 9049 2722
Inspector: Jane Laird

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 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 registered nursing home which provides care for up to 43 patients accommodated between two units.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager and date registered:** Lavina Ann Harris 13 June 2007
Person in charge at the time of inspection: Lavina Ann Harris	**Number of registered places:** 43 comprising: 20 – NH – DE within Beech Unit 23 – NH – MP and MP(E) within Sycamore Unit
Categories of care: Nursing Home (NH) DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP (E) - Mental disorder excluding learning disability or dementia – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 12 – Beech Unit 23 – Sycamore Unit A maximum of 20 patients in category NH-DE accommodated in the Beech Unit and a maximum of 23 patients in category NH-MP/MP (E) accommodated in the Sycamore Unit.

4.0 Inspection summary

An unannounced inspection took place on 5 March 2020 from 10.30 hours to 18.20 hours following receipt of information via the duty desk at RQIA.

It is not the remit of RQIA to investigate whistleblowing or 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.

The concerns raised, with RQIA, were in relation to staffing levels, staff interactions with patients, care delivery, incontinence management, the environment, management of complaints and governance arrangements. These concerns were partially substantiated and details were discussed with the manager during feedback. As a result of the inspection findings RQIA contacted the management of Cedarhurst Lodge to gain assurances that the areas for improvement would be addressed with immediate effect. Further details of areas for improvement identified during the inspection are included within the main body of this report.

The following areas were examined during the inspection:

- Staffing Arrangements
- Care Delivery
- Incontinence Management
- Environment
- Management of Complaints
- Governance Arrangements

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	5	*4

*The total number of areas for improvement includes two standards which have been carried forward for review at the next care inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Lavina Ann Harris, manager and Hilda Sepelagio, deputy 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 dated 11 November 2019

The most recent inspection of the home was an unannounced finance inspection undertaken on 11 November 2019. Other than those actions detailed in the QIP no further actions were required.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from 24 February 2020 to 8 March 2020
- staff training records
- incident and accident records
- three patient's care records
- a sample of governance audits/records
- complaints record
- a sample of monthly monitoring reports from December 2019.

Areas for improvement identified at the last finance inspection were not reviewed as part of this inspection, due to the inspection's focus; and have been carried forward to the next care inspection.

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 previous inspection(s)

<table>
<tr><th colspan="3">Areas for improvement from the last finance inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 14.25

Stated: Second time</td><td>The registered person shall ensure that a reconciliation of money and valuables held ad accounts managed is carried out at least quarterly. The reconciliation is recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.</td><td rowspan="2">Carried forward to the next care inspection</td></tr>
<tr><td>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.</td></tr>
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Area for improvement 2 **Ref**: Standard 2.8 **Stated:** Second time	The registered person shall ensure that each patient is given written notice of all changes to the agreement and these are agreed in writing by the patient or their representative. Where the patient or their representative is unable to sign or chooses not to sign, this is recorded.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	

6.2 Inspection findings

6.2.1 Staffing arrangements

The manager discussed the daily staffing levels within each unit and that these levels were reviewed regularly to ensure the assessed needs of the patients were met. Review of staff duty rotas evidenced that planned staffing levels had been adhered to.

A discussion with staff confirmed that they were satisfied with current staffing arrangements. Comments from staff included:

- “Very supported by management.”
- “Great team effort.”
- “Really love working here.”

We also sought staff opinion on staffing via the online survey. There was no response in the time frame allocated.

We reviewed the staff training records which confirmed that staff received mandatory training and that a system was in place to monitor staff attendance at training sessions. However, the nursing home and residential home training records were combined. An area for improvement was made to ensure these records were maintained separately.

We also sought the opinion of patients and relatives on staffing via questionnaires. There was no response in the time frame allocated. Any comments in returned questionnaires received after the return date would be shared with the manager for their information and action as required.

6.2.2 Delivery of care

There was a relaxed atmosphere within the home and patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Cedarhurst Lodge. Comments included:

- “I am very happy here.”
- “The food is just great here.”

- "Staff are all good."
- "The staff are looking after me well."

Staff were observed to use every interaction as an opportunity for engagement with patients and they demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

6.2.3 Incontinence Management

We reviewed patient care records which evidenced that an assessment of needs regarding incontinence care had been completed. The care plan included the recommended type of continence products to be used, the promotion of continence, skin care and level of assistance.

Discussion with staff and observation during the inspection evidenced that there were adequate stock of continence products available in the home. The storage of continence products is discussed further in 6.2.4.

We observed staff attending to patients' toileting needs on several occasions throughout the inspection in an attentive and discreet manner.

6.2.4 Environment

On review of staff practices and the homes environment including bedrooms, bathrooms, lounges and storage areas a number of infection prevention and control deficits were identified. As follows: Hand washing practices were limited across all grades of staff and the use of hand sanitising gel was not observed throughout the inspection. We observed catering and care staff in the kitchen on a number of occasions during the inspection without any personal protective equipment (PPE).

Continence aids were identified as being left open outside of packaging and on top of pedal bins within communal bathrooms which risked contamination prior to patient use and PPE was observed outside of packaging within drawers in communal areas. Identified patient equipment evidenced that these had not been effectively cleaned following use and were inappropriately stored in identified bathrooms.

Equipment and furniture used by patients was also identified as torn/damaged and could not be effectively cleaned, including armchairs in identified lounges, fallout mats, pedal bins, floor coverings and an identified bedframe. Cupboards within the Sycamore dining room were unclean and the cutlery tray was broken with debris evident inside. Wall paper was torn in several bedrooms within the Sycamore unit and dust was evident to high and low surfaces including ceiling fans and inside light fittings.

A malodour was evident on entering the Sycamore unit. This was traced to a mattress within a patient's bedroom. On examination of the mattress it was found to be stained internally and not fit for purpose. The mattress was replaced during the inspection and a detailed review of all mattresses was scheduled to be undertaken following the inspection. We also observed bed linen and duvets within a clean linen store that were worn and/or discoloured and on examination of the records completed daily by staff we identified that there was no clear system for establishing the frequency of bed clothes being changed. The records recorded "bed changed/bed made" but failed to elaborate what action had been taken.

The above deficits were discussed in detail with the manager as requiring immediate action. Following the inspection an action plan was received from the home detailing the actions taken to address the deficits which included repair/replacement of patient equipment/furniture and a deep clean of the home and patient equipment. In order to provide the necessary assurances and to drive/sustain improvements an area for improvement was identified.

Concerns were identified in the management and storage of chemicals within communal areas throughout the home. Within the Beech unit we observed a domestic trolley, which contained cleaning chemicals, left unattended in the corridor and we found an unlocked cupboard with chemicals and patients' topical creams. We further identified that a large container of liquid laundry detergent connected to a washing machine within the patient's kitchen area of the Sycamore unit was not secure. The importance of securing hazardous chemicals was discussed with the manager and an area for improvement was made.

We observed several large storage containers of prescribed food supplements for patients on modified diets which were easily accessible within the Beech lounge/dining area. This was discussed with the manager as a potential risk to the health and welfare of patients and the supplements were removed during the inspection to ensure patient safety. This information was shared with the pharmacy inspector and an area for improvement was made.

A number of fire doors were propped open throughout the home rendering them ineffective in the event of a fire. This was discussed with the manager and an area for improvement was made.

We further identified staff handbags within an unlocked store and unsupervised access to equipment such as a cooker, washing machine and microwave within the Sycamore unit. Other domestic appliances such as a kettle, toaster and microwave were observed within the Beech unit which were also easily accessible to patients. The manager stated that the above equipment was safe to be stored within these areas but acknowledged that the storage area for staff handbags should have been locked and agreed to monitor this going forward. On review of the risk assessments that had been carried out by the manager it was identified that the overall risk to patients was assessed as a "medium" risk. This was discussed with the manager who provided written confirmation that an action plan had been completed in combination with the risk assessment outlining measures to reduce the associated risks to patients and agreed to review this regularly. This was identified as an area for improvement.

6.2.5 Management of Complaints

Review of the home's complaints records evidenced that although systems were in place to ensure complaints were being recorded appropriately the last recorded complaint was January 2016. A discussion was held with the management team during the inspection regarding the importance of recording any expression of dissatisfaction. The manager agreed to review this going forward and to communicate this with relevant staff. This will be reviewed at a future inspection.

6.2.5 Governance arrangements

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded.

A number of audits were carried out on a monthly basis by the manager and/or deputy manager including audits of the environment, IPC, care records and hand hygiene. The most recent audits carried out in February 2020 resulted in 100% compliance with no deficits identified. The audits were not specific to either the nursing or residential home and did not indicate the location of where the audit had been completed. A discussion was held with the manager around the effectiveness of these audits due to the issues identified during the inspection and an area for improvement was identified.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the regional manager. Copies of the report were available for patients, their representatives, staff and trust representatives. Although the reports documented that audits had been carried out, they failed to identify many of the issues that were evident during the inspection in relation to the environment, IPC management and care records. Assurances were provided that future monitoring visits would review the content of the audits carried out by management and establish appropriate action plans where necessary.

6.2.6 Activities and socialising

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. On the day of the inspection the activity coordinators were very enthusiastic in their role and discussed the provision of activities within the home. During the inspection patients were accompanied to the local shops and cinema and there was clear evidence of a relaxed, pleasant and friendly atmosphere between patients and staff.

We observed that the majority of staff did not wear a name badge and the activity schedule within the Sycamore patient kitchen area was dated 24 February 2020. The manager agreed to review the format in which the activity schedule is displayed and following the inspection confirmed that staff name badges had been ordered. This will be reviewed at a future inspection.

6.2.7 Record keeping

Review of three patient care records evidenced that a number of care plans, written in 2015, had not been updated to reflect the patients' current needs. In addition pain assessment had not been carried out for several months for identified patients.

Specific details and examples were discussed in detail with the manager who acknowledged the shortfalls in the documentation and agreed to communicate with relevant staff the importance of accurately recording such information within patients' care records. In order to provide the necessary assurances and to drive/sustain improvements an area for improvement was made.

6.2.8 Management of mealtimes

Lunch commenced at 12.30 hours. Patients were accompanied to the dining room and a range of drinks were offered. Trays were delivered to patients in their bedroom as per their personal choice and staff were observed assisting patients with their meal appropriately in an unhurried manner. We observed that the menu was not displayed within the Sycamore dining room and discussed this with the manager who stated that a choice of two meals is provided to all patients

and recorded daily by the kitchen staff but acknowledged that the menu should be on display to inform patients and agreed to monitor this during daily walk arounds.

Areas of good practice

Evidence of good practice was found in relation to communication between patients, staff and other key stakeholders and maintaining good working relationships. Further areas of good practice was identified in relation to the culture and ethos of the home, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

The following areas were identified for improvement in relation to infection prevention and control (IPC), control of substances hazardous to health (COSHH), safe storage of medication, fire safety, risk management, quality governance audits and care records.

	Regulations	Standards
Total number of areas for improvement	5	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Lavina Ann Harris, Manager and Hilda Sepelagio, Deputy 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 nursing 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 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27 **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance. Ref: 6.2.4
	Response by registered person detailing the actions taken: A deep clean was carried out in both units following the last inspction to address the deficts highlighted.The Home is currently on isolation due to Co-Vid 19.A robust Infection Prevention Control Audit is in place whereby specific areas are being audited and any issues identified are being addressed.There is a detailed refurbishment and redecoration plan for the units for 2020 which will be commenced once the Covid 19 precautions are lifted.
Area for improvement 2 **Ref**: Regulation 14 (2) (a) (b) and (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all chemicals are securely stored in accordance with COSHH legislation, to ensure that patients are protected from hazards to their health. Ref: 6.2.4
	Response by registered person detailing the actions taken: All chemicals in the Home are all being stored in lockable cupboards/storage rooms with Risk Assessments in place.
Area for improvement 3 **Ref**: Regulation 27 (4)(b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall take adequate precautions against the risk of fire to ensure the safety and wellbeing of patients in the home. Specific reference to ensuring that fire doors are not propped open. Ref: 6.2.4
	Response by registered person detailing the actions taken: Fire doors are not propped open,a specific resident identified during the inspection has been propping the door open despite a chain DRU being in place. Resident is being encouraged daily to not do this but she retains capacity and remains non-compliant.There is a care plan in relation to this in her care records.This has also been discussed with her Care Manager.

Area for improvement 4 **Ref**: Regulation 27 (2) (t) **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall, having regard to the number and needs of the patients, ensure that a risk assessment to manage health and safety is carried out and updated when necessary. With specific reference to: • domestic appliances such as kettle, toaster, microwave, washing machine and cooker within patient areas • staff handbags Ref: 6.2.4
	Response by registered person detailing the actions taken: Domestic Appliances are kept locked in cupboards when not in use. Use of same is only under full staff supervison. Staff personal belongings are being locked in a designated cupboards.
Area for improvement 5 **Ref**: Regulation 13 (1) (a) **Stated:** First time **To be completed by:** 5 April 2020	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. Specific reference to care plans and daily records: • care plans must be person centred and relevant to the patients current care needs • risk assessments and care plans to be reviewed when a patient is admitted back into the home from hospital Ref: 6.2.7
	Response by registered person detailing the actions taken: Supervision is ongoing with trained staff regarding the review of care plans and risk assessments on return of residents from hospital.The Registered Manager and Deputy Manager are auditing the care records and maintaining a record of same with action being addressed.The Regional Manager is checking the care plan audits during her Regulation 29 monitoring visits to the Home.
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 14.25 **Stated:** Second time **To be completed by:** 30 November 2019	The registered person shall ensure that a reconciliation of money and valuables held ad accounts managed is carried out at least quarterly. The reconciliation is recorded and signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection.

Area for improvement 2 **Ref**: Standard 2.8 **Stated:** Second time **To be completed by:** 31 December 2019	The registered person shall ensure that each patient is given written notice of all changes to the agreement and these are agreed in writing by the patient or their representative. Where the patient or their representative is unable to sign or chooses not to sign, this is recorded. Ref: 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection.
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall ensure that all prescribed medicines are safely and securely stored to prevent unauthorised access and use. With specific reference to the storage of patients prescribed supplements. Ref: 6.2.4
	Response by registered person detailing the actions taken: Supplements identified during the Inspection were removed immediately,and all prescribed suppplements now stored in a locked cupboard.
Area for improvement 4 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 5 April 2020	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. • Environmental and hand hygiene audits should be sufficiently robust to ensure that any IPC deficits are appropriately identified and actioned • Governance audits in respect of care records should be initiated to ensure care plans and care records are maintained as required • Environmental audits are specific to the nursing home • Training records are maintained separately for the nursing home. Ref: 6.2.5
	Response by registered person detailing the actions taken: Robust environmental and hygiene audits are now in place.The Regional Manager is checking all audits during her regulation 29 audit on a monthly visit to the home.Any action required will be highlighted in the report and rechecked to ensure compliance.Training records are now being maintained separately from the Residential home..

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

The Regulation and Quality Improvement Authority

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