The Regulation and Quality Improvement Authority

Inspection Report

16 May & 22 June 2022

Cedarhurst Lodge

Type of service: Nursing (NH)
Address: Cedarhurst Road, Belfast, BT8 7RH
Telephone number: 028 9049 2722

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Electus Healthcare 1 Limited **Responsible Individual:** Mrs Hazel McMullan – applicant	**Registered Manager:** Mrs Julie-Ann Jamieson– not registered
Person in charge at the time of inspection: Mrs Julie-Ann Jamieson	**Number of registered places:** 43 Maximum number of 43 service users with 31 persons within categories NH-MP and MP(E) and 12 persons within category NH-DE accommodated within the dementia 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:** 43
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 43 patients. The home is divided into three units. The Beech unit provides nursing care for patients living with dementia. The Sycamore and Oak units provide nursing care for patients living with a mental illness. All three units are located on the ground floor. Patients have access to communal lounges, dining rooms and a garden. There is a Residential Care Home on the same site which occupies part of the ground floor; the manager has managerial responsibility for both the nursing and residential service.	

2.0 Inspection summary

An unannounced inspection took place on 16 May 2022, from 9.30am to 7.15 pm by a care inspector and continued on 22 June 2022 from 10.45am to 11.45am by a finance inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

We found that there was safe, effective and compassionate care delivered in the home and the home was well led by the Manager.

The home was warm, clean and comfortable. Patients were well presented in their appearance and appeared happy and settled in the home. Comments from patients were positive in regards to their interactions with staff and with the food provision in the home. Those patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

New areas requiring improvement were identified and are detailed in section 6.0.

The findings of this report will provide the Manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the Manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection nine patients were spoken with individually and others were engaged in small groups in communal areas. One relative and 17 staff were spoken with. Eight questionnaires were returned from patients, three comments received from patients were discussed with the Manager for her appropriate action as necessary.

The remaining five returned questionnaires contained mostly positive feedback regarding the care and services in Cedarhurst Lodge Nursing Home. The relative we spoke with expressed no concerns about the care their mother received and told us how all the staff are “very good”. We received no feedback from the staff online survey.

Patients spoken with on an individual basis told us that they were happy with the care and services provided in Cedarhurst Lodge.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 29 November 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref: Regulation 30** **Stated: Second time**	The registered person shall ensure that RQIA is appropriately notified of any accident in the home where medical advice is sought.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced this area for improvement has been met.	
Area for Improvement 2 **Ref:** Regulation 13 (7) **Stated:** Second time	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection. This relates specifically to the following: • notices are not displayed in poly pockets.	**Met**
	Action taken as confirmed during the inspection: A number of notices were seen not laminated throughout the home; this was discussed with the Manager and removed on the day of inspection.	

Area for improvement 3 **Ref:** Regulation 27 **Stated:** First time	The registered person shall ensure that the environmental deficits identified during this inspection form part of a time bound refurbishment action plan; this action plan should be available for inspection at all times and evidence meaningful oversight by the manager.	**Not met**
	Action taken as confirmed during the inspection: A refurbishment action plan was not available on inspection and the Manager had limited knowledge of the content of the action plan. The action plan was later emailed to RQIA but lacked sufficient detail regarding timeframes for completion of works. This area for improvement has not been met and will be stated for a second time.	
Area for improvement 4 **Ref:** Regulation 13 (1) (b) **Stated:** First time	The registered person shall ensure that all unwitnessed falls are managed in line with best practice guidance: This specifically relates to: • The consistent recording of neurological observations • If observations are stopped before the recommended timeframe a clear rationale must be recorded • Falls risk assessments are reviewed and updated to reflect the fall.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced this area for improvement has been met.	

Area for improvement 5 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that staff are bare below and not wearing jewellery in keeping with best practice guidance.	**Met**
	Action taken as confirmed during the inspection: Staff were observed bare below the elbow on the day of inspection. This area for improvement has been met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 14.25 **Stated:** Second time	The registered person shall ensure that a reconciliation of money and valuables held and 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.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of records confirmed that reconciliations of monies and valuables, managed on behalf of patients, (including monies retained in the patients' bank account) were undertaken on a monthly basis. The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.	
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.	**Met**
	Action taken as confirmed during the inspection: A review of two patients' files evidenced that copies of correspondence forwarded to patients, or their representatives, informing them of changes in the weekly fee were retained in both files. The documents were signed and returned by the patient agreeing to the increase.	

Area for improvement 3 **Ref:** Standard 38 **Stated:** First time	The registered person shall ensure a recruitment checklist is appropriately completed and retained in the home for all staff members employed.	**Not met**
	Action taken as confirmed during the inspection: Recruitment records were not available on site for review. Email review of a number of checklist did not evidence they were completed appropriately. This area for improvement has not been met and will be stated for a second time.	
Area for improvement 4 **Ref:** Standard 41 **Stated:** First time	The registered person shall ensure that the staff duty rota is maintained in keeping with legislation and best practice guidance; and does not evidence the use of white sticky labels.	**Not met**
	Action taken as confirmed during the inspection: Review of the duty rota identified a number of staff were entered on the rota with their first name only and errors or alterations made to the duty rota were not in keeping with best practice guidance. This area for improvement has not been met and will be stated for a second time.	
Area for improvement 5 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure the daily menu is appropriately displayed in all three units.	**Not met**
	Action taken as confirmed during the inspection: The daily menu was not on display in any of the three units. This area for improvement has not been met and will be stated for a second time.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. It was disappointing to see that despite an area for improvement regarding recruitment from the previous inspection, recruitment files were not available on site for review in the nursing home. A number of recruitment checklists were reviewed via email by the inspector after the inspection; the checklists reviewed were not fully completed. An area for improvement is stated for a second time.

There were systems in place to ensure staff were trained and supported to do their job. The Manager had good oversight of staff compliance with the required training.

Review of governance records provided assurance that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or Northern Ireland Social Care Council (NISCC) and that these registrations were effectively monitored by the Manager on a monthly basis.

Any nurse in charge of the home during the Manager's absence should undergo a competency and capability assessment for this role; this helps to ensure that they have the necessary knowledge and understanding prior to taking charge of the home. Review of these competency and capability assessments evidenced that they had not been reviewed on a yearly basis to ensure that nursing staff remained competent to undertake such a role in the absence of the Manager. An area for improvement was identified.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the Manager was not on duty. Deficits were noted in the quality of the duty rota; some staff had been entered onto the rota using their first name only and if corrections or alterations were made to the rota these changes were not made in line with best practice guidance. An area for improvement has not been met and is stated for a second time.

Discussion with staff and observations in the Beech unit identified concerns regarding the high dependency of patients and the number of staff on duty. Staff told the inspector how they feel under pressure particularly in the morning time and have forfeited their breaks on occasion so the needs of the patients can be met. This was discussed with the Manager who agreed to review the staffing and patient dependency in the Beech unit. An area for improvement was identified.

Staff members were seen to respond to patients needs in a timely manner and were seen to be warm and polite during interactions. It was clear through these interactions that the staff and patients knew one another well.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs; and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them. Patients who required care for wounds had this clearly recorded in their care records.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails and alarm mats. It was established that safe systems were in place to manage this aspect of care.

Examination of records and discussion with staff confirmed that the risk of falling and falls were well managed. Review of records showed that staff took appropriate action in the event of a fall, for example, they completed neurological observations and sought medical assistance, if required. The appropriate care records were reviewed and updated post fall.

Patients who were less able to mobilise were assisted by staff to change their position. However, a review of repositioning records evidenced that patients were not always repositioned as prescribed in their care plans. Repositioning booklets and care plans did not identify the assessed repositioning schedule, assessed pressure relieving mattress or setting. An area for improvement was identified.

The dining experience was an opportunity of patients to socialise the atmosphere was calm, and relaxed. It was observed that patients were enjoying their meal and their dining experience. Staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. The patients commented positively about the food. However, it was noted that the menu was not displayed in any of the three units; an area for improvement is stated for second time.

Nutritional assessments had been conducted on a monthly basis by staff using the Malnutrition Universal Screening Tool (MUST), and there was evidence that patients' weights were checked at least monthly to monitor for weight loss or gain. If required, records were kept of what patients had to eat and drink daily.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included a sample of patient bedrooms, communal lounges, dining rooms, bathrooms, the laundry and storage spaces.

There was evidence that some work had commenced towards the refurbishment of the home. Communal areas and bathrooms had been repainted. Work is still ongoing and there are plans to update and redecorate the patient bedrooms in the next phase of the refurbishment plans. The Manager was unsure about the content of the refurbishment action plan for the hone and it was not readily available on inspection. The refurbishment action plan was later emailed to RQIA for review but it lacked sufficient detail regarding timeframes for completion of the work. An area for improvement has not been met and is stated for a second time.

Several pieces of bedroom furniture was observed worn and broken and in need of replacement. This was discussed with the Manager. A follow up telephone call with the Manager confirmed new bedroom furniture has been ordered and will arrive in the next few days.

In two separate areas within the Beech unit cleaning products were observed in areas accessible to patients, this was discussed with the Manager and an area for improvement was identified.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. The fire risk assessment available for review was dated 9 March 2022; a number of required actions were identified. There was evidence that a number of actions had been addressed and work was ongoing to address the remaining actions within the required timeframe. Records of completed fire drills in the home had been maintained and identified which staff had participated.

Review of records, observation of practice and discussion with staff confirmed that training on infection prevention and control measures and the use of PPE had been provided. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

Systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. Environmental infection prevention and control audits had been conducted monthly. All visitors, including health care professionals, to the home had a temperature check and symptom checks when they arrived at the home. They were also required to wear PPE. Visits were by appointment.

5.2.4 Quality of Life for Patients

A programme of activities was available for review in two units and took into account group activities and one to one activities for those patients who could not engage in, or did not wish to engage in, group activity. Patients were seen doing some art and enjoying karaoke on the day of inspection in the Oak and Sycamore units. The Beech unit did not have any structured activity programme or a dedicated activity staff member. Care staff were seen to engage with patients in a compassionate manner within the Beech unit. The provision of activities in the Beech unit was discussed with the Manager and an area for improvement was identified.

5.2.5 Management and Governance Arrangements

There has been a change in the management of the home since the last inspection. Mrs Julie-Ann Jamieson has been appointed as the home manager. RQIA were appropriately informed of this change and an application for her registration is in progress with RQIA.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to residents. There was evidence of auditing across various aspects of care and services provided by the home. A review of the care record audits did not evidence the identified deficits within the action plan had been addressed, it was also observed on two occasions how the registered nurses had audited their care records; to ensure there are no conflict of interest and to ensure the integrity of the audit, the auditor should be independent. This was discussed with the Manager and an area for improvement was identified.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. It was established that systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

It was established that the Manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

Discussion with the Manager in regard to complaints management established that these were well managed and used as a learning opportunity to improve practices and/or the quality of services provided by the home.

The Manager maintained records of regular staff and departmental meetings. The records contained an attendance list and the agenda items discussed. Meeting minutes were available for those staff who could not attend.

The home was visited each month by a representative of the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (April 2015).**

	Regulations	Standards
Total number of Areas for Improvement	4*	6*

*The total number of areas for improvement includes one area under Regulation and three areas under the Standards that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Julie-Ann Jamieson, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that the environmental deficits identified during this inspection form part of a time bound refurbishment action plan; this action plan should be available for inspection at all times and evidence meaningful oversight by the manager. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: The deficits identified on the day have been addressed.The action plan has been updated and is under constant review by the home manager.A copy of the action plan is available in the managers office.
Area for improvement 2 **Ref:** Regulation 20 (1) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall, having regard to the size of the nursing home, the statement of purpose and the number and needs of patients, ensure that at all times suitably qualified, competent and experienced persons are working in such numbers as are appropriate for the health and welfare of patients. This is stated with specific reference to the review of staffing levels within the Beech unit. Ref: 5.2.1
	Response by registered person detailing the actions taken: Staffing is 1:4 which is within the ratio for the Beech unit.An additional member of staff has been put on the Beech unit from 8-2 until the dependency levels have been carried out within the unit. Staffing will then be reassessed.

Area for improvement 3 **Ref:** Regulation 12 (1) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in regards to the repositioning of patients: • that patients are repositioned in keeping with their prescribed care • that repositioning records are accurately and comprehensively maintained at all times • the type of mattress, correct setting and assessed repositioning regime must be documented correctly in patients care plan and repositioning booklets. Ref: 5.2.2
	Response by registered person detailing the actions taken: All staff received supervisions around the importance of repositioning and of accurate record keeping. All mattresses are now included in the patients care plans and repositioning booklet.Face to face training has been provided and all staff reminded regarding their responsibilities to record appropriately. Compliance is being monitored as part of the internal governance system.The Operations Manager and the Home Manager have audited these records.
Area for improvement 4 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that chemicals are not accessible to patients in any area of the home in keeping with COSHH legislation. Ref: 5.2.3
	Response by registered person detailing the actions taken: Training has been provided to housekeeping staff around COSSH by JY Hygiene. All staff were made aware of the importance of correct storage of chemicals.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 38 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure a recruitment checklist is appropriately completed and retained in the home for all staff members employed. Ref: 5.1 and 5.2.1
	Response by registered person detailing the actions taken: The recruitment checklist is now completed and retained within the home.All documents pertaining to this checklist are kept in staff files.Files have been audited during Reg 29s and by the Head of HR.

Area for improvement 2 **Ref:** Standard 41 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that the staff duty rota is maintained in keeping with legislation and best practice guidance. • The duty rota should evidence the full name of all staff working in the home • Alterations or corrections made to the duty rota should be made in accordance with best practice guidance. Ref: 5.1 and 5.2.1
	Response by registered person detailing the actions taken: Rota has been amended to ensure full names and capacity in which staff work. Rota is checked daily to ensure accuracy and person in charge is clearly marked.Staff have been reminded that only the manager and the deputy manager can amend the rotas.The manager and deputy manager are aware that Tippex is not suitable for alterating/correcting the rota.This will be monitored routinely by senior staff that visit the home.
Area for improvement 3 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure the daily menu is appropriately displayed in all three units. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: The Manager has spoken to the catering staff and required them to ensure that the daily menus are displayed in a suitable format with a range of meal choices daily. Manager will monitor this on walk arounds to monitor compliance with this standard.
Area for improvement 4 **Ref:** Standard 41.7 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that competency and capability assessments for nurses in charge of the home in the absence of the Manager are kept up to date and regularly reviewed. Ref: 5.2.1
	Response by registered person detailing the actions taken: All registered nurses have an up to date nurse in charge competency in place and these will be reviewed annually. There is also a tracker in place to aid in identifying when renewal date is due.The home manager will review these monthly and the Operations Manager will review during Reg 29 visits.

Area for improvement 5 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 16 June 2022	The registered person shall ensure a structured programme of activities is developed and implemented following discussion with the patients. Arrangements for the provision of activities should be in place in the absence of an activity co-ordinator. Activities must be an integral part of the care process with daily progress notes reflecting activity provision. This is stated with specific reference to the provision of activities in the Beech unit. Ref: 5.2.4
	Response by registered person detailing the actions taken: Activity co-ordinators (PALS) have to produce a weekly Activity Planner on a Monday morning for the home manager to check over. PALS spread their times over the three units.Care staff in the units are also to provide activities in the absence of the PALS.Senior staff within the units will oversee activities and the manager will monitor activities on her daily walk around.
Area for improvement 6 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 30 June 2022	The registered person shall ensure that a robust system of audits is maintained to promote and make proper provision for the nursing, health and welfare of patients. Such governance audits shall be completed in accordance with legislative requirements, minimum standards and best practice. This is stated with specific reference to care plan audits: • Registered nurses should where possible not audit their own work • Where deficits have been identified there should be evidence that these have been addressed within an agreed timeframe. Ref: 5.2.5
	Response by registered person detailing the actions taken: Care plan matrix has been introduced to ensure that all care plans are audited within correct time frame.Peer review has been introduced to ensure that nurses no longer audit their own care plans. Home manager to review monthly.OM to review when completing Reg 29 visits.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care