Unannounced Care Inspection Report
17 June 2019

Woodmount

Type of Service: Nursing Home (NH)
Address: 15 Melmount Road, Strabane BT82 9ED
Tel No: 028 7188 4234
Inspector: Michael Lavelle

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 is registered to provide nursing care for up to 32 persons.

3.0 Service details

Organisation/Registered Provider: Woodmount Responsible Individual(s): Alfred Lindsay Woods	Registered Manager and date registered: Amanda Craig 8 April 2016
Person in charge at the time of inspection: Amanda Craig	**Number of registered places:** 32
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 30

4.0 Inspection summary

An unannounced inspection took place on 17 June 2019 from 07.30 to 14.40.

The inspection assessed progress with any areas for improvement identified during and 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.

Evidence of good practice was found in relation to staffing, training, supervision and appraisal and communication between residents, staff and other key stakeholders. Further areas of good practice were found in relation to the culture and ethos of the home, governance arrangements, management of incidents, quality improvement and maintaining good working relationships.

No areas requiring improvement were identified.

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

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

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Amanda Craig, registered manager, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent inspection dated 8 January 2019

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 8 January 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

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 including 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 weeks commencing 10 June 2019 and 17 June 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- nurse in charge competencies
- one staff recruitment and induction file
- three patient care records
- a selection of patient care charts including reposition charts
- a sample of governance audits/records
- environment and equipment cleaning records
- complaints record and compliments received
- staff supervision and appraisal planner
- annual quality report
- falls policy
- a sample of reports of visits by the registered provider
- RQIA registration certificate.

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

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

6.0 The inspection

6.1 Review of outstanding areas for improvement from previous inspection

Areas of improvement identified at the previous care inspection have been reviewed and are met.

6.2 Inspection findings

6.3 Is care safe?

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

We arrived at the home at 07.30 hours and were greeted by the nurse in charge who was friendly and welcoming. They confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for weeks commencing 10 June 2019 and 17 June 2019 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the

nursing and care staff. The registered manager should clearly identify which hours are worked by the activity co-ordinator in the home on the staffing rota.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patient's needs. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Woodmount.

Review of one staff recruitment file confirmed staff were recruited in accordance with relevant statutory employment legislation and mandatory requirements. Appropriate pre-employment checks are completed and recruitment processes included the vetting of applicants to ensure they were suitable to work in the patients in the home. Review of the recruitment file and discussion with the registered manager evidenced that gaps in employment had been explored but not recorded. We reminded the registered manager to ensure they explore and record all gaps in employees' employment history.

Staff spoken with said they completed a period of induction alongside a mentor and they would actively support new staff during their induction to the home. Review of records confirmed that a comprehensive induction was given to one recently recruited employee. Review of records evidenced the registered manager had a robust system in place to monitor staffs registration with their relevant professional bodies.

Review of records and discussion with staff and the manager confirmed that staff training, supervision and appraisal was well maintained and actively managed.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

We reviewed accidents/incidents records since January 2019 in comparison with the notifications submitted by the home to RQIA. Records were maintained appropriately and notifications were submitted in accordance with regulation. One head injury had not been notified. This was discussed with the registered manager and submitted to RQIA retrospectively on the day of the inspection.

Records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. If required, an action plan was devised to address any identified deficits. This information was also reviewed as part of the monthly monitoring visits.

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control measures were generally well adhered to. Staff were knowledgeable in relation to best practice guidance with regards to hand hygiene and use of personal protective equipment (PPE) and were observed to wash their hands/use alcohol gels and use PPE at appropriate times. Cleaning records were reviewed and were well completed. We observed one example of poor practice where a staff member did not adhere to standard precautions. This was discussed with the staff member and registered manager for action as required.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices. There was also evidence of consultation with relevant persons. Care plans were in place for the management of restrictive practices including bedrails and buzzer mats.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm and well decorated.

Fire exits and corridors were observed to be clear of clutter and obstruction. Stairwells were also observed to be clear. Records evidenced that systems were in place to manage and record fire drills and fire alarm tests within the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

6.4 Is care effective?

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

Review of three patient care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process. Generally care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of infection, weight loss, falls and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Review of wound management for one patient evidenced that when a wound was identified, an initial wound assessment was completed and a wound care plan developed to direct the care in managing the wound in keeping with the tissue viability nurse (TVN) recommendations. Body maps were completed identifying the location of the wound and wound observation charts completed to monitor the progress of the wound at the time of wound dressing. However, wound evaluations were not always well completed and we identified two examples where the dressing was not renewed in keeping with prescribed care. This was discussed with the registered manager who agreed to have supervision with registered nurses in relation to wound management. This will be reviewed at a future care inspection.

We encouraged the registered manager to ensure that patient care records and documentation used by kitchen staff reflect the new international dysphasia diet standardisation initiative (IDDSI) terminology which came into effect in April 2019.

Minor deficits were identified in relation to record keeping in some care records and supplementary care records, particularly repositioning records. This was discussed with the registered manager for action as required. This will be reviewed at a future care inspection. Care records reflected that, where appropriate, referrals were made to healthcare professionals such as General Practitioners (GPs), tissue viability nurse (TVN), dietician, chiropodist, optician and speech and language therapists (SALT). There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals.

We observed the serving of the mid-morning snacks and midday meal. Patients were assisted to the dining room and staff were observed assisting patients with their meal appropriately. Patients appeared to enjoy the mealtime experience and were offered a choice of meals and drinks. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Review of the menu evidenced that planned meals had been adhered to.

Discussion with staff evidenced they were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they would raise theses with the registered manager or the nurse in charge. When we spoke with staff they had a good knowledge of patients' abilities and level of decision making; staff know how and when to provide comfort to patients because they know their needs well.

All grades of staff consulted with demonstrated the ability to communicate effectively with their colleagues and other health care professionals.

Discussion with registered manager and review of records confirmed that staff meetings were held regularly and records maintained. Records also evidenced recent patient meetings held in January 2019 and May 2019 and minutes were available.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between residents, staff and other key stakeholders.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care compassionate?

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

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff and review of the activity programme displayed in the lounge area evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. Excursions were also planned for later in the month. Discussion with the activity co-ordinator confirmed ongoing art therapy for patients in the home that has been funded by the local council. We observed patients painting vases they made in the afternoon and much of the work they did was on display in the home. Review of records confirmed contemporaneous records were kept by the activity co-ordinator of all activities that take place, with the names of the person leading them and the patients who participate. We discussed the time allocated for activities and the need for registered nurses to review activities as part of the care process with the registered manager. They agreed to review this with staff. This will be reviewed at a future care inspection.

The environment in the home had been adapted to promote positive outcomes for the patients. Many of the bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. The dining room was attractively set with table clothes and flowers and we saw clocks within the home along with prompts for the date and weather.

We reviewed the compliments file within the home. Some of the comments recorded included:

"Thanks very much for the care and attention given to …. during her stay in Woodmount."
"Lots of thanks for all the care you gave my mother in her few weeks. Heartfelt thanks."

Consultation with 10 patients individually, and with others in smaller groups, confirmed they were happy and content living in Woodmount. Some of the patient's comments included:

"They are very good to me in here."
"I am happy here."
"The girls are lovely. It is very homely here."
"I am dying about this place. I am very content and happy."
"The carers are very kind. I couldn't say nothing bad, they are very good. I have no complaints. They deserve more money."
"They are looking after me fairly well."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Five relative questionnaires were provided; we had one response within the timescale specified. The respondent was very satisfied with care across all four domains. Two relatives were spoken with during the inspection. Some of the comments received included the following:

"It is 100 percent. One of the best homes I have ever been in. They have music, pottery work and painting."
"It is very good. The staff are friendly and good. The patients are well looked after."

Staff were asked to complete an online survey; we received no responses within the expected timeframe. Six members of staff were spoken with during the inspection. Some of the comments received included the following:

"I have no concerns. The manager is approachable."
"I love it here. Everyone is so friendly. The manager is a nice woman."
"We have great teamwork and there is great communication."

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

We reviewed the annual quality report for 2018 which was completed in January 2019. It was very well written and presented and reflected well on the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

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

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. We reminded the registered manager that any hours worked as a nurse should be clearly recorded on the staffing rota. Discussion with staff, patients and visiting professionals evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

There was evidence of good management oversight of the day to day working in the home. A number of audits were completed to assure the quality of care and services; areas audited included wounds, care plans, hand hygiene and accidents and incidents. Audits generated action plans that highlighted areas for improvement and there was evidence that the deficits identified were actioned as required.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. Review of records evidenced that quality monitoring visits were completed on a monthly basis on behalf of the responsible individual in accordance with the relevant regulations and standards. We recommended that the registered provider use unique identifiers on completion of monthly monitoring reports and ensure that any actions identified as part of their visit are reviewed at the subsequent visit.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed appropriately in line with best practice guidance. Patients spoken with said they would be confident if they raised a complaint that it would be dealt with accordingly.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

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

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

The **Regulation** and **Quality Improvement Authority**

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

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