Unannounced Care Inspection Report
28 February 2017

Woodmount

Type of Service: Nursing Home
Address: 15 Melmount Road, Strabane, BT82 9ED
Tel no: 028 7188 4234
Inspector: Bridget Dougan

1.0 Summary

An unannounced inspection of Woodmount took place on 28 February 2017 from 14.00 to 17.00.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The focus of the inspection was meals, mealtimes and nutrition.

Is care safe?

There was evidence of competent and safe delivery of care on the day of inspection. Staff, patients and relatives expressed no concerns regarding staffing levels. There was evidence that staff had attended mandatory training and other training relevant to their roles and responsibilities. A recommendation has been made for update training in the management of patients with swallowing difficulties for all relevant staff.

Is care effective?

Care records reflected the assessed needs of patients' were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals. There was evidence that the care planning process included input from patients and/or their representatives, as appropriate.

Each staff member understood their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager.

There were no requirements or recommendations made.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients were given a choice in regards to food and fluid choices and the level of help and support requested.

There were no requirements or recommendations made.

Is the service well led?

Systems were in place to monitor and report on the quality of nursing and other services provided. Complaints, incidents and accidents were managed in accordance with legislation.

There were no requirements or recommendations made.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Amanda Craig, registered 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 13 September 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Woodmount/Mr Alfred Lindsay Woods and Mrs Roberta Jillian Woods	**Registered manager:** Mrs Amanda Craig
Person in charge of the home at the time of inspection: Mrs Amanda Craig	**Date manager registered:** 08/04/16
Categories of care: NH-I, NH-PH, NH-PH (E)	**Number of registered places:** 32

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection

- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection we met with 25 patients, two registered nurses, four care staff, one catering and one domestic staff.

Six questionnaires were also issued to patients, staff, and relatives. Refer to section 4.5.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- accident and incident records
- notifiable events records
- complaints and compliments records
- sample of audits
- policy on meals and mealtimes.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 13 September 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and was validated at this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 13 September 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 19 (2) **Stated:** First time **To be completed by:** 30 September 2016	The registered provider must ensure that a record of all complaints has been maintained and is available for inspection in the home at all times.	**Met**
	Action taken as confirmed during the inspection: A record of all complaints had been maintained and was available for inspection. Refer to section 4.6 for further details.	

Requirement 2 **Ref**: Regulation 14 (4) **Stated:** First time **To be completed by:** 30 September 2016	The registered provider must make arrangements, by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse. **Action taken as confirmed during the inspection**: Training records evidenced that 15 staff had attended adult safeguarding training on 17 October 2016.	**Met**
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 17.1 **Stated:** Second time **To be completed by:** 30 September 2016	**This recommendation was not reviewed during this inspection and has been carried forward for review at a future inspection.** The registered provider should ensure that care records are audited, using a robust system that provides traceability of audit. **Action taken as confirmed during the inspection**: The registered manager had developed an audit tool and there was evidence that care records were audited on a monthly basis. An action plan was in place to address any deficits identified.	**Met**
Recommendation 2 **Ref**: Standard 39.4 **Stated:** Second time **To be completed by:** 30 November 2016	The registered person should ensure that staff receives further training in developing and reviewing care plans. **Action taken as confirmed during the inspection**: Registered nurses attended training on developing and reviewing care records in November 2016.	**Met**
Recommendation 3 **Ref**: Standard 13.6 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that all incidents of actual, alleged or suspected abuse are promptly reported in line with Departmental policy on adult safeguarding. **Action taken as confirmed during the inspection**: There was evidence that all incidents of actual, alleged or suspected abuse had been promptly reported in line with Departmental policy on adult safeguarding.	**Met**

4.3 Is care safe?

The registered manager 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 rotas for the weeks commencing 13, 20 and 27 February 2017 evidenced that the planned staffing levels were adhered to.

Discussion with patients, staff and two relatives evidenced that there were no concerns regarding staffing levels.

Review of the training matrix/schedule for 2016/17 indicated that all staff had completed mandatory training to date. All relevant staff had also attended food hygiene training in April 2016 and enteral feeding training had been provided for five registered nurses in May 2016. Additional training in the management of patients with swallowing difficulties had been attended by five care staff in March 2016. The registered manager agreed that further update training in food thickeners/the management of swallowing difficulties should be provided for all relevant staff. A recommendation has been made in this regard. Staff consulted with and observation of care delivery and interactions with patients, clearly demonstrated that knowledge and skills gained through training and experience were embedded into practice.

There was evidence of a nutritional policy dated March 2016 and a system was in place to ensure all relevant staff had read and understood the policy. Up to date nutritional guidelines were available and used by staff on a daily basis.

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, well decorated, fresh smelling and clean throughout.

Fire exits and corridors were observed to be clear of clutter and obstruction and equipment was appropriately stored.

Areas for improvement

One recommendation has been made in respect of update training in the management of patients with swallowing difficulties

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

Review of three patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that care had been assessed, planned, evaluated and reviewed in accordance with NMC guidelines. Risk assessments informed the care planning process.

Care records reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff confirmed that if they had any concerns, they could raise these with the registered manager.

Patients and their representatives expressed their confidence in raising concerns with the home's staff/management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Observation of the afternoon tea confirmed that patients were given a choice in regards to food and fluid choices and the level of help and support requested. The daily menu was displayed in the dining room and offered patients a choice of two meals for lunch and dinner. A choice was also available for those on therapeutic diets. A choice of cakes and biscuits was available for afternoon tea, with alternatives available for those on therapeutic diets. A pancake making demonstration took place to mark 'Pancake Tuesday' and patients enjoyed warm pancakes with a selection of toppings.

Where patients required assistance with meals, staff were observed to offer patients reassurance and assistance in a discreet, unhurried and sensitive manner.

Patients spoken with were complimentary regarding the care they received and life in the home. Those 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.

As part of the inspection process, we issued questionnaires to staff, patients and patients' representatives. Six staff and two relatives completed and returned questionnaires within the required time frame. Some comments are detailed below.

Staff

- "Staff all work well as part of a team."
- "I really enjoy working here"
- "the residents are well looked after, I have no concerns"

Relatives

Relatives indicated that they were either "very satisfied" and/or "satisfied" that the care was safe, effective and compassionate and the home was well led. No additional written comments were received.

Areas for improvement

No areas for improvement were identified during the inspection

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities.

The certificate of registration issued by RQIA was displayed in the home. Discussion with the registered manager, a review of care records and observations confirmed that the home was operating within its registered categories of care.

Review of the home's complaints records and discussion with the registered manager evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

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.

There was evidence that a range of audits had been completed on a monthly basis, including care records, medication management, patients' weights and nutrition. Action plans were in place to address any deficits.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Amanda Craig, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements - None

Recommendations	
Recommendation 1 **Ref**: Standard 12.9 **Stated:** First time **To be completed by:** 30 April 2017	The registered provider should ensure that all relevant staff receives updated training in the management of feeding techniques for patients who have swallowing difficulties. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** Updated training has been planned for the end of April for Thick N Easy for all relevant staff.

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

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