Unannounced Follow-up Care Inspection Report
21 January 2019

Railway Lodge Care Home

Type of Service: Nursing Home
Address: 299 Kingsway, Dunmurry, Belfast BT17 9EP
Tel No: 028 9060 9930
Inspector: Lyn Buckley

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 provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 69 persons.

3.0 Service details

Organisation/Registered Provider: Healthcare Ireland (Belfast) Limited **Responsible Individual:** Ms Amanda Celine Mitchell	**Registered Manager:** Mrs Karen Agnew
Person in charge at the time of inspection: Karen Agnew – registered manager	**Date manager registered:** 13 April 2018
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. TI – Terminally ill.	**Number of registered places:** 69

4.0 Inspection summary

An unannounced inspection took place on 21 January 2019 from 11.00 to 16.45 hours.

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 (Regulations) and the Care Standards for Nursing Homes 2015 (Standards).

The inspection focused on assessing the level of the progress and compliance with the areas for improvement identified during the last unannounced care inspection on 4 June 2018.

We can confirm that all areas of improvement identified during the June 2018 inspection have been met.

There were no areas for improvement identified during this inspection.

With one exception all those consulted with during this inspection commented positively regarding the care provided, the staffs' caring and respectful attitude, staffing levels and the management arrangements for the home.

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 Karen Agnew, 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

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 3 July 2018. Other than those actions detailed in the QIP no further actions were required to be taken.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- the returned QIP from the previous medicines management inspection.

During the inspection the inspector met with12 patients individually and with others in groups, two patients' relatives and 12 staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. Ten patients' questionnaires and 10 patients' relatives/representatives questionnaires were left for distribution. A poster was provided for staff inviting them to provide feedback to RQIA online. The inspector provided the registered manager with 'Have we missed you' cards which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

A poster informing visitors to the home that an inspection was being conducted was displayed beside the sign in book in the foyer.

The following records were examined during the inspection:

- nursing and care staff duty rotas from 14 to 27 January 2019
- records pertaining to accidents occurring in the home from 1 October 2018
- a sample of governance records

- four patients' care records
- the complaints record
- three staff recruitment and induction records.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 areas for improvement from the most recent inspection dated 3 July 2018

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector. This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 22 June 2018

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 19 (1) and (2)

Stated: First time</td><td>The registered person shall ensure that recruitment and other records referred to in Regulation 19 (1) and (2) are, at all times available for inspection.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of three staff recruitment records evidenced that this area for improvement has been met.</td></tr>
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6.3 Inspection findings

6.3.1 Staffing Arrangements

Discussion with the registered manager confirmed the planned staffing levels for the nursing home. These levels were also subjected to regular review to ensure the assessed needs of the patients were met. This was particularly important given the building work that was ongoing within the home which meant that patients had to be transported to lounges or dining rooms on the other side of the home or on a different floor from where their bedroom was located. Patients said that they were comfortable with the arrangements. Patients affected by the building work noise due to the positon of their bedrooms had been offered alternative accommodation for the duration of the work.

Review of the nursing and care staff duty rotas from 14 to 27 January 2019 evidenced that the planned staffing levels were adhered to. Nursing and care staff confirmed that there was sufficient staff on duty to ensure the needs of patients were met.

Patients and relatives consulted, with the exception of one person, confirmed that they were very satisfied with number of staff on duty and that staff were attentive, caring and respectful.

Observations of the delivery of care evidenced that the needs of patients were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner.

In addition to discussions during the inspection we also consulted patients and relatives via questionnaires. We received three questionnaires within the timeframe specified. Only one person indicated that they were a relative. Two recorded that they were very satisfied that care was safe, effective, and compassionate; and that the home was well led. The third respondent indicated that they were satisfied. There were no additional comments recorded.

Staff spoken with commented positively regarding the care they delivered, staffing arrangements and support from the management team. Staff were also invited, via a poster left with the registered manager, to respond to an online survey. At the time of issuing this report we had received no responses.

Areas for improvement

No areas for improvement were identified.

	Regulations	Standards
Total number of areas for improvement	0	0

6.3.2 Management of Accidents and Incidents

We reviewed accidents and incident records from 1 October 2018 in comparison with notifications received by RQIA. in accordance with Regulations. Records were maintained as required and RQIA were appropriately notified.

We also reviewed patients care records regarding the management of falls. Care records evidenced that when a patient was admitted to the nursing home their history regarding falls

was considered as part of the assessment process. Care plans were then developed to address how the risk of falling was to be managed. In addition, and if required, nursing staff considered the use of equipment such as bedrails or a pressure mat as part of the falls management plan. If equipment was to be put in place the relevant risk assessments and care plans, for the equipment, were also completed.

Review of records evidenced that when a patient sustained a fall, nursing staff delivered the required care and treatment given the patient's condition and reviewed all relevant risk assessments and care plans as part of the post falls analysis process.

The registered manager also undertook a review of all the falls occurring in the home on at least a monthly basis. The data was analysed to identify if any patterns of trends were emerging and/or if further action was required to reduce risk.

Areas for improvement

No areas for improvement were identified.

	Regulations	Standards
Total number of areas for improvement	0	0

6.3.3 Management and Governance Arrangements

Since the last care inspection there has been no change to the management arrangements for the home. RQIA had been informed regarding ongoing refurbishment and building works and the current phase of works would be reviewed by RQIA when completed as part of our registration process. The registered manager confirmed that she was keeping patients and relatives informed of progress with the building works. As discussed in section 6.3.1 staffing levels were also kept under review to ensure the needs of patients were met.

We reviewed the governance arrangements in relation to infection prevention and control measures, management of falls, management of complaints, management of restraint such as bedrails and/or pressure mats and care records.

The registered manager had a system and process in place to review each of the areas examined and records were maintained which evidenced that were deficits were identified through the audit process; action plans were developed to address them.

The registered manager also held 'overview' records pertaining to the number and type of restraint equipment in use and the number, type and origin of any wound or pressure ulcer sustained by a patient. These records enabled the registered manager to ensure that patients received effective care and treatment and that care plans were reviewed regularly to reflect patients' assessed needs and any recommendations made by other healthcare professionals such as the tissue viability nurse (TVN).

Review of the home's complaints record evidenced that systems were in place to ensure that any concerns expressed by patients, relatives, members of the public and/or staff, regarding the care of patients or about services delivered in the nursing home, were managed appropriately. Complaints were also audited as part of the governance arrangements on at least a monthly basis. Any learning or deficits identified were discussed with staff and action plans developed to drive improvement as required.

Areas for improvement

No areas for improvement were identified.

	Regulations	Standards
Total number of areas for improvement	0	0

6.3.4 Patient Care Records

We reviewed four patients' care records in relation to the admission process, management of falls, management of wounds, and the management of pressure area care.

Care records reflected that where appropriate, referrals had been made to other healthcare professionals such as GPs or TVNs. Care charts such as repositioning charts evidenced that contemporaneous records were maintained. As stated previously care plans and risk assessments were reviewed regularly.

Areas for improvement

No areas for improvement were identified.

	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

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