Unannounced Care Inspection Report
11 October 2016

Manor Lodge

Type of Service: Nursing Home
Address: 5 The Manor, Blacks Road, Dunmurry, BT10 0NB
Tel no: 028 9062 9331
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Manor Lodge took place on 11 October 2016 from 09.30 to 16.30 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

There were systems in place to monitor staff performance and compliance with mandatory training. The staff consulted with were knowledgeable about their specific roles and felt that the training they had recently undertaken in accordance with the organisations Dementia Care Framework had been beneficial to patients and to themselves. The home was clean, well decorated and warm throughout. Infection prevention and control measures were adhered to and fire exits and corridors were maintained clear from clutter and obstruction.

Is care effective?

A range of risk assessments were completed and the outcomes were reflected in the care plans. There was evidence that patient care records had been audited and where shortfalls had been identified remedial action had taken place. Communication was well maintained in the home and all those consulted with expressed their confidence in raising concerns with the home's staff/ management. The patients' dining experience had improved however a recommendation has been stated for the second time regarding ensuring patients who require a modified diet are afforded choice at mealtimes.

Is care compassionate?

Staff interactions were observed to be compassionate, caring and timely and all patients and relatives consulted with provided positive comments in relation to the care. Patients, relatives and staff were very positive in their comments and staff, in particular stated that "things are much better now". Communication systems were stated to have improved with nursing staff discussing the patients' wellbeing with care staff on a daily basis. Care staff found this helpful and supportive. The arrangements for the provision of activities had improved.

Is the service well led?

All comments received in relation to the care afforded to patients and the responsiveness of the manager were positive. The home was observed to be operating within the categories of care for which the home is registered. RQIA had been informed appropriately of any notifiable incidents and there were systems in place to review urgent communications, safety alerts and notices where appropriate. There were systems in place to monitor and report on the quality of nursing and other services provided

The term 'patients' is used to describe those living in Manor Lodge which provides both nursing and residential care

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*

*Refers to a recommendation stated for the second time

Details of the Quality Improvement Plan (QIP) within this report were discussed with Shily Paul, temporary acting 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 medicines management inspection undertaken on 15 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: Four Seasons Healthcare Dr Claire Royston	**Registered manager:** Shily Paul
Person in charge of the home at the time of inspection: Shily Paul	**Date manager registered:** Acting – No application
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI, NH-DE, RC-I	**Number of registered places:** 39

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, care delivery/care practices were observed and a review of the general environment of Suffolk suite was undertaken. The inspector also met with eight patients individually, two care staff, the activities coordinator, one registered nurse, three patient's representatives and two representatives of the resident experience team of Four Seasons Healthcare.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- two patient care records
- staff training records
- accident and incident records
- notifiable incidents
- quality audits
- activities records
- complaints records
- staff supervision and appraisal planner

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 September 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection

4.2 Review of requirements and recommendations from the last care inspection dated 30 June 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 12 (1) (b) and (c) **Stated:** First time	The registered person must ensure the environment of the home and the delivery of dementia care reflects current best practice guidelines for dementia care. A dementia audit should be completed and an action plan developed and implemented based on the findings of the audit.	**Met**
	Action taken as confirmed during the inspection: A dementia audit was completed in July 2016 to establish a baseline. Actions taken following the audit included; external garden area for patients had been enhanced and tidied, new signage was ordered, attention was given to the two lounge areas for patients and they presented as more comfortable and the dining room was upgraded. The appearance of the environment had noticeably improved.	
Requirement 2 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time	The registered person must ensure that an on-going programme of staff training in relation to dementia practice is undertaken by staff and a robust system is established that evidences training undertaken by staff is embedded into practice.	**Met**
	Action taken as confirmed during the inspection: The organisations dementia care framework initiative had commenced in the home. Staff are required to complete training in dementia practice by January 2017. The review of staff training records evidenced that the training schedule, in place, to achieve this was on target.	
Requirement 3 **Ref:** Regulation 20 (1) (a) **Stated:** First time	The registered provider must ensure that the staffing and deployment arrangements; including the number, competency and experience of staff in Suffolk unit is appropriate for the health and welfare of patients and embodies best practice in dementia care.	**Met**
	Action taken as confirmed during the inspection: Staffing arrangements within Suffolk unit were reviewed. There was a 'core' team of nursing and care staff rostered for day duty. These staff were undertaking the training in accordance with the dementia care framework. Night duty remains problematic however the organisation was recruiting for permanent nursing staff at the time of the inspection.	

Requirement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered provider must ensure that the administration of medicines is completed in a safe and timely manner and registered nurses are competent in the safe administration of medicines.	**Met**
	Action taken as confirmed during the inspection: The administration of medications was observed to have been completed in a timely manner. The medicines management competency assessment for registered nurses had been reassessed by the temporary acting manager.	
Requirement 5 **Ref:** Regulation 18 (2) (n) **Stated:** First time	The registered provider must ensure that a meaningful activities programme is available for patients. The activities programme must be appropriately resourced and must be developed to meet the range of patient needs and their known likes and dislikes.	**Met**
	Action taken as confirmed during the inspection: The arrangements for the provision of activities had been reviewed. Two personal activities leaders are employed and the review of the activities records evidenced that a structured approach had been established. Life story work had been completed by the activities leaders and records were being maintained, on an individual basis of any activity a patient had participated in. In discussion with the manager it was advised that the activities leaders are more specific when recording the actual activity a patient engaged in.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 43 **Stated:** Second time	The registered provider should ensure that the communal areas in the dementia unit should be readily accessible for patients to use; this includes the two lounge areas and the outside patio/paved area.	**Met**
	Action taken as confirmed during the inspection: An inspection of the environment of the home confirmed that improvements had been made to the lounge areas and the outside garden/patio area had been tidied. The appearance of the garden area had been enhanced with flowers, shrubs and seating.	

Recommendation 2 **Ref:** Standard 43 **Stated:** Second time	The registered provider should ensure that patients in the nursing unit have a choice of which lounge they wish to use. Soft furnishings should be purchased to enhance the appearance of these areas.	**Met**
	Action taken as confirmed during the inspection: An inspection of the environment of the home confirmed that improvements had been made to the lounge areas. New furniture had been purchased and the appearance of both lounge areas was more inviting and comfortable for patients.	
Recommendation 3 **Ref:** Standard 4.9 **Stated:** First time	The registered provider should ensure that any information in relation to patients' wellbeing is reviewed by registered nurses and actioned, where appropriate, on a daily basis. Evidence should be present, in the daily progress records, that registered nurses have reviewed and acted on, where applicable, any supplementary information maintained on behalf of patients.	**Met**
	Action taken as confirmed during the inspection: Discussion with registered nurses and care staff and a review of supplementary care records evidenced that a more robust system to the recording and monitoring of this information had been established. Personal care records completed by care staff were retained in the nurses' office and registered nurses review the records daily and discuss the wellbeing of individual patients with care staff on a daily basis.	
Recommendation 4 **Ref:** Standard 4.10 **Stated:** First time	The registered person should ensure that a robust system regarding the auditing of patients care records is established and where a shortfall is identified the care record is re-audited to ensure that remedial action has taken place.	**Met**
	Action taken as confirmed during the inspection: The review of patient care records evidenced that all care records had been audited and where a shortfall had been identified the remedial action taken to address the shortfall was in evidence.	

Recommendation 5 **Ref:** Standard 37.1 **Stated:** First time	The registered person should ensure that any record retained in the home which details patient information is stored safely and in accordance with DHSSPS policy, procedures and guidance and best practice standards.	**Met**
	Action taken as confirmed during the inspection: As stated in recommendation 3, supplementary care records which are maintained by care staff are now retained in the office within the dementia suite. This documentation is no longer stored or available in the lounge areas of the home.	
Recommendation 6 **Ref:** Standard 12 **Stated:** First time	The registered person must ensure that the dining experience for patients reflects current best practice guidelines for dementia care. The manager must ensure staff adhere to best practice guidelines at all times.	**Met**
	Action taken as confirmed during the inspection: The serving of the midday meal was observed. Dining tables were attractively set with condiments available on each table. Brightly coloured crockery was used to provide a colour contrast to the table and enhance the visual experience for patients. Written menus were on each table and a pictorial menu was also on the wall of the dining room. .An audit of the patients dining experience had been completed in August 2016 and will be undertaken again in six months' time in accordance with the organisations policy.	
Recommendation 7 **Ref:** Standard 12.13 **Stated:** First time	The registered provider should ensure that patients who require a specialised diet are afforded a choice of meal at each mealtime.	**Partially Met**
	Action taken as confirmed during the inspection: During the observation of the serving of the midday meal we were unable to confirm if patients who required a modified diet were afforded choice at mealtimes. This was discussed with the manager who agreed to review the arrangements.	
Recommendation 8 **Ref:** Standard 39.7 **Stated:** First time	The registered provider should ensure that a robust system is established that evidences training undertaken by staff is embedded into practice.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of the supervision planner confirmed that staff receive individual supervision on a regular basis.	

Recommendation 9 **Ref:** Standard 6.14 **Stated:** First time	The registered provider should ensure that the personal care afforded to patients is monitored on a daily basis by the manager or clinical lead until such times as the manager is satisfied with the standard of personal care delivery.	**Met**
	Action taken as confirmed during the inspection: As stated in recommendation 3 the discussion with registered nurses and care staff and a review of supplementary care records evidenced that a more robust system to the recording and monitoring of this information had been established. Personal care records completed by care staff are retained in the office and registered nurses review the records daily and discuss the wellbeing of individual patients with care staff on a daily basis.	

4.3 Inspection findings

The focus of this inspection was to review the progress made in relation to the requirements and recommendations of the previous inspection. At the time of the previous inspection, 30 June 2016, a number of concerns were in evidence regarding Suffolk suite. Suffolk suite is registered to provide care and support for persons living with dementia.

Discussion with staff and a review of the staff training records confirmed that training in respect of dementia care practice had commenced. The organisations Dementia Care Framework programme had been commenced in the home in September 2016 and the home has 18 weeks to complete the programme. Staff training is included with the focus being for staff to understand living with dementia from the perspective of the person. Staff commented that the resident experience training had been very beneficial with one staff member commenting, “it really made me think differently.”

Discussion with the manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

The manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. The review of the duty rota from 3 October to 16 October 2016 confirmed the planned staffing levels were adhered to. The manager stated the staffing in Suffolk suite, particularly during the day time period had stabilised and there was continuity of the staff members and a Sister had been appointed in Suffolk suite to oversee the provision of care. There were no issues raised by patients, staff or patient representatives regarding the staffing arrangements of the home.

Comments received from staff and relatives included:
“It’s good to have a nurse here all the time who really knows the patients.”
“Couldn’t get a better group of staff, so caring.”

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident. Care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken and included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, tidy, well decorated and warm throughout. There was an obvious improvement to the environment including the purchase of new bed linens, furnishings and the garden and patio areas for patients to enjoy had been tidied and enhanced.

The review of patient care records evidenced that care records had been audited and that where a shortfall had been identified remedial action had been taken. The care records reflected the assessed needs of patients were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

The manager stated that care records had been audited using a quality auditing tool which had been developed specifically in relation to dementia care and as part of the Dementia Care Framework programme.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. Supplementary personal care records are now retained in the nurses' office and are reviewed by nursing staff on a daily basis.

Observation of the mid-day meal confirmed that dining tables were attractively set and a range of condiments were available. Meals were delivered on trays to patients who choose to not come to the dining room, the meal was appropriately covered and condiments and the patients preferred choice of drink , for example; juice or milk were on the tray. The meal time was not rushed in any manner and there were sufficient staff on duty to assist patients with their meal. A registered nurse was present in the dining room to assist and monitor patients' nutritional intake. The day's menu was displayed on the dining room tables and a pictorial menu was also displayed on the wall of the dining room. Two issues arose in relation to the dining experience. Firstly the record of menu choice for 12 October 2016 had already been completed by 11.30 hours on 11 October 2016. The manager should review the timing of the completion of the menu choice record and ensure this is completed in a manner/time conducive to the patients; this was discussed and agreed with the manager at the time of the inspection. Secondly we were not able to confirm that patients, including patients who required a modified diet, were afforded a choice of meals at mealtimes. This was discussed with the manager and was a recommendation of the previous inspection of 30 June 2016. The recommendation has been stated for a second time.

The mid-morning tea trolley was also observed. Patients were offered a choice of snack including fresh fruit, yoghurts and biscuits.

The arrangements for the provision of activities was reviewed. The home has two personal activities leaders (PAL), one of whom is designated to work solely in Suffolk suite. A more robust approach to the planning of the activities programme had been established and the activities leaders had completed life story/history information regarding patients to assist with the planning process. Individual records were maintained on a daily basis, discussion took place with the manager to regarding the recording of the activities patients participated in as it was unclear when viewing the record. The manager agreed to do this.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. At the time of issue of this report there were no completed questionnaires returned. However, comments received from relatives during the inspection included:
"Staff are wonderful, couldn't get better."
"Staff have helped us so much."

Comments received from staff during the inspection included:
"Things are much better."
"The nurse (Sister) checks with us every day about how the patients are."

Discussion with the manager and staff, and a review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. Audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints and incidents/accidents. The results of these audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

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

Areas for improvement
The manager should also review the arrangements for ensuring that patients who require a modified diet are afforded choice at mealtimes. This recommendation is stated for the second time.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with, Shily Paul, temporary 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 via web portal 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

Recommendations	
Recommendation 1 **Ref:** Standard 12.13 **Stated:** Second time **To be completed by:** 30 November 2016	The registered provider should ensure that patients who require a specialised diet are afforded a choice of meal at each mealtime. **Response by registered provider detailing the actions taken:** This has been addressed.There are two choices available for specialised diet and the patients are asked for their choice at meal time.

Please ensure this document is completed in full and returned via web portal

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