Unannounced Care Inspection Report
10 May 2017

Woodgrove

Type of Service: Nursing Home
Address: 67 Hillsborough Road, Lisburn, BT28 1 JN
Tel no: 028 9260 7302
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Woodgrove took place on 10 May 2017 from 09:15 to 16:15.

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?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies, staff training and development and the environment. Observation of the delivery of care and discussion with patents and staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The acting manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns.

A review of the home's environment was undertaken. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Infection prevention and control measures were adhered to. Sluice rooms and bathroom/toilets were observed to be clutter free and well organised.

We discussed the management of fire safety and were assured that fire checks were completed weekly. Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no areas for improvement identified in the delivery of safe care.

Is care effective?

We reviewed four care records and evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences. Areas for improvement were identified with the completion of body maps and the recording of wound care; two recommendations were made.

Discussion with the acting manager and staff evidenced that nursing and care staff 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 with care staff.

Is care compassionate?

We arrived in the home at 09:15 and were greeted by staff who were helpful and attentive. Patients were enjoying their breakfast in the dining room or in their bedrooms as was their personal preference; some patients remained in bed, again in keeping with their personal preference.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. All of the patients spoke highly of the staff. A number of their comments are included in the report.

We spoke with two relatives; both were satisfied with the standard of care, communication with staff and spoke highly of the care. Numerous compliments had been received and were displayed in the home in the form of thank you cards. A number of them are included in this report.

We reviewed the provision of activities and were informed by patients that they looked forward to the different events that were planned throughout the day. We spoke with the PAL who was well motivated and enthusiastic regarding their role in the home. A copy of the weekly activity programme was displayed throughout the home and included events to meet the patients' religious wishes.

There were no areas for improvement identified in the delivery of compassionate care.

Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff evidenced that there was a clear organisational structure in the home. In discussion, patients and relatives were aware of the roles of staff in the home and to whom they should speak to if they had a concern.

A review of the duty rota evidenced that the acting manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the manager's working patterns provided good opportunity to allow them to have contact as required.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the regional manager. An action plan was included within the report to address any areas for improvement. The action plan was reviewed at the next visit. A copy of the quality monitoring reports were available in the home.

There were no areas for improvement identified with the well led domain.

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**	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Daniel Oliveira, who had day to day operational responsibility of the home and the recently appointed manager Cherith Douglas, who was completing her induction. 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 12 April 2017. Other than those actions detailed in the QIP there were no further actions required to be taken. There were no further actions required to be taken following the most recent 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 Health Care Dr Maureen Claire Royston	**Registered manager:** See Box Below
Person in charge of the home at the time of inspection: Daniel Oliveira	**Date manager registered:** Daniel Oliveira- Acting – No Application Required
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 32

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with seven patients individually and with the majority in small groups, one registered nurse, three care staff, the housekeeper, one domestic, the Personal Activity Leader (PAL) and two patient's visitors/representative.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from relatives and staff not on duty. Ten staff and patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- duty rota for all staff for the week of the inspection
- 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
- two staff recruitment files
- competency and capability assessments of nurses
- staff register
- four patient care records
- record of staff meetings
- patient register
- complaints record
- record of audits
- RQIA registration certificate
- certificate of public liability insurance
- monthly monitoring reports

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 April 2017

The most recent inspection of the home was an unannounced medicines management inspection. There were no issues identified during this inspection, and a QIP was neither required, nor included, as part of this inspection report.

4.2 Review of requirements and recommendations from the last care inspection dated 17 October 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 4 **Stated:** First time	The registered provider should ensure that the care record in relation to an identified patient is updated with input from the patient's representative to reflect changing care needs.	**Met**
	Action taken as confirmed during the inspection: The acting manager confirmed that this care record had been reviewed as recommended at the time of the previous inspection. A review of care records evidenced that they were updated to reflect changing needs. This recommendation has been met.	

4.3 Is care safe?

The acting manager confirmed the planned daily staffing levels for the home and that these levels were calculated using the Care Home Equation for Safe Staffing (CHEST). They confirmed that staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 8 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. A Personal Activity Leader (PAL) was employed to deliver activities. Observation of the delivery of care and discussion with patients evidenced that their needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; two were returned following the inspection. Both of the respondents answered 'no' to the question "Are there sufficient staff to meet the needs of the patients?" One staff commented that extra staff were required in the morning and the other was of the opinion that generally improvement was needed to staffing levels. The comments included were shared with the acting manager.

Patients and relatives spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in timely manner. We sought relatives' opinion on staffing via questionnaires; two were returned in time for inclusion in this report. Both relatives were either very satisfied or satisfied with staffing. One commented that more senior staff were required; this comment was also shared with the acting manager.

A nurse was identified on the staffing rota to take charge of the home when the acting manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. The assessments were signed by the acting manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home. The acting manager confirmed that each assessment was reviewed annually.

A review of two staff recruitment records evidenced that they were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records confirmed that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

A record of staff including their name, address, contact number, position held, contracted hours, date of receipt of Access NI certificate, date commenced and date position was terminated (where applicable) was held and provided an overview of all staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the acting manager. A review of the records of NMC registration evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The record of the checks of care staff registration included the expiry date of their registration with NISCC.

The acting manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe.

We discussed the provision of mandatory training with staff and reviewed the training records for 2016/2017. Training records evidenced good compliance; for example from January 2017 84% of staff had completed fire safety training, 84% adult safeguarding and 90% had completed the theory element of moving and handling. The acting manager confirmed that they had systems in place to facilitate compliance monitoring.

The acting manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the acting manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

Review of four patient 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 risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since January 2017 confirmed that these were appropriately managed. Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. The kitchen was being refurbished at the time of the inspection. The dining room was being used as the kitchen and an area of the downstairs lounge was being used as a dining room. Posters informing visitors of the temporary arrangements were displayed in the home. Patients were well informed regarding the planned work and reported that there had been no significant disruption to their routine. The planned work was scheduled to be completed within five days.

Infection prevention and control measures were adhered to. We spoke with one member of housekeeping staff who were knowledgeable regarding the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths. Sluice rooms and bathroom/toilets were observed to be clutter free and well organised. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

We discussed the management of fire safety with the acting manager who confirmed that fire checks were completed weekly. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

No areas for improvement were identified with the delivery of safe care.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

A review of two care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. A body map had not been completed on admission for either patient, a recommendation was made. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

We reviewed the management of catheter care. Care plans were in place which detailed the frequency with which catheters were due to be changed and systems were in place to alert staff to when the next change was due. One patient's care records evidenced that their catheter was changed in accordance with the prescribed frequency. The patient had a pain assessment in place which was reviewed regularly and reflected that the patient was able to express pain and reliably inform staff if/when they required their pain medication.

We reviewed the management of wound care for two patients. One patient was assessed with a grade one pressure ulcers. Initial wound assessments and care plans were completed. The daily care records did not consistently record the care delivered or an assessment of skin condition. It was unclear from the records if a dressing was required or in place. The registered nurse on duty was knowledgeable of the patient's condition and confirmed that no dressing was required and provided an update on the condition of the patient's skin.

We reviewed the management of wound care for a patient with a grade four pressure ulcer. A care plan was place to direct the care required and an initial wound assessment form completed at the time of each dressing change. A review of completed documentation for the period 7 April 2017 to 6 May 2017 evidenced that the prescribed wound care was adhered to with good detail of the condition of the wound recorded. There were systems in place to remind staff when the dressing was due for renewal. The care plan for maintaining skin integrity evidenced that the patient was able to change their position independently; this was also reflected in in the pressure ulcer risk assessment. On 6 May 2017 the dressing regime had been changed; this was recorded on the initial wound assessment chart but the care plan had not been updated to reflect the change in the dressing regime. Records evidenced that wound care had been consistently delivered and the alternative dressing had been applied on 8 May 2017. Following discussion with the acting manager it was recommended that wounds and wound care should be accurately and consistently recorded for all grades of wounds. Where there is a change to the dressing regime the care plan should be updated to reflect the change.

Discussion with the acting manager and staff evidenced that nursing and care staff 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 reported that there was effective teamwork and that if they had any concerns, they could raise these with the nurse in charge or the registered manager. In one returned questionnaire from staff they commented that due to a change in the handover arrangements they felt they no longer received a proper handover. This comment was discussed with the manager who confirmed that this issue had been raised at a recent staff meeting and action taken to ensure that all staff receive an effective hand over report at the commencement of their shift.

The acting manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most

recent staff meetings were held on 25 January 2017 with registered nurses and 17 January 2017 with care staff. The acting manager explained that now a permanent manager had been appointed meetings would be scheduled with all staff groups in the forthcoming weeks.

A record of patients including their name, religion, address, date of birth, marital status, religion, date of admission, date they left the home (where applicable) and details of where they were transferred to, details of death (where applicable) and the name of the public body responsible for arranging each patients admission was held in a patient register. This registered provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

Body maps should be completed on admission to the home.

Wound care should be accurately and consistently recorded for all grades of wounds. Where there is a change to the dressing regime the care plan should be updated to reflect the change.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

We arrived in the home at 09:15 and were greeted by staff who were helpful and attentive. Patients were enjoying their breakfast in the dining room or in their bedrooms as was their personal preference; some patients remained in bed, again in keeping with their personal preference.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. 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. Discussion with patients individually and with others in smaller groups, confirmed that living in Brooklands was a positive experience. All of the patients spoke highly of the staff. It was evident that patients knew staff and the acting manager well. The following are examples of comments provided by patients:

“I’m happy in the home and when you need the staff they generally come quickly.”
“Things are fine, I have no complaints.”

We spoke with two relatives; both were satisfied with the standard of care, communication with staff and spoke highly of the care. One relative discussed an issue with food and confirmed that they had also discussed these issues previously with the acting manage. With the relatives permission we shared their comments with the acting manager who agreed to discuss the issues further with the relative.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. The following are examples of comments received on thank you cards:

“Thank you for all your care and attention to our … your thoughtfulness and kindness will not be forgotten.”
“We appreciate the work that you do and know that mum was very settled while she was here.”

"With heartfelt thanks for all the care and attention you have shown to … especially in her last hours."

We reviewed the provision of activities and were informed by patients that they looked forward to the different events that were planned throughout the day. We spoke with the PAL who was well motivated and enthusiastic regarding their role in the home. They confirmed that there was wide a variety of activities planned each week. A copy of the weekly activity programme was displayed throughout the home and included events to meet the patients' religious wishes.

Discussion with the acting manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. The home continues to use the "Quality of Life" system which patients, relatives/visitors and staff can access through the portable iPad available in the reception of the home. We reviewed the summary report for the period 1 January2017 – 10 May 2017; there was a total of 35 questionnaires completed by relatives during this period with an overall satisfaction rate of 96%, 46 questionnaires completed by patients with an overall satisfaction rate of 96% and 41 questionnaires completed by staff with an overall satisfaction rate of 78%. The acting manager confirmed that when a questionnaire is submitted they receive an alert by e mail and are required to review the completed questionnaire and respond to any areas for improvement.

We issued questionnaires for ten relatives; two were returned within the timescale for inclusion in this report. Both relatives were either very satisfied or satisfied that care was safe, effective and compassionate and that the service was well led. Comments with regard to staffing are discussed in section 4.3.

Ten questionnaires were issued to nursing, care and ancillary staff; two were returned prior to the issue of this report. Overall the staff members were very satisfied with the care provided across the four domains. Additional comments with regard to staffing and handover reports have been discussed in section 4.3 and 4.4.

Any comments from relatives and staff in returned questionnaires received after the return date will be shared with the acting manager for their information and action as required.

Areas for improvement

No areas for improvement were identified with the delivery of safe care.

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

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

Discussion with staff evidenced that there was a clear organisational structure in the home. In discussion, patients and relatives were aware of the roles of staff in the home and to whom they should speak to if they had a concern. A new manager was recently recruited and was completing her induction at the time of the inspection. The acting manager explained that they

would work alongside the new manager for a number of weeks. Patients and relatives spoken with were aware of the changes to management and confirmed that they had met the new manager.

A review of the duty rota evidenced that the acting manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients, relatives and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required. Patients and relatives confirmed that the acting manager was approachable and were confident that he would address any issues or concerns raised by them appropriately.

Discussion with the acting manager and review of the home's complaints records evidenced that systems were in place to ensure 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.

A review of records evidenced that monthly audits were completed, for example care records and medication audits. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the regional manager on behalf of the responsible person. An action plan was included within the report to address any areas for improvement. The action plan was reviewed at the next visit. A copy of the quality monitoring reports were available in the home.

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 Daniel Oliveira, acting manager and the recently appointed manager Cherith Douglas, 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 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

Statutory requirements: There were no statutory requirements made as a result of this inspection.

Recommendations	
Recommendation 1 **Ref**: Standard 23.1 **Stated:** First time **To be completed by:** 7 June 2017	The registered provider should ensure that body maps are completed on admission to the home. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Following the Inspection feedback discussion had with all Registered members of staff regarding the importance of completion of body maps on admission. Registered staff were advised that when a new resident comes to the home that skin is checked thoroughly on the day of admission by a Registered nurse and same documented appropriately. Registered staff asked to complete a reflection on this and use it for learning purposes.
Recommendation 2 **Ref**: Standard 23.2 **Stated:** First time **To be completed by:** 7 June 2017	The registered provider should ensure that wound care is accurately and consistently recorded for all grades of wounds. Where there is a change to the dressing regime the care plan should be updated to reflect the change. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Following the Inspection feedback discussion had with all Registered members of staff in regards to Wound Care. Training needs identified and same acted on by Home Manager. Grading of wound guidelines given to all Registered staff for learning purposes. Registered staff supervised with wound care and completion of wound assessments charts. Discussion had with all Registered staff in regards to importance of wound care and regular and accurate completion of documentation.

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