Unannounced Care Inspection Report
15 November 2019

Woodgrove

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

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 provides care for up to 32 patients.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Maureen Claire Royston	**Registered Manager and date registered:** Karen Blair 18 December 2018
Person in charge at the time of inspection: Karen Blair	**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. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 25

4.0 Inspection summary

An unannounced inspection took place on 15 November 2019 from 08:50 hours to 16:20 hours.

Evidence of good practice was found in relation to the provision and training of staff, staffs attentiveness to patients and patient safety. The environment was safely managed.

There were examples of good practice found throughout the inspection in relation to the management of skin care, nutrition and falls. Patients were attended to by their GP and other healthcare professionals as they required. Staff were well informed of the needs of the patients, advocated on their behalf and worked well as a team to deliver the care patients' required.

The daily routine supported patient choice with systems in place to seek the opinion of patients, relatives and visitors to the home. There was a varied and meaningful activity programme in place which patients told us they enjoyed. Systems were in place to provide management with oversight of the services delivered.

One area for improvement was identified in relation to the assessment and care planning process at the time of admission to the home.

Comments received from patients and their relatives are included in the main body of this report.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Karen Blair, 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.

4.2 Action/enforcement taken following the most recent inspection dated 10 January 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 10 January 2019. No further actions were required to be taken following the most recent inspection on 10 January 2019.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home, 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.

The following records were examined during the inspection:

- duty rota for all staff for the period 11 – 17 November 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
- two staff recruitment and induction files
- four patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records

- complaints record
- compliments received
- a sample of reports of the monthly visits made on behalf of 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 areas for improvement from previous inspection

There were no areas for improvement identified as a result of the last care inspection.

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.

In order to determine if care was delivered safely we talked with a number of the patients. Patients told us that staff attended to them promptly and if they were in their bedrooms staff came as quickly as they could when they called them. The patients said that staff were pleasant and attentive to them. Patients said:

- "I like the staff they are very happy."
- "They look after me well."
- "The staff come quickly when I buzz, I always have my call bell near."

A system was in place to identify appropriate staffing levels to meet the patient's needs. A review of the staff rotas for week commencing 11 November 2019 confirmed that the staffing numbers identified were provided. There were sufficient staff available to ensure that catering and housekeeping duties were undertaken. An activity co-ordinator was employed to plan and deliver a range of social activities; they were supported by the wider staff team on the delivery of activities.

We discussed the staffing levels with nursing and care staff; all were satisfied that there was enough staff to meet the patients' needs. It was obvious from the relaxed interactions between staff and patients that there were good relationships between them.

We provided questionnaires to gain the views of relatives and staff who were not available during the inspection. Unfortunately there were no responses received.

We discussed how staff were recruited and reviewed the recruitment records. The records confirmed that the appropriately checks had been completed with applicants to ensure they were suitable to work with older people. Newly appointed staff completed a structured induction to enable them to get to know the patients, working practices and the routine of the home.

The home provides a range of training for staff relevant to their roles and responsibilities. The manager monitors compliance with training for all staff. Staff registration with their regulatory body is checked on a monthly basis to ensure they remain appropriately registered.

We discussed how patients are protected from abuse. Safeguarding and protection of patients is included in the induction and annual training programme for staff including how can report any concerns.

Assessments to identify patients' needs were completed at the time of admission to the home and were reviewed regularly. Where a risk to a patient was identified, for example a risk of falls or poor nutrition, a plan of care to minimise each risk was put in place. We observed that some patients had bedrails erected or alarm mats in place; whilst these types of equipment had the potential to restrict patients' freedom we were satisfied that these practices were the least restrictive possible and used in the patient's best interest.

If a patient had an accident a report was completed. We saw from the care records that the circumstances of each fall were reviewed at the time and the plan of care altered, if required. The manager reviewed the accidents in the home on a monthly basis to identify any trends and consider if any additional action could be taken to prevent, or minimise, the risk of further falls. Patients' next of kin and the appropriate health and social care trust were informed of all accidents. RQIA were also appropriately notified.

The environment in Woodgrove was warm and comfortable. The home was clean and fresh smelling throughout. Patients' bedrooms had been individualised with items that were important to the patients and reflected their likes and interests. No issues were observed with fire safety. The access to fire escapes was clear and fire doors in place were secured with magnetic hold open devices.

Areas of good practice

The following areas were identified for improvement in relation to the provision and training of staff, staffs attentiveness to patients and patient safety. The environment was safely managed.

Areas for improvement

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

	Regulations	Standards
Total numb 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.

We spoke with ten patients individually who were very happy with the care they were receiving. They confirmed that staff arranged visits from healthcare professionals, for example their GP, podiatry, opticians and dentists when they needed them. If they were required to attend hospital appointments the staff made the necessary arrangements for them to attend.

We reviewed four patients' care records and observed that in three records assessments to identify patient need were completed and care plans were in place to direct the care required. However in one of the care records the assessments had not commenced on the day of admission and completed within five days; initial plans of care based on the pre admission assessment and referral information were not in place within 24 hours of admission. This was identified as an area for improvement.

We reviewed the management of nutrition, patients' weight 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.

Arrangements were in place to identify patients who were unable to mobilise or move independently and therefore at greater risk of skin breakdown. Pressure relieving care was recorded on repositioning charts. These charts evidenced that the patients were assisted by staff to change their position regularly.

We reviewed how patients' needs in relation to wound prevention and care were met. Records confirmed that wounds care was in keeping with the care plan instructions. Records also evidenced that where necessary advice on the management of wounds was sought from healthcare professionals in the local health and social care trust. For example podiatry and tissue viability nurses (TVN).

Patients' nutritional needs were identified through assessment and appropriate care planning to identify the specific support required by each patient. Patients' weights were kept under review and checked a minimum of monthly to identify any patient who had lost weight. Referrals were made to dietetic services as required and details were recorded in the patient's care records.

We discussed at length the management of patients on modified diets and the challenge of managing risk for patients, with capacity, who do not wish to adhere to the recommended texture. The home works closely with the relevant health and social care trust and advocate strongly on behalf of patients' right. We discussed with a representative of the local trust the need to ensure that patients' rights are at the centre of decision making and the management of risk.

We reviewed the prevention and management of falls. Care records evidenced that a post falls review was completed within 24 hours of the patient sustaining a fall to identify the possible reason for the fall and take any preventative action necessary. We reviewed the accident book and can confirm that recorded accidents were appropriately managed with medical advice sought as required.

Patient care was discussed at the beginning of each shift in the handover report. All of the staff spoken with were knowledgeable of individual patient need and of each patient's routine.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the management of skin care, nutrition and falls. Patients were attended to by their GP and other healthcare professionals as they required. Staff were well informed of the needs of the patients, advocated on their behalf and worked well as a team to deliver the care patients' required.

Areas for improvement

An area for improvement was identified in relation to ensuring that assessment and care planning commence at the time of admission to the home.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

We arrived in the home at 08:50 hours and were welcomed in by the manager. We walked round the home mid-morning; the majority of patients were in their bedrooms as there was improvement work being carried out on the passenger lift. The lift was out of operation which meant that the patients on the first floor could not access the facilities on the ground floor, for example the dining room. Arrangements were in place to ensure that any disruption to the daily lives of patients was kept to a minimum. The small lounge on the first floor was being used as a dining room. Patients were well informed of the ongoing work and the proposed timescales for completion. One patient, who resided on the ground floor, told us they were enjoying the peace and quiet of having the entire lounge to themselves.

There continues to be a varied programme of activities which include games, one to one sessions and social events. Each patient had been provided with a booklet detailing the Christmas programme of events; the programme included the date for the Christmas lunch in a local hotel, the dates various schools were visiting, the date of the Mayor of Lisburn visit to the home and other daily activities. Patients were informed of the varied programme and told us they were looking forward to the all the seasonal events. The patients spoke highly of the Personal Activity Leader (PAL) and it was obvious from their responses to questions regarding activities that they enjoyed the activities provided and that the PAL was well known to them. We spoke with the PAL who continues to be well motivated and enthusiastic about her role in the home.

Patients told us that they were supported to make daily choices, for example, where to spend their day, have their meals and what time they liked to go to bed. They told us:

- "The food is very good."
- "I'm comfortable here."
- "Everyone is great, if you ask for something they will try their best."
- "You couldn't get better."
- "First class, 100% to all of them."

We met with the relatives of two patients. Both were very happy with the way their relatives were being looked after. They spoke highly of the staff and of the availability of the manager to speak with should they have any queries or concerns.

As previously discussed we provided questionnaires in an attempt to gain the views of relatives, and staff who were not available during the inspection; unfortunately there were no responses received.

We discussed how patient and relative opinion was sought on the day to day running of the home. The manager explained that systems were in place to provide patients, relatives and visitors to the home an opportunity to complete an electronic questionnaire to gain their opinions on their experience of the home. Once a questionnaire has been completed and submitted the manager is alerted by email to view the responses and take action where required.

The home has received numerous compliments, mainly in the form of thank you cards. The most recent cards were displayed throughout the home for patients and visitors to see. These are some of the comments included:

- "In Woodgrove I can't thank you enough for the outstanding care you gave my …" (September 2019)
- "Thank you so much for everything you did for… I will always be grateful to you all."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the daily routine, the provision of a varied and meaningful activity programme and the systems in place to seek the opinion of patients and relatives.

Areas for improvement

No 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.

There are well established management arrangements in the home. The manager, who has responsibility for the day to day operation of the home, has been registered with RQIA since 2018 and was knowledgeable of her responsibility with regard to regulation and notifying the appropriate authorities of events. They are supported in their role by a deputy manager who was present throughout the inspection and knowledgeable of the day to day running of the home and patient care. Staff, patients and relatives reported that the manager was very approachable and available to speak to. Support is also provided by the regional manager.

The manager reviews the services delivered by completing a range of monthly audits. Areas audited included the environment, medications, care records and accidents and incidents.

The owner of the home is required to checks the quality of the services provided in the home. This is done by the operations manager during monthly unannounced visits to the home; a report is made of the outcome of these visits. The reports included the views of patients, relatives and staff, a review of records, for example accident reports, complaints records and a review of the environment. The reports of these visits were available in the home.

A complaints procedure was available in the home. Records were available of any complaints received. The records included the detail of the complaint, the outcome of any investigations, the action taken, if the complainant was satisfied with the outcome and how this was determined.

Examples of compliments received have been provided in section 6.5 of this report.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the management arrangements and the systems to provide management with oversight of the services delivered.

Areas for improvement

No 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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Karen Blair, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** Ongoing from the date of inspection.	The registered person shall ensure that: • the assessment of patient need is commenced on the day of admission and completed within five days of admission to the home • initial plans of care based on the pre admission assessment and referral information are in place within 24 hours of admission Ref: 6.4
	Response by registered person detailing the actions taken: Developed an admission checklist which shows when documentation has to be completed and RN/CHAP sign. Reviewed by Home Manager daily until completion. Four Seasons Health Care admission TRaCA to be completed by either HM or RM

Please ensure this document is completed in full and returned via Web Portal

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