Unannounced Care Inspection Report
17 October 2016

Woodgrove

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

1.0 Summary

An unannounced inspection of Woodgrove Nursing Home took place on 17 October 2016 from 10.10 to 17.15.

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?

Observations made, review of documentation and discussion with the registered manager and staff demonstrated that care provided to patients was safe. One issue with the management of fire doors was identified and discussed. Following the inspection, evidence was provided by the registered manager that the planned work had been completed and the issue addressed.

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

Is care effective?

There was evidence of good delivery of care with positive outcomes for patients. Care records evidenced that generally registered nurses assessed, planned, evaluated and reviewed care in partnership with patients and / or their representatives. Issues raised by patients' and their representatives in relation to specific aspects of care delivery were followed up with the registered manager as part of the inspection process. As a result, a recommendation was made in relation to record keeping and the registered manager agreed to speak with the patients and relatives concerned and continue to monitor the issues raised.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients were praiseworthy of staff and confirmed that they were generally happy with all aspects of care. There was a variety of activities available for patient participation. As already stated, the registered manager agreed to follow up the issues raised with the respective patients and patient representatives.

Is the service well led?

There was evidence of the home having systems and processes in place to monitor the delivery of care and services within Woodgrove. Compliance with the recommendation made in the effective domain of this report will assist to improve the overall services provided, the experience of patients and leadership within the home.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Leah Waddell, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent medicines management

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 11 April 2016. There were no requirements or recommendations made. 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 Health Care Dr Maureen Claire Royston	**Registered manager:** Mrs. Leah Waddell
Person in charge of the home at the time of inspection: Mrs. Leah Waddell	**Date manager registered:** 28 October 2014
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 submitted since the previous care inspection
- 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

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. We also met with 14 patients, one registered nurse, three care staff, the administrator, kitchen assistant and three resident's visitors/representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- accident and incident records
- audits
- complaints records
- Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC) staff registration records
- staff induction and appraisal records
- minutes of staff and relatives meetings
- monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 April 2016

The most recent inspection of the home was an unannounced medicines management inspection. There were no requirements or recommendations made as a result of that inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 27 January 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 36.2 **Stated:** Second time **To be Completed by:** 15 February 2016	It is recommended that when the updated Palliative and end of life care manual is issued by Four Seasons Healthcare staff receive an induction/training on the content to ensure their knowledge and care delivery is reflective of best practice in palliative and end of life care.	**Met**
	Action taken as confirmed during the inspection: There was recorded evidence that 17 staff read the Palliative and end of life care manual issued by Four Seasons. A review of training records provided evidence that 27 healthcare staff have also undertaken e-learning palliative care training relevant to the manual. The registered manager	

	confirmed that this training is compulsory for all staff to attend to ensure their knowledge and care delivery is reflective of best practice in palliative and end of life care.	
Recommendation 2 **Ref:** Standard 44.1 **Stated:** First time **To be Completed by:** 15 February 2016	The malodour in the identified room should be addressed.	**Met**
	Action taken as confirmed during the inspection: A review of the general environment of the home included the identified room. All areas of the home were found to be clean and fresh smelling. The registered manager confirmed that a replacement floor covering is on order for the identified room and the purchase order was verified during the inspection.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager works in a supernumerary capacity Monday - Friday and the vacancy for the post of deputy manager has been advertised.

A review of the staffing rota for week commencing 10 October and 17 October 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff rotas, it was confirmed that administrative, maintenance, catering, domestic and laundry staff were employed in sufficient numbers for the efficient running of the home. An activity leader is also employed 20 hours per week in addition to care staff. Staff spoken with, were satisfied that there were sufficient staff to meet the needs of the patients. However, two staff raised an issue regarding perceived inequity in staffing arrangements between both floors some mornings. This was discussed with the registered manager who agreed to monitor the situation.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Two completed induction programmes were reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. Staff spoken with stated they were well supported during their induction period. One staff member stated that following completion of the three day induction sometimes, there was a lack of attention to detail by some care staff who were new to caring duties. The staff member felt that this staff group should have a longer period of support. This was discussed with the registered manager who provided an assurance that all care staff were given up to 12 weeks to complete their induction workbook and during that time they were always allocated another member of staff to work with and have the support of two mentors. The registered manager also advised that if a new member of care staff was experiencing difficulty, they were provided with additional support and kept supernumerary and that the registered manager meets all new staff at the end of their probationary period regarding competence.

The registered manager also advised that she does a daily “walk around” to monitor standards and that monitoring quality, including attention to detail, was also undertaken by registered nurses and senior care assistants.

The registered manager confirmed that with the exception of those on sick leave, all staff have completed their mandatory training for the current year. Training records indicated that a range of additional training was available for staff. The registered manager advised that a link nurse system is also in place in relation to moving and handling, palliative care and pressure ulcer prevention and treatment. All staff spoken with during the inspection were satisfied with the training provided to fulfil their duties. Discussion with the registered manager, staff on duty and a review of the records confirmed that there were systems in place to ensure that all staff receive supervision and appraisal. Competency and capability assessments were undertaken for registered nurses who are given the responsibility of taking charge of the home in the absence of the registered manager.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager was aware of the regional guidance issued in July 2015 entitled “Adult Safeguarding Prevention and Protection in Partnership” and the contact details of the Adult Protection Gateway Services. Staff spoken with also clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding.

A review of three 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 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. Action plans were in place to address any deficits identified. This information informed the responsible individual’s monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection confirmed that these were appropriately managed.

A review of the home’s environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. All areas of the home were found to be warm, well decorated, fresh smelling and clean. There was evidence of ongoing decorating and refurbishment.

Fire exits and corridors were observed to be clear of clutter and obstruction. However, one bedroom door was observed propped open: an automatic door closure was not in place. It was ascertained that the patient liked to have their bedroom door open. The registered manager advised that a mechanism to hold the door open which links to the fire alarm system was on order. The registered manager provided evidence to RQIA on 24 October 2016 that an automatic door closure had been fitted.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. The review of three care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. 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.

The registered nurse was aware of the local arrangements and referral process to access relevant healthcare professionals and there was evidence of recommendations prescribed by other healthcare professionals being adhered to.

Discussion with staff and a review of the duty rota evidenced that nursing staff were required to attend a handover meeting at the beginning of each shift. However, staff reported a recent change whereby care staff now receive a shortened version of the handover from the registered nurse on duty, advising them of any changes in patients' condition. Care staff were of the opinion that this change has led to the potential for confusion between day and night staff with regard to the sharing of patient preferences. The registered manager agreed to monitor the quality of the handover provided to care staff to ensure that the necessary information regarding changes in patients' condition and preferences is communicated effectively.

Discussion with the registered manager and minutes of meetings confirmed that staff meetings were held on a three monthly basis. Staff confirmed that the minutes from staff meetings were made available to all staff. They also confirmed that if they had any concerns, they could raise these with the registered manager.

The registered manager advised that she operates an open door policy and meets with patients and relatives on a daily basis. In addition, the home seeks the views of patients and relatives through an electronic survey "Quality of Life." The registered manager advised that the findings were reviewed weekly and if required an action plan was developed. A summary of the findings was currently been developed for patients and relatives. A review of records evidenced that a relatives' meeting was last held on 16 March 2016.

Two patients and two relatives expressed dissatisfaction with specific aspects of care including the length of time they/their relative had to wait following a request to attend to a care need. The issues raised were discussed at length with the registered manager and the patients' care records were also cross referenced. Clarification was provided around some of the issues. The care record in relation to one identified patient was not reflective of the clarification provided by the registered manager. This care record should be updated, with input from the patient's representative to reflect changing care needs. A recommendation was made.

The registered manager agreed to speak with the patients and relatives concerned regarding their concerns and to continue monitoring the issues raised.

Areas for improvement

A recommendation is made in relation to care records.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate and caring. Consultation with 14 patients individually confirmed that they were afforded choice, privacy, dignity and respect. As previously discussed two patients raised issues in relation to the length of time they had to wait following a request for assistance. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their care and that they were offered choice at mealtimes and throughout the day.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. 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. Staff were aware of the requirements regarding patient information and confidentiality.

Discussion with the patients confirmed that there were opportunities to maintain friendships and socialise within the home. There was evidence of patient participation in the programme of events including writing poems. Plans were in place for celebrations at Hallowe'en.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. No returned questionnaires have been received by RQIA within the specified timeframe.

Staff expressed high levels of satisfaction with the care provided to patients and confirmed that communication was generally good in the home. They were also positive about the training and support mechanisms in place to do their job.

Staff comments included:
"Care 100%."
"At times difficult to respond to call bells immediately."
"Care is excellent, communication between day and night staff is the only downfall."

Discussions were held with approximately fourteen patients. Apart from the issues already identified, patients spoken with were positive regarding the care they were receiving, complementary of the staff and of the food served.

Patients' comments included:
"Staff are very kind."
"Very happy with my care, the staff, the food and my room."
"Everything is great."

During the inspection three relatives were spoken with, they were generally positive regarding the care delivered, communication and staff attitude. However, as previously discussed one relative expressed dissatisfaction with the length of time their relative had to wait following a request to attend to a care need and another relative stated that fresh drinking water was not always available in their relative's room. The issues raised were brought to the attention of the registered manager who agreed to discuss further with the relatives concerned and take any appropriate action required including addressing the recommendation made earlier in this report.

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities and confirmed that they had access to the home's policies and procedures. Patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern. There was a system in place to identify the person in charge of the home in the absence of the manager.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager confirmed that the home was operating within its registered categories of care.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents. The results of 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.

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.

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any areas for improvement. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Leah Waddell, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP 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	
Statutory requirements	
Recommendations	
Recommendation 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 17 October 2016	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. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** Care file fully completed and care plan updated to reflect residents current care needs. This will be monitored by Home Manager during Quality of Life care file audits.

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

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