Secondary Unannounced Care Inspection

Name of Establishment:	**Woodgrove**
RQIA Number:	**1310**
Date of Inspection:	**19 February 2015**
Inspector's Name:	**Sharon McKnight**
Inspection No:	**17199**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Woodgrove
Address:	67 Hillsborough Road Lisburn BT28 1JN
Telephone Number:	(028) 9260 7302
Email Address:	woodgrove@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Health Care Mr James McCall
Registered Manager:	Ms Leah Waddell
Person in Charge of the Home at the Time of Inspection:	Ms Leah Waddell
Categories of Care:	NH-I, NH-DE, NH-PH, NH-PH (E) NH-TI, RC-I
Number of Registered Places:	32
Number of Patients Accommodated on Day of Inspection:	25
Scale of Charges (per week):	£581.00 - £601.00
Date and Type of Previous Inspection:	16 December 2013 Unannounced Primary Care Inspection
Date and Time of Inspection:	19 February 2015 09 05 – 14 35
Name of Inspector:	Sharon McKnight

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the Provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process

4.0 Methods/Process

Specific methods/processes used in this inspection include the following:

- Discussion with the registered manager
- discussion with staff
- discussion with patients individually and to others in groups
- review of a sample of policies and procedures
- review of a sample of staff training records
- review of a sample of care plans
- observation during a tour of the premises
- evaluation and feedback.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients/Residents	8 patients individually and with the majority generally
Staff	4
Relatives	0
Visiting Professionals	0

Questionnaires were provided by the inspector, during the inspection, to patients' representatives and and staff to seek their views regarding the quality of the service.

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	0	0
Relatives/Representatives	6	3
Staff	6	4

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Woodgrove Care Home is situated a short distance from Lisburn city centre, on the Hillsborough Road, close to the Lagan Valley Hospital. It is owned and operated by Four Seasons Health Care Ltd. The current registered manager is Ms Leah Waddell.

The home is a two storey building with accommodation offered on both floors. Accommodation is offered in single and shared bedrooms. There are lounges located on both floors. Bath/shower rooms and WC's are accessible to all communal and bedroom areas throughout the home. The first floor is serviced by a passenger lift ensuring patients have access to all areas of the home. The home also provides for catering and laundry services on the ground floor.

The home is registered to provide care for a maximum of 32 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH(E)	physical disability other than sensory impairment over 65 years
TI	terminally ill

8.0 Executive Summary

The unannounced inspection of Woodgrove Care Home was undertaken by Sharon McKnight on 19 February 2015 between 09 05 and 14 30 hours. The inspection was initially facilitated by the nurse in charge Mike Cocisiu. Ms Leah Waddell, registered manager, arrived in the home a short time after the inspection commenced. Ms Waddell was available throughout the day and was provided with verbal feedback at the conclusion of the inspection.

The focus of this inspection was Standard 19: Continence Management and to assess progress with the issues raised during and since the previous inspection of 16 December 2013.

As a result of the previous inspection one requirement and three recommendations were issued. These were reviewed during this inspection and the inspector evidenced that they have been fully complied with. Details can be viewed in the section immediately following this summary.

Inspection Findings

Review of five patients' care records evidenced that bladder and bowel continence assessments were undertaken as part of the assessment process within the home. These assessments clearly identified what the patient's continence needs were. The outcome of these assessments was incorporated into the patients' care plans on continence care.

The management of urinary catheters was reviewed. The frequency with which catheters were required to be changed was recorded in the care plan. Care records evidenced that, over a fourteen months period, catheters had been changed in keeping with prescribed timescales.

Discussion with staff and review of training records evidenced that staff have attended training in the management of continence. Staff have also participated in a formal supervision regarding continence management and completed workbooks on "Bowel Management" and "Caring for Residents with a Urinary Catheter."

Staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters required to be changed.

From a review of the available evidence, discussion with relevant staff and observation of are delivery, the inspector can confirm that the level of compliance with the standard inspected is compliant.

Additional Areas Examined

- Care Practices
- Complaints
- Patient finance questionnaire
- NMC declaration
- Patients comments
- Relatives comments
- Staff comments
- Environment

Areas for improvements were identified with care practices and two requirements have been made.

Conclusion

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard. However improvements to the morning routine require to be addressed to ensure care is delivered in a timely manner. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. The issues identified with the morning routine were discussed at length with the registered manager.

As a result of this inspection a total of two requirements were made.

The inspector would like to thank the patients, the deputy manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

9.0 Follow-up on the Requirements and Recommendations Issued as a Result of the Previous Primary Unannounced Care Inspection Conducted on 16 December 2013

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	19(1)(a), schedule 3, 3(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence care delivered.	Review of patients repositioning charts evidenced that this requirement has been complied with.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	16.2	It is recommended that all induction programmes are reviewed, and where required developed, to ensure that an awareness of the procedures for protecting vulnerable adults are included in the induction programme for all staff.	Review of the two day introductory induction and the three month common induction evidenced that an awareness of the procedures for protecting vulnerable adults was included in the induction programme for all staff.	Compliant
2	10.7	It is recommended that the use of alarm mats is discussed with the patient, where appropriate, and if the patient is unable to give their consent then consultation with relatives and healthcare professionals, if required, in regard to best interest decisions for the patient, should be undertaken and records maintained of the outcome of these discussions.	Care records reviewed contained evidence of consultation with relatives and healthcare professionals, if required, in regard to best interest decisions for the patient and the provision of alarm mats.	Compliant

3	5.3	It is recommended that care plans are updated to ensure the required care is accurately recorded.	Care plans reviewed had been updated to reflect changes to patients' care.	Compliant

9.1 Follow-up on any Issues/Concerns Raised with RQIA since the Previous Inspection such as Complaints or Safeguarding Investigations

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Since the previous inspection on 16 December 2013, RQIA have been notified by the registered manager of referrals in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

Following discussion with the registered manager RQIA were satisfied that SOVA issues were dealt with in the appropriate manner and in accordance with regional guidelines and legislative requirements.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of five patients' care records evidenced that bladder and bowel continence assessments were undertaken as part of the assessment process within the home. These assessments clearly identified what the patient's continence needs were. The outcome of these assessments was incorporated into the patients' care plans on continence care. The care records contained details of the specific continence aids the patient required. Care records also made reference to the Bristol Stool Chart and the patients' normal stool type. This is good practice. Care records evidenced that continence and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. Skin care, fluid requirements and patients dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. The management of urinary catheters was reviewed. The frequency with which catheters were required to be changed was recorded in the care plan. Care records evidenced that, over a fourteen months period, catheters had been changed in keeping with prescribed timescales. Review of patient's care records evidenced that patients and/or their representatives were informed of changes to patient need and/or condition and the action taken by staff in response to need. Discussion with staff and observation made during the inspection evidenced that there were adequate stocks of continence products available in the nursing home. The management of continence pants was discussed with the registered manager who informed the inspector that new products were currently being introduced and that the style of these products does not required continence pants.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
Policies and procedures were in place to guide staff regarding the promotion of bladder and bowel continence and management of incontinence. The inspector can also confirm that the following guideline documents were in place: • NICE guidelines – "Faecal incontinence: The management of faecal incontinence in adults." • NICE guidelines - "Urinary continence: The management of urinary incontinence in women." • RCN guidance – "Catheter care, RCN guidance for nurses" • RCN guidance – "Improving continence care for patients."	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not applicable	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with staff and review of training records evidenced that staff have attended training in the management of continence. Staff have also participated in a formal supervision regarding continence management and completed workbooks on “Bowel Management” and “Caring for Residents with a Urinary Catheter.” Staff spoken with on the day of the inspection were knowledgeable regarding the management of urinary catheters and the frequency with which the catheters required to be changed. There were no patients resident in the home at the time of this inspection who had a stoma appliance.	Compliant

Inspector’s overall assessment of the nursing home’s compliance level against the standard assessed	**Compliant**

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were evident between patients and staff. Patients were well presented with their clothing suitable for the season.

The inspector arrived in the home at 09 05 hours and undertook a tour of the premises. There were four patients in the dining room on the ground floor. The catering assistant was serving breakfast. There were no staff present to provide supervision or encouragement to assist patients to eat. Therefore two patient's breakfasts were largely uneaten.

On the first floor two patients spoken with commented that it was a long time between getting up and receiving breakfast. On the day of inspection breakfast service started at 09 45 hours. The inspector observed two patients who were not assisted with breakfast until 10 40 hours. Staff spoken with confirmed that morning tea was served at 11 30 hours and lunch at 12 45 hours.

Registered nurses on duty confirmed that the administration of the morning medication commenced at approximately 09 30 hours and was usually completed by 10 45 hours. However on the day of the inspection the morning medication round on the first floor was not concluded until 11 40 hours.

The morning routine was discussed with the registered manager who was aware of the issues identified by the inspector. Increased dependency of patients was cited by the registered manager and staff as a factor. There were a number of patients being nursed in bed on the first floor of the home indicating the dependency of patients was high

The registered manager explained that to assist with the increased workload in the morning identified medications were now administered by night staff at 07 00 hours.

Given the issues identified in the paragraphs above a requirement is made that the delivery of care in the home is reviewed to ensure that:

- Patients receive their breakfast in a timely manner
- There is meaningful supervision of patients throughout the serving of breakfast
- Medicines are administered as close to the prescribed time as possible and that appropriate dosage intervals are observed

This review must include the deployment of staff between 08 00 and 11 00 hours.

The inspector reviewed the management of healthcare associated infections. Discussion with staff and observation of practice evidenced that staff were unsure how to manage the identified healthcare associated infection and the type of personal protective equipment required. Staff must receive training in the management of healthcare associated infections and this training must be embedded into practice.

11.2 Complaints

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being managed.

The inspector discussed the management of complaints with the registered manager and reviewed the complaint record. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.3 Patient Finance Questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.4 NMC Declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC and that the registration status of all nursing staff was checked at the time of expiry.

11.5 Patients' Comments

During the inspection the inspector spoke with eight patients individually and with the majority of others in smaller groups. Patient spoken with confirmed that staff were polite and respectful, that they could call for help if required and that they were satisfied with the standard of care, facilities and services provided in the home. Patients were aware of who to speak to if they had concerns and wanted to make a complaint.

As previously discussed two patients would like to have their breakfast served earlier. This was discussed with the registered manager and as detailed in section 11.1 of this report a requirement has been made. There were no other issues or concerns raised with the inspector about care delivery in the home.

11.6 Relatives' Comments

The inspector did not speak with any relatives during the inspection. The relatives of three patients completed questionnaires. The responses in the returned questionnaires were positive and no concerns were identified.

11.7 Staff Comments

During the inspection the inspector spoke with four staff and received four completed questionnaires. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, additional training in relation to care

delivery and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes.

Two staff indicated in returned questionnaires that, whilst they were satisfied with the standard of care delivery, they were dissatisfied with the staffing arrangements, especially in the morning. One response indicated that they felt that the morning care was “rushed” and there was “no time to talk or listen to patients.” This was discussed with the registered manager at the conclusion of the inspection. There were no other issues or concerns raised by staff about care delivery in the home.

11.8 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients’ bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a high standard of hygiene.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Leah Waddell as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

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Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Before admission to the Nursing Home, the Home Manager or deputy manager carries out a pre -admission assessment. Information is gathered from the resident (if possible), the representatives, the care records and information from the care management team. This helps to form the basis of the pre admission assessment. Risk assessments such as the Braden score are also carried out where possible at this stage. Following a review of all information, a decision is made in regard to the ability of the Home to meet the needs of the resident. However if it is	Compliant

an emergency admission and a pre admission assessment is unable to be made, then this is completed over the telephone with written comprehensive and multi disciplinary information regarding the resident being faxed or emailed to the Home.When the manager is satisfied that the Home can facilitate the needs of the resident will the admission take place. On admission to the Home, an identified nurse will complete the initial assessments using a patient centred approach. The nurse gathers information from the resident/ representative and the pre admission assessment and also from the Care Management team to assist them in this process Within twelve hours of admission , an admission assessment including photography consent,record of personal effects and a record of "My Preferences"is completed.A Needs assessment which includes sixteen areas of need and any additional comments to be completed in the comment section is required to be completed to enable a patient centred plan of care to be formulated for the resident. In addition to the above documentation being completed, the nurse will complete risk assessments using the braden tool to assess the residents skin. A body map is completed as well as a wound assessment if required. A moving and handling assessment, falls risk assessment, bed rail assessment, pain assessment and nutritional assessments including the MUST, Four Seasons Healthcare nutritional & oral assessment are also completed. Continence and bowel assessments are completed within seven days of admission. Following a discussion with the resident/representative and using sound clinical judgement,the nurse willdevelop a plan of care tailored to meet the residents needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plans and consent forms. The Home Manager and Regional Manager will complete audits on a regular basis to quality assure this process.	

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as aforementioned in Section A, within seven days following admission. The named nurse will then	Compliant

formulate care plans to meet the identified needs in consultation with the resident /representative. These care plans demonstrate how best to promote maximum independence, focusing on what the resident is able to do for themselves as well as what assistance may be required. Any recommendations made from other members of the multi-disciplinary team will also be included in that care plan.Care plans have goals set that are realistic and achievable. All registered nurses within the Home are fully aware of the process involved in referring a resident to a Tissue Viability Nurse where needed.Referral forms are held in a designated file in the nurses office. This file contains the name of the TVN, address and phone number.Once the form has been submitted , the nursing staff will follow this up with a phonecall to the TVN where advice can be given prior to their visit. Referrals to Podiatrists are also made via this process. Where a resident is deemed "at risk" of developing pressure damage, a pressure ulcer management treatmnet plan is implemented. Care plans written will include skin care, frequency of repositioning, mattress type and setting. The care plan will also give due consideration to input and advice from other members of the MDT. The plan is agreed with the resident /representative, Care Manager and MDT.The Regional Manager is informed of this on their Reg 29 visits or sooner if applicable. Again, based on an assessment of the resident's nutritional needs and MUST score, the registered nurse will make a referral to the dietician if this is necessary. Referral forms to the dieticians are held in the Home.The dietician is available over the telephone to give advice and are very prompt in attending to residents with nutritional concerns. All advice and recommendations made from the dietetics team are formulated into care plans and updated when necessary. The kitchen staff are informed of any modifications to a residents diet. The care plan is evaluated and reviewed on a monthly basis or sooner if necessary. Residents, representatives and MDT members, as well as staff in the home are kept informed of any changes.	

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Needs assessment, risk assessments and care plans are all reviewed and evaluated at a minimum of monthly.However if there is a change in condtion these assessments are reviewed immediately.The care plan dictates the frequency of review and reassessment, with agreed time intervals recorded on the plan of care. The resident is assessed on a daily basis, with any changes notedin the daily progress notes, care plans and evaluation forms. The 24 hour shift report will also include any changes in condition of a resident to alert the Home Manager. The Home Manager and Regional Manager will complete audits to quality assure the above process and compile action plans.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care.Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are readily available for staff to refer to . The validated pressure ulcer grading tool which the Home use to screen residents who have skin damage is the EPUAP grading system.If a pressure ulcer is present on admission,or a resident develops a pressure ulcer during admission, then an initial wound assessment is completed with a plan of care. This plan of care includes the grade of the ulcer, dressing regime,wound cleansing regime, frequency of repositioning, mattress type and setting and time interval for review. Following this assessment, an ongoing wound assessment and care plan evaluation form is completed at every dressing change. If there is any change to the dressing regime, or condition of the ulcer, this is also recorded. The Home has current nutritional guidelines such as "Promoting Good Nutrition " RCN Nutrition Now, PHA Nutritional Guidelines and Menu checklist for residential and care homes, NICE guidelines- Nutrition support in Adults -all available for staff to access. Staff also utilise FSHC policies and procedures in relation to nutritional care, diabetic	Substantially compliant

care, care of subcutaneous fluids and care of residents requiring Percutaneous Endoscopic Gastrostomy (PEG) feeding.	

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are maintained of all nursing interventions, activities and procedures that are carried out in relation to each resident. these records are contemporaneous and are in accordance with the NMC guidelines.All care delivered includes an evaluation and an outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines. Records of meals provided for each resident at each mealtime are recorded on a daily menu choice form. The catering manager also keeps records of the food served and any special dietary needs. Residents assessed as being "at risk" of malnutrition and dehydration or eating excessively have all their food and fluids recorded in FSHCfood and fluid booklets on a daily basis. These charts are recorded over a 24 hour period with the fluid being totalled at the end of that period.The nurse can use this information in their daily evaluation. Any deficits	Substantially compliant

are identified and appropriate action being taken. Referrals if needed are made to the relevant MDT members as necessary. Any changes to a resident's care planis discussed with them or their representative. Care records are audited on a regular basis by the Manager or the Deputy Manager, and an action plan is formulated to address any deficits and areas were improvement is needed. This is discussed with the nurse during a supervision session.	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The outcome of care is delivered, monitored and recorded on a daily basis.This is recorded in the progress notes with a minimum of one entry during the day and one during the night. The outcome of care is reviewed as indicated on the care plan, or more frequently if there is a change in the resident's condition, or if there are any recommendations made by any mebers of the MDT. Residents/representatives are involved in this evaluation process.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Generally, care management reviews are held six-eight weeks following admission and then annually thereafter.Reviews can be arranged in response tochanging needs, expressions of dissatisfaction with care, or, at the request of the resident /representative. The Trust are responsible for arranging these reviews and inviting the resident/representative to attend them. A member of the Nursing staff will also attend these reviews. Copies of the minutes of the review are sent to the resident/representative, with a copy being held in the resident's file. Any recommendations made are actioned by the Home, with care plans being reviewed to reflect the changes. The resident and their representative are kept informed of progress being made towards the agreed goals.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
the Home follows FSHC policies and procedures in relation to nutritin and follows best practice guidelines as stated in Section D. Registered nurses will fully assess each resident's dietary needs on admission and review on an ongoing basis.The care plan will reflect the diet type, any modifications, personal preferences in regards to likes/dislikes, dependency levels and any specialised equipment needed. Recommendations made by dieticians or Speech & Language therapists are also reflected in the care plans. These care plans are evaluated monthly or sooner should a resident's needs dictate. The Home has a three week menu which is reviewed six monthly taking into account seasonal food. the menu is compiled following consultation with residents and their representatives if appropriate and also through food questionnaires. The PHA document "Nutritional and menu checklist for residential & Nursing Homes " is used to ensure the menu is not only nutritious but varied. Copies of instructions and recommendations from the dieticians and SALT are made available in the kitchen along with a diet notification sheet which informs catering staff of each resident's specific dietary needs. Residents are offered a choice of two meals and desserts at each meal time.If the resident does not want anything	Compliant

from the daily menu, an alternative meal of their choice will be provided. The menu offers the same choice as far as possible to those residents requiring therapeutic or specialised diets. each resident is offered a choice of meal which is recorded on the daily menu sheet. A variety of condiments, sauces and drinks are available throughout. the daily menu is displayed in the dining room and the three weekly menu displayed in a folder in the reception area.	

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Registered nurses are in the process of receiving dysphagia training and have received training on enteral feeding on 30/08/13.Training for care and kitchen staff on nutrition in the elderly and dysphagia is being arranged. Some care staff & kitchen staff have already attended dysphagia training on 18/12/13. The SALT team and dieticians also give informal advice and guidance when visiting the home. Nurses can access up to date guidance for example NICE guidelines "Nutrition Support in Adults" and NPSA document- "Dysphagia Diet Food Texture Descriptors". All recommendations	Substantially compliant

made by SALT are incorporated into the care plans and include diet type and consistency of fluids, position for feeding, equipment to use and any assistance required. The kitchen receive a copy of SALT recommendations and is kept in a file for reference. Meals are served as follows- Breakfast 8.30am-10.30am Morning Tea 11am Lunch- 12.45- 1pm Afternnon Tea-2.30pm Evening Tea- 5pm Supper- 8pm There are variations to the above for example a resident may wish to have their meal outside of these times. Hot & cold drinks and a variety of snacks are available throughout the day & night and upon request. There are foods available outside of these times for those residents who require modified or fortified diets. Cold drinks, including fresh water are available at all times in lounges and resident's bedrooms and are replenished on a regular basis. Any concerns noted around a resident's eating & drinking are detailed on each individual care plan. Likes and dislikes are recorded, type of diet, consistency of fluid and any special equipment required and level of assistance needed. A diet notification sheet is completed and a copy given to the kitchen to retain on file. Meals are not served unless a staff member is present in the dining room. Those residents who require supervision or assistance are given individual attention and assisted at a pace suitable to them. Appropriate aids such as specialised cutlery, plate guards or specialised drinking cups are also included in the care plans. Each nurse and care assistant have completed the E learning module on pressure area care. The home has a link nurse who has received enhanced training to provide education and support to other nurses in the home as and when necessary. Central training on wound care related topics are arranged for nurses requiring additional support. All nurses within the Home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Substantially compliant

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Secondary Care Inspection

Woodgrove

19 February 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Ms Leah Waddell, either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	13(1)(a) & (b)	The registered person must review the delivery of care in the home to ensure that: • Patients receive their breakfast in a timely manner • there is meaningful supervision of patients throughout the serving of breakfast • medicines are administered as close to the prescribed time as possible and that appropriate dosage intervals are observed This review must include the deployment of staff between 08 00 and 11 00 hours. **Ref section 11, 11.1**	One	The deployment of staff will be reviewed to ensure that all residents receive their breakfast in a timely manner. This will be montiored by the Registered Manager and deputy. The monitoring of chart is in place to ensure that medications continue to be commenced and finished in a timely manner. Night staff continue to administer 6am and 7 am medications as percribed. The morning routine has been reviewed and amended on both floors with monitoring in place to analyse its efficiency. Home Manager is arranging swallowing awareness updates for all kitchen staff.	By end of March 2015
2	20(1)(c)(i)	The registered manager must ensure that staff receive training in the management of healthcare associated infections and that this training is embedded into practice. **Ref section 11, 11.1**	One	Supervisions have been carried out with all staff members by Home Manager and Deputy Manager. Further Face to Face Infection Control training for all staff/departments has been arranged for May 2015.	By end of March 2015

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person/identified responsible person:

Name of Registered Manager Completing Qip	Leah Waddell
Name of Responsible Person / Identified Responsible Person Approving Qip	Jim McCall Carol Cousins CAROL COUSINS

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	X	Sharon McKnight	9-04-15
Further information requested from provider			