Unannounced Care Inspection Report
20 November 2017

Woodgrove

Type of Service: Nursing Home
Address: 67 Hillsborough Road, Lisburn, BT28 1 JN
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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 32 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Maureen Claire Royston	**Registered Manager:** See Box Below
Person in charge at the time of inspection: Joanne McConville	**Date manager registered:** Joanne McConville, Registration pending
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 registered places:** 32

4.0 Inspection summary

An unannounced inspection took place on 20 November 2017 from 10:30 to 16:45.

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.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to provision and development of staff, adult safeguarding and the home's environment.

There were examples of good practice found in relation to the assessment of patient need, communication between staff, management arrangements and maintaining good working relationships.

Areas requiring improvement were identified in relation to risk assessment and the use of footrests on wheelchairs.

Patients said they were happy living in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	*3

*The total number of areas for improvement includes two which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Joanne McConville, 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 May 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 10 May 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with four patients individually and with the majority in small groups, five staff and one patients' relative. Questionnaires were also left in the home to obtain feedback from patients and relatives. Opportunities for staff not on duty during the inspection to provide feedback were also provided.

The following records were examined during the inspection:

- duty rota for nursing and care staff for week commencing 20 and 27 November 2017
- staff training records
- induction records for agency staff
- incident and accident records
- three patient care records
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 the most recent inspection dated 10 May 2017

The most recent inspection of the home was an unannounced care inspection.
The completed QIP was returned and approved by the inspector and was validated during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 10 May 2017

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 23.1

Stated: First time</td><td>The registered provider should ensure that body maps are completed on admission to the home.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of three care records evidenced that body maps were not consistently completed on admission and readmission to the home. This area for improvement has not been met and is stated for a second time.</td></tr>
</table>

Area for improvement 2 **Ref**: Standard 23.2 **Stated:** First time	The registered provider should ensure that wound care is accurately and consistently recorded for all grades of wounds. Where there is a change to the dressing regime the care plan should be updated to reflect the change.	**Not met**
	Action taken as confirmed during the inspection: A review of one patient's wound care records evidenced that changes to the frequency of dressing changes were not included in the wound care records. This area for improvement has not been met and is stated for a second time.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The manager confirmed the planned daily staffing levels for the home and that the provision of registered nurses had recently been reviewed to ensure there were sufficient staff on duty to meet the assessed needs of the patients. The manager explained that a number of registered nurses posts were vacant. An action plan was in place for recruitment and to ensure the provision of registered nurses whilst recruitment was ongoing. A number of nurses were currently supplied from employment agencies. The manager explained that they attempted to block book staff to ensure consistency and continuity of care. A profile containing confirmation of the AccessNI check, registration with the Nursing and Midwifery council (NMC) and training was held in the home for each agency nurse. Records evidenced that registered nurses, supplied from an employment agency, completed an orientation programme at the commencement of their first shift; this orientation included a tour of the building and the actions to take in the event of emergencies. We reviewed the completed induction records of two staff; the records were signed by the nurse providing the induction and the agency nurse who was being inducted.

A review of the staffing roster for week commencing 20 and 27 November 2017 evidenced that the planned staffing levels were adhered to. Observation of the delivery of care and discussion with patients evidenced that their needs were met by the levels and skill mix of staff on duty.

Patients and the relative spoken with during the inspection commented positively with regarding to staff and care delivery. Patients were satisfied that when they required assistance they were attended to in timely manner. We sought relatives' opinion on staffing via questionnaires; one was returned within the timescale for inclusion in the report. The relative responded that they were very satisfied that there was enough staff to help their relative.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; no responses were received following the inspection.

The manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

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.

The manager was knowledgeable regarding her role and responsibilities in relation to adult safeguarding and their obligation to report concerns. We reviewed compliance with safeguarding training; there were only three staff who had not completed training and two of these were staff had recently commenced employment.

A review of completed accident and incident reports for the period 17 October to 17 November 2017 evidenced that these had been appropriately notified and managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, lounges and dining rooms. The home was found to be tidy, warm, fresh smelling and clean throughout. Patients spoken with were complimentary in respect of the home's environment. A programme of refurbishment was in place; the manager explained that a number of rooms have been recently redecorated and that there were plans to replace much of the flooring throughout the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the provision and development of staff, adult safeguarding and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

A review of three patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process.

We reviewed the management of wound care for two patients. Care plans for wound care were in place and included the size of the wounds and, were applicable, the grade of pressure wounds. There were individual care plans in place for each wound. The care plan for one patient detailed the frequency with which dressing were required to be changed; ongoing wound assessment charts were completed at each dressing change and evidenced that the prescribed regime was adhered to. The care plan for the second patient did not reference how often the dressing should be changed. The registered nurse explained that the frequency had changed following each review by the tissue viability nurse; this was not reflected in the care records. As previously discussed wound care should be accurately and consistently recorded. This was identified as an area for improvement under the standards during the previous care inspection. This area for improvement is now stated for a second time.

We observed a patient being transported in a wheelchair which had no footrests in place. The patient's moving and handling records did not identify any risks from the use of foot rests. Footrests should be used with patients when being transported in wheelchairs unless a risk has been identified. Any risk should be recorded in the patient's care records. This was identified as an area for improvement under the standards.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as TVN, SALT and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

We spoke with the two registered nurses on duty who confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. The registered nurses explained that care staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted. This was verified by the three care staff spoken with.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the assessment of patient need and communication between staff.

Areas for improvement

An area for improvement was identified in relation to risk assessment and the use of footrests on wheelchairs.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 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.

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. There was evidence that patients were involved in decision making about their care. Patients were consulted with regard to where they liked to spend the day, meal and were offered a choice of meals, snacks and drinks throughout the day.

Patients said that they were generally happy living in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. The following are examples of comments provided by patients:

"You'll not get better staff"
"You only have to ask staff and they will go out of their way to help.""

We spoke with the relative of one patient, who commented positively with regard to the standard of care, attitude of staff and communication in the home.

We spoke with the Personal Activity leader (PAL) who continues to be enthusiastic regarding the provision of activities. Patients were aware of the PAL, her role within the home and the activities provided which included weekly events to support patients' religious and spiritual needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy and listening to and valuing patients and their relatives.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	**0**	**0**

6.7 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.

Discussion with the manager and observation of patients evidenced that the home was operating within its registered categories of care. The most recent certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. In discussion patients and relatives were aware of the roles of the staff in the home and whom they should speak to if they had a concern. The manager had recently been appointed and was being supported through their induction by experienced managers within the company. The manager confirmed their intention to apply to RQIA for registration as the manager of Woodgrove. It was good to note that patients and relatives spoken with were aware of the changes to management and confirmed that they had met the new manager.

A review of notifications of accidents/incidents recorded during the period 17 October – 17 November 2017 confirmed that these were managed appropriately. The manager had systems in place to ensure they had oversight of the recording and management of accident/incidents.

Discussion with the manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management arrangements and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	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 Joanne McConville, 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 Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 23.1 **Stated:** Second time **To be completed by:** 18 December 2017	The registered provider should ensure that body maps are completed on admission to the home. **Ref: Section 6.2**
	Response by registered person detailing the actions taken: Communication has been shared with all Staff Nurses and evidence of receipt. This will be monitored by HM during care file audits Guidance contained in nurse file
Area for improvement 2 **Ref**: Standard 23.2 **Stated:** Second time **To be completed by:** 18 December 2017	The registered provider should ensure that wound care is accurately and consistently recorded for all grades of wounds. Where there is a change to the dressing regime the care plan should be updated to reflect the change. **Ref: Section 6.2**
	Response by registered person detailing the actions taken: Communication has been shared with all staff and evidence of receipt retained. All residents with wounds have had a care files audit completed and are up to date in relation to dressing regiemes and wound care This will be monitored weekly by HM Tissue Viability Training to be arranged January 18 with Trust Tissue Viability Nurse
Area for improvement 3 **Ref**: Standard 45 **Stated:** First time **To be completed by:** 18 December 2017	The registered person shall ensure that footrests are used with patients when being transported in wheelchairs unless a risk has been identified. Any risk should be recorded in the patient's care records. Ref: Section 6.5
	Response by registered person detailing the actions taken: All staff within the home have received communication regarding the use of footrests. Wheelchairs without footrests have been removed from use Following a review no resident is at risk of harm due to use of footrests in the home currently

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

The Regulation and Quality Improvement Authority

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