The Regulation and Quality Improvement Authority

Inspection Report

2 July 2024

Wood Lodge

Type of service: Nursing Home
Address: 50 Mill Hill, Castlewellan, BT31 9NB
Telephone number: 028 4377 8511

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: G & M Lodge Caring Ltd **Responsible Individual:** Mr Ricardo Daniel Goncalves Oliveira	**Registered Manager:** Mrs Maria O'Hare **Date registered:** 18 October 2023
Person in charge at the time of inspection: Mr Peter Morgan, Nurse in Charge, 09.40 am to 10.25 am Mrs Teresa McClean, Group Project Manager, 10.25 am to 12.30 pm Mrs Maria O'Hare, Manager, 12.30 pm to 5.15 pm	**Number of registered places:** 49 There shall be a maximum of 3 residents within NH-LD, a maximum of 2 named residents receiving residential care in category RC-I and 1 named resident receiving residential care in category RC-PH
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. LD – Learning disability. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 35
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 49 patients. Patients' bedrooms are located over two floors and patients have access to communal lounge, dining and garden areas.	

2.0 Inspection summary

An unannounced inspection took place on 2 July 2024 from 09.40 am to 5.15 pm by a care inspector.

The inspection assessed progress since the last inspection and sought 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 staff training and maintaining good working relationships.

There were examples of good practice in relation to the culture and the ethos of the home in maintaining the privacy and dignity of patients and valuing patients and their representatives.

Three areas requiring improvement were identified during the inspection; these are discussed in the main body of the report.

The home was found to be clean, tidy, well-lit, comfortably warm and free from malodour.

Staffing arrangements were found to be satisfactory and reviewed regularly by the manager in order to meet the assessed needs of the patients. Staff were seen to be professional and polite as they conducted their duties and told us they were supported in their role with training and resources.

Patients were observed to be well looked after regarding attention to personal care and appearance and were seen to be content and settled in the home. Staff treated patients with respect and kindness. The lunchtime meal was served to patients by staff in an unhurried, relaxed manner.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience. Addressing the areas for improvement will further enhance the quality of care and service in the home.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Mrs Maria O'Hare, Manager, at the conclusion of the inspection.

4.0 What people told us about the service

Patients and staff provided positive feedback about Wood Lodge. Patients told us that they felt well cared for, enjoyed the food and that staff were caring and kind. Staff said there were enough staff on duty to meet patients' needs, that the manager was approachable and they felt well supported in their role.

Patients spoken with commented, "The staff are great. They made me welcome and I've settled in well. If I use my call bell they're here promptly. The grounds are beautiful, the food is excellent and I've no issues at all" and "All staff and the manager know me well. My room is comfortable and I like to attend the activities provided.''

Following the inspection we received no patient, patient representative or staff questionnaires within the timescale specified.

Cards and letters of compliment and thanks were received by the home. Comments were shared with staff. This is good practice.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Wood Lodge was undertaken on 8 June 2023 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. The manager confirmed that a robust system was in place to ensure staff were recruited correctly to protect patients, in accordance with relevant statutory employment legislation and mandatory requirements. Staff spoken with confirmed that a structured orientation and induction programme was undertaken at the commencement of their employment.

Staff said that they worked well together and that they supported each other in their roles. Staff also said that, whilst they were kept busy, staffing levels were generally satisfactory apart from when there was an unavoidable absence.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met and that patient dependency was regularly reviewed to inform staffing levels. Examination of the staff duty rota confirmed this.

The provision of mandatory training was discussed with staff. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Review of the staff training and development plan for 2024/2025 evidenced that staff had attended training regarding adult safeguarding, deprivation of liberty safeguards (DoLS) level 2, moving and handling, first aid, control of substances hazardous to health (COSHH), infection prevention and control (IPC) and fire safety.

We discussed the Mental Health Capacity Act – Deprivation of Liberty Safeguards (DoLS). Staff were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. The manager confirmed that staff training is kept under review and that trained staff have completed deprivation of liberty safeguards (DoLS) level 3.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. Mrs Marie McGrady, Operations Manager, was identified as the appointed safeguarding champion for the home.

Staff told us they were aware of individual patient's wishes, likes and dislikes. It was observed that staff responded to requests for assistance promptly in an unhurried, caring and compassionate manner. Patients were given choice, privacy, dignity and respect.

5.2.2 Care Delivery and Record Keeping

Staff attended a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable about individual patient's needs including, for example, their daily routine preferences. Staff respected patients' privacy and dignity by offering personal care to patients discreetly. It was also observed that staff discussed patients' care in a confidential manner.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients' care records were held confidentially.

Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patient's care needs and what or who was important to them.

Care records regarding patients with behavioural issues were reviewed and evidenced that they were clearly documented and well maintained to direct the care required and reflect the assessed needs of the patient. However, appropriate risk assessments and evaluations had not been completed. Neurological observations for patients who had sustained a head injury due to self-injurious behaviour, where a person harms themselves due to a diagnosed condition such as a learning disability were unavailable to view.

It was noted that appropriate bodies had been informed such as patients' next of kin and the Trust, however, patients' General Practitioner (GP) had not been informed. This was discussed with the manager and an area for improvement was identified.

Supplementary records regarding personal care including the provision of showers/baths were noted to be well documented.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, the speech and language therapist (SALT) and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), SALT or the dietician.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff.

We observed the serving of the lunchtime meal in the dining room on the ground floor. Staff had made an effort to ensure patients were comfortable throughout their meal. A choice of meal with condiments was offered and the food was attractively presented and smelled appetising. The food appeared nutritious and was covered on transfer whilst being taken to patients' rooms. There was a variety of drinks available. Patients wore clothing protectors if required and staff wore aprons when serving or assisting with meals. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Adequate numbers of staff were observed assisting patients with their meal appropriately, in an unhurried manner. The menu plan for three weeks with a separate dessert menu was displayed on the wall outside the kitchen to show patients what meal choices were available. It was not reflective of the food being served for lunch and patients said they were unaware that a menu was available as it had not been displayed in the dining room. The daily menu is required to be displayed in a suitable format including pictorial where necessary, in a suitable location showing what is available at each mealtime. This was discussed with the manager and an area of improvement was identified.

Patients able to communicate indicated that they enjoyed their meal.

5.2.3 Management of the Environment and Infection Prevention and Control

We observed the internal environment of the home and noted that the home was comfortably warm and clean throughout.

It was noted that areas of the home had been refurbished and that identified areas require attention as vinyl flooring appeared raised in places that could cause a future possible trip hazard and carpets appeared worn. This was discussed with the manager who confirmed that a refurbishment plan is in place. This will be reviewed at the next inspection.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were suitably furnished and comfortable.

A variety of methods was used to promote orientation. There were clocks and photographs throughout the home to remind patients of the date, time and place. Patient call systems were noted to be answered promptly by staff.

On review of the home's environment, inappropriate storage of items and equipment was observed in identified bathrooms. Items that had the potential to be shared communally, such as shampoo and shower gel were seen to be stored in bathrooms. In one bathroom it was noted that a number of products used for personal care were stored in an unlocked trolley. This was discussed with the manager and an area for improvement was identified.

Equipment used by patients such as hoists, shower chairs and wheelchairs were noted to be effectively cleaned.

The kitchen, nurses' station, treatment rooms and sluice rooms were observed to be appropriately locked.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors and fire exits were clear from clutter and obstruction.

Personal protective equipment (PPE), for example, face masks, gloves and aprons were available throughout the home. Dispensers containing hand sanitiser were seen to be full and in good working order. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

5.2.4 Quality of Life for Patients

It was observed that staff offered choices to patients throughout the day which included, for example, preferences for what clothes they wanted to wear and food and drink options. Patients could have a lie in or stay up late to watch TV if they wished and they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of the time in their room and staff were observed supporting patients to make these choices.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. The programme of activities was displayed on the noticeboard in the foyer advising patients of forthcoming events. Patients' needs were met through a range of individual and group activities such as going for morning walks, reminiscence therapy, family video calls, playing bingo, quizzes, puzzles, attending games, armchair exercises and arts and crafts.

Daily visiting was in place and the manager confirmed that patients can have visitors at any reasonable time. Staff reported positive benefits of this to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

Since the last inspection there has been no change in the management arrangements.

Discussion with staff and patients evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the manager.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

A review of records and discussion with the manager confirmed that a process was in place to monitor the registration status of registered nurses with the Nursing and Midwifery Council (NMC) and care staff registration with the Northern Ireland Social Care Council (NISCC).

Review of competency and capability assessments evidenced they were completed for trained staff left in charge of the home when the manager was not on duty and for the management of medication.

It was noted that staff supervision and appraisal had commenced. The manager confirmed that arrangements were in place to ensure that all staff members have regular supervision and an appraisal completed this year.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding the provision of activities, care records, falls, wounds and IPC practices including hand hygiene.

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

It is required that the home is visited each month by a representative of the registered provider to consult with patients, their representatives and staff and to examine all areas of the running of the home. These reports were made available for review by patients, their representatives, the Trust and RQIA. The reports of these visits showed that where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed.

The manager confirmed no complaints have been raised this year and that systems were in place to ensure that complaints were managed appropriately. Patients and staff said that they knew who to approach if they had a complaint.

Records reviewed evidenced that patient, patient representative and staff meetings were held on a regular basis. Minutes of these meetings were available.

Staff said that there were good working relationships and commented positively about the manager and described her as approachable, supportive and available to offer advice.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (December 2022)

	Regulations	Standards
Total number of Areas for Improvement	1	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Maria O'Hare, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** From the date of inspection 2 July 2024	The registered person shall ensure that all head injuries are managed in line with current best practice and that neurological observations are completed for twenty-four hours in line with post fall protocol and are reported to the patients' General Practitioner (GP) in accordance with legislation and procedures. Contemporaneous records should be maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: A Quality Improvement (QI) project, led and championed by the Registered Nurses, was successfully completed, resulting in the development of a pathway for managing suspected non-fal -related head injuries. This pathway includes key prompts to ensure that head injuries are managed in accordance with relevant legislation, best practice guidelines, and established procedures. Modeled on the Post-Fall Guidance for Care Homes, the pathway's implementation was supported through supervision and training sessions for the Registered Nurses. Additionally, the Home's Quality Assurance Framework was revised and updated to ensure oversight and alignment with the pathway.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 12 **Stated:** First time **To be completed:** From the date of inspection 2 July 2024	The registered person shall ensure that a daily menu is on display in a suitable format and in an appropriate location, showing patients what is available each mealtime. Ref: 5.2.2
	Response by registered person detailing the actions taken: Following discussions with the Catering Manager, a new system has been implemented to ensure that menus are displayed in an accessible format and in appropriate locations within the dining room. This will be monitored by the Registered Manager and during the provider's visits to ensure continued compliance.
Area for improvement 2 **Ref:** Standard 46 **Stated:** First time **To be completed by:** From the date of inspection 2 July 2024	The registered person shall ensure that items and equipment is appropriately stored within the home; this relates to inappropriate storage within identified communal bathrooms, in order to adhere to best IPC practice and to minimise the risk of infection. The manager should ensure bathrooms are monitored to ensure that they remain clutter free. Ref: 5.2.3
	Response by registered person detailing the actions taken: All care staff have been reminded to ensure that communal bathrooms are kept free of inappropriate items and remain clutter-free. This will be reviewed daily by the Registered Manager and/or Nurse in Charge during routine walkarounds. Compliance will also be monitored during the provider's visits.

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