Wood Lodge
RQIA ID: 1311
Mill Hill
Castlewellan
BT31 9NB

Inspector: Sharon McKnight
Inspection ID: IN021928

Tel: 0284377 8511
Email: lizorourke@woodlodgecare.com

# Unannounced Care Inspection
# of
# Wood Lodge

## 10 June 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

## 1. Summary of Inspection

An unannounced care inspection took place on 10 June 2015 from 10:30 to 14:30 hours.

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and The Department of Health, Social Services and Public Safety's (DHSSPS) Care Standards for Nursing Homes, April 2015.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.3 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Wood Lodge which provides both nursing and residential care.

### 1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 18 December 2015.

### 1.2 Actions/Enforcement Resulting from this Inspection

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

### 1.3 Inspection Outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 0 | 3 |

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager Liz O'Rourke as part of the inspection process. The timescales for completion commence from the date of inspection.

## 2.Service Details

| | |
|---|---|
| **Registered Organisation/Registered Person:**<br>G & M Lodge Care Ltd<br>Liam John Lavery | **Registered Manager:**<br>Liz O'Rourke |
| **Person in Charge of the Home at the Time of Inspection:**<br>Liz O'Rourke | **Date Manager Registered:**<br>31 March 2014 |
| **Categories of Care:**<br>RC-I, RC-PH, NH-I, NH-PH, NH-PH(E), NH-TI<br>Maximum of 26 residents in residential categories RC-I and RC-PH | **Number of Registered Places:**<br>49 |
| **Number of Patients Accommodated on Day of Inspection:**<br>Total of 43 patients – 29 nursing<br>14 residential | **Weekly Tariff at Time of Inspection:**<br>Residential £470<br>Nursing £593 |

## 3. Inspection Focus

The focus of this inspection was to review the level of compliance attained regarding the requirements and recommendations made as a result of the previous inspection of 18 December 2015.

## 4. Methods/Process

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

- discussion with the registered manager
- discussion with staff
- discussion with patients
- discussion with a relative
- review of records
- observation during a tour of the premises
- evaluation and feedback.

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report.

During the inspection, the inspector met with six patients individually and with the majority generally, one registered nurse, three care staff, two housekeeping staff and the relative of one patient.

The following records were examined during the inspection:

- care records of four patients
- recruitment records of two staff
- risk assessments for privacy screens.

## 5. The Inspection

### 5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced estates inspection dated 2 June 2015. Given the short timescale between inspections a report of the estates inspection had not been issued at the time of this inspection. There were no issues from the estates inspection on 2 June 2015 to be followed up during this inspection.

### 5.2 Review of Requirements and Recommendations from the last care Inspection

<table>
<tr><th colspan="2">Last Care Inspection Statutory Requirements</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Requirement 1<br><br>Ref: Regulation 21, schedule 2<br><br>Stated: First time</td><td>The registered manager must ensure that all of the required records are obtained prior to staff commencing employment.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:<br>Review of two recruitment files evidenced that all of the required records had been obtained prior to staff commencing employment. This requirement has been met.</td></tr>
</table>

| | | |
|---|---|---|
| **Requirement 2**<br><br>**Ref**: Regulation 25 (b)<br><br>**Stated:** First time | A facility must be created on the computerised care record system to ensure that agency nurses can record entries to patients care records and that the record of who created the entry is correctly logged. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The registered manager confirmed that 'guest log' facilities had been created on the computerised system to ensure that all entries made by agency nurses were accurately logged and traceable to the individual nurse.<br><br>A guest facility had also been created for agency care assistants. However there was only one guest log in and on occasion there would be more than one agency care assistant on shift. This was reviewed by the registered manager and administrator and prior to the end of this inspection additional guest log facilities had been created with a written record to evidence who had accessed each log in and on what date.<br><br>This requirement has been met. | |
| **Last Care Inspection Recommendations** | | **Validation of Compliance** |
| **Recommendation 1**<br><br>**Ref**: Standard 5.6<br><br>**Stated:** First time | Repositioning charts should be consistently recorded to evidence regular repositioning. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of three patient repositioning charts evidenced that, according to the number of entries, patients were repositioned regularly. This recommendation as stated has been met.<br><br>However the charts examined did not consistently include the time the patient was repositioned or the change of position. This is further discussed on section 4.3 of this report. | |

| | | |
|---|---|---|
| **Recommendation 2**<br><br>**Ref**: Standard 5.3<br><br>**Stated:** First time | The registered manager should ensure that an individual care plan is in place for each wound. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of one patient's care records evidenced that there was a care plan in place with individual wound assessments and progress charts. This recommendation has been met. | |
| **Recommendation 3**<br><br>**Ref**: Standard E21<br><br>**Stated:** First time | The registered manager should ensure that each room is individually assessed and where possible ceiling mounted screens provided. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>A risk assessment was in place for the use of mobile screens in each of the shared rooms. The registered manager explained that the provision of ceiling mounted screens was not practical due to the layout of the rooms. The inspector was satisfied that the screens provided supported patient privacy. This recommendation has been met. | |
| **Recommendation 4**<br><br>**Ref**: Standard 19.1<br><br>**Stated:** First time | The specific type of continence products that patients/residents' require should be included in the patients'/residents care plans. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>The specific type of continence products that patients required was not included in the care plans reviewed. This recommendation has not been met and is stated for a second time. | |

| | | |
|---|---|---|
| **Recommendation 5**<br><br>**Ref**: Standard 19.2<br><br>**Stated:** First time | Publications on the management of bladder and bowel continence and catheter and stoma care should be readily available in the home to inform and guide staff on best practice. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The registered manager confirmed that best practice guidance on the management of bladder and bowel continence, catheter and stoma care were now available in the home. This recommendation has been met. | |

### 5.3 Inspection findings

**Is Care Safe? (Quality of Life)**

Review of staffing, observation of care delivery and discussion with staff, patients and a relative evidenced that staffing levels were appropriate to meet the needs of the patients in a timely manner.

The registered manager confirmed that there was a rolling programme of mandatory training which was available through an e learning programme. Staff spoken with commented positively regarding the option of completing their training on line. The registered manager confirmed that she would monitor compliance levels with the e learning to ensure that staff completed the required training.

**Is Care Effective? (Quality of Management)**

A deputy manager was appointed in February 2015 to provide support to the registered manager. The deputy manager will work the majority of their hours as a registered nurse but had been allocated time to undertake managerial tasks, for example, the staff duty roster.

Review of four care records evidenced that a range of assessments and risk assessments, for example moving and handling, nutrition and pain assessments, had been completed for all patients. However there was no comprehensive assessment of nursing need undertaken at the time of admission to the home, in two of the care records reviewed. Where nursing needs had been identified care plans were not always in place to direct staff on the management of the care required.

As previously discussed in section 4.3 review of three patients repositioning charts evidenced that, charts examined did not consistently include the time the patient was repositioned or the change of position.

**Is Care Compassionate? (Quality of Care)**

Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required. Good relationships were evident between patients and staff. Those patients who were unable to verbally express their views were observed to be well groomed and were relaxed and comfortable in their surroundings.

All grades of staff demonstrated their knowledge of individual patients. A member of the housekeeping team told of a patient's previous interests and of how they engaged with the patient and accompanied them to a football match. A review of bed side charts evidenced that those patients who were being nursed in bed, were attended by staff on a regular basis.

Discussion took place with six patients individually and with the majority of others in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were positive.

One patient's relative confirmed that they were happy with the standard of care and communication with staff in the home. They confirmed that they were confident that any issues raised with the registered manager or registered nurses would be addressed. The relative provided a number of examples of the compassionate care their loved one had received.

Staff spoken with stated that they were happy working in the home and were satisfied that they were enabled to delivery care in a timely manner. No issues were raised with the inspector.

**Areas for Improvement**

A comprehensive and holistic assessment should be completed for each patient. The assessment should commence on the day of admission and be completed within five days of admission to the home. A detailed plan of care should be generated from this assessment in accordance with the DHSSPS Care Standards for Nursing Homes, April 2015.

It is recommended that the time patients are repositioned is recorded together with the position of the patient.

| **Number of Requirements:** | **0** | **Number of Recommendations**: | **2** |
|---|---|---|---|

## 6 Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Liz O'Rourke, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

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

Matters to be addressed as a result of this inspection are set in the context of the current registration of 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.

### 6.1 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 (Northern Ireland) 2005.

### 6.2 Recommendations

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

### 6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

## Quality Improvement Plan

| Recommendations | |
|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 19.1<br><br>**Stated:** Second time<br><br>**To be Completed by:**<br>10 July 2015 | The specific type of continence products that patients/residents' require should be included in the patients'/residents care plans. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>This has been discussed with staff and the specific type of product is included in careplans. |
| **Recommendation 2**<br><br>**Ref:** Standard 4, criteria 1<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>10 July 2015 | It is recommended that a comprehensive and holistic assessment is completed for each patient. The assessment should commence on the day of admission and be completed within five days of admission to the home. A detailed plan of care should be generated from this assessment |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Each patient on admission has an admission checklist which is signed and dated by staff member and requires to be completed within allocated time. |
| **Recommendation 3**<br><br>**Ref:** Standard 4, criteria 9<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>10 July 2015 | It is recommended that the time patients are repositioned is recorded together with the change of position of the patient. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>This has been discussed with staff and staff have been reminded that documentation is completed correctly ensuring date and time is entered. |

| | | | |
|---|---|---|---|
| **Registered Manager Completing QIP** | Liz ORourke | **Date Completed** | 08:07:15 |
| **Registered Person Approving QIP** | Liam Lavery | **Date Approved** | 08:07:15 |
| **RQIA Inspector Assessing Response** | Sharon McKnight | **Date Approved** | 8-07-15 |

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

***Please complete in full and returned to RQIA nursing.team@rqia.org.uk ****