Unannounced Secondary Care Inspection

Name of Establishment:	**Wood Lodge**
Establishment ID No:	**1311**
Date of Inspection:	**18 December 2014**
Inspector's Name:	**Sharon McKnight**
Inspection ID	**17203**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Home:	Wood Lodge
Address:	Mill Hill Castlewellan BT31 9NB
Telephone Number:	0284377 8511
E mail Address:	lizorourke@woodlodgecare.com
Registered Organisation/ Registered Provider:	Mr Liam John Lavery
Registered Manager:	Mrs Elizabeth O'Rourke
Person in Charge of the Home at the Time of Inspection:	Mrs Elizabeth O'Rourke
Categories of Care:	RC-I, RC-PH, NH-I, NH-PH, NH-PH(E), NH-TI
Number of Registered Places:	49
Number of Patients Accommodated on Day of Inspection:	33 patients 12 residents
Scale of Charges (per week):	NH - £567 RC - £450
Date and Type of Previous Inspection:	21 May 2014 Secondary Unannounced Inspection
Date and Time of Inspection:	18 December 2014 10 40 – 15 00 hours
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 staff duty rotas.
- Review of a sample of care plans.
- Review of the complaints, accidents and incidents records.
- Evaluation and feedback.
- Observation during a tour of the premises.

5.0 Consultation Process

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

Patients/Residents	**7patients/residents individually and with the majority generally.**
Staff	**7**
Relatives	**0**
Visiting Professionals	**0**

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**0**	**0**
Relatives/Representatives	**4**	**1**
Staff	**6**	**2**

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.

Prior to this inspection RQIA were contacted by a whistle blower expressing concerns in the following areas:

- Non adherence to recruitment procedures.
- Access to the computerised care record system by agency staff.
- Restrictive practice.

It is not the remit of RQIA to investigate complaints made by or on 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. On this occasion, as an inspection was scheduled to be undertaken, the date of the inspection was brought forward and the inspection focus extended to include the following areas:

- A review of staff recruitment procedure within the home.
- A review of a sample of staff recruitment files.
- Discussion with the registered manager re the management of the computerised care Record system and access for agency staff.
- A review of the use of restrictive practice.
- Discussion with staff regarding their knowledge and understanding of restrictive practice.

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

Wood Lodge Nursing and Residential Home is situated on a seven acre site on the outskirts of Castlewellan, County Down. All local amenities are in the nearby town of Castlewellan. The nursing home is owned and operated by the registered provider, G & M Lodge Care Ltd. The responsible individual is Mr Liam Lavery. The current registered manager is Liz O'Rourke.

Accommodation for patients / residents is provided over the two floors of the home. Access to the first floor is via a passenger lift and stairs. Bedroom accommodation consists of single and double bedrooms. There are a range of sitting rooms and washrooms / toilets located throughout the home. The dining room is situated on the ground floor with scenic views of the local countryside. Catering and laundry services are available on the ground floor of the home.

The home is registered to provide care for a maximum of 49 persons under the following categories of care:

Nursing care

I	Old age not falling into any other category, if required, to a maximum of 31 Patients
PH	Physical disability other than sensory impairment under 65
PH(E)	Physical disability other than sensory impairment over 65 years
TI	Terminally ill

Residential care

I	Old age not falling into any other category
PH	Physical disability other than sensory impairment under 65

8.0 Executive Summary

This unannounced inspection of Wood Lodge was undertaken by inspector Sharon McKnight on 18 December 2014 between 10 40 and 15 00 hours. The inspection was facilitated by Mrs Liz O'Rourke, registered manager, who was available throughout the day and was provided with verbal feedback at the conclusion of the inspection.

As a result of the previous inspection on 21 May 2014 three requirements and four recommendations were issued. Review of the requirements evidenced that they have been fully complied with. A recommendation with regard to the completion of repositioning charts was made following review of a requirement. Review of three of the previous recommendations evidenced that two have been complied with and one is assessed as moving towards compliance and is stated for a second time. One recommendation is carried forward for review at a future inspection. Details can be viewed in the section immediately following this summary.

During the course of the inspection, the inspector met with patients/ residents and staff. The inspector observed care practices, examined a selection of records, issued staff and relative questionnaires and carried out a general inspection of the nursing home environment as part of the inspection process.

The inspector reviewed assessments and care plans in regard to the management of continence in the home. Bladder and bowel continence was assessed in the holistic assessment of need. These assessments were reviewed and updated regularly. Continence management, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Areas for improvements were identified in the care records and a recommendation has been made.

Staffs spoken to on the day of the inspection were knowledgeable regarding the management of continence and urinary catheters. It is recommended that best practice publications on the management of bladder and bowel continence and catheter and stoma care should be readily available in the home to support and guide staff on best practice.

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

Following review of the issues raised by the whistle blower requirements were made with regard to the recruitment processes within the home and the arrangements for accessing the computerised record system. There was no evidence identified during this inspection to substantiate the positioning of furniture as a form of restraint within the home or the inappropriate use of restrictive practice. The seriousness of this allegation was discussed with the registered manager and it was agreed that she would continue to monitor the positioning of furniture in the lounges and dining room.

Conclusion

The inspector can confirm that at the time of this inspection the delivery of care to patients/residents was evidenced to be of a good standard. There were processes in place to ensure the effective management of the standard inspected.

Therefore, two requirements and five recommendations are made as a result of this inspection. One of the recommendations is stated for a second time and one is carried forward for review at a future inspection. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

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

The inspector would also like to thank the relative and staff who completed questionnaires.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Regulation 16(2)	The registered manager must ensure: • Interventions regarding pain management are included in the care records. • Repositioning charts are in place for those patients' assessed at risk of receiving pressure ulcers, particularly those who mainly reside in bed. • Care records are reviewed and audited. Any trends or deficits identified should be followed up and actioned in keeping with the homes policies and procedures and best practice.	**Review of care records evidenced:** • **Pain management was included in the care records for both nursing and residential clients.** • **Repositioning charts were being completed for those patients at risk of receiving pressure ulcers, particularly those who mainly reside in bed.** • **The record of care plan audit now includes the date of re-audit and if the deficit has been addressed.** **This requirement is assessed as compliant.**	**Compliant**

2	Regulation 19(1)(a)	The registered person shall maintain in respect of each patient a record which includes the information, documents and other records specified in Schedule 3 relating to the patient.	**Review of care records evidenced that the required records were in place. This requirement is assessed as compliant.** **However review of repositioning charts evidenced that they were not consistently recorded to evidence regular repositioning. A recommendation has been made.**	**Compliant**
3	17(1)	The registered person shall review the auditing process regarding the management of care records in the home to ensure they are maintained in keeping with best practice. The registered person shall review the management and control of operations in the home to ensure the standards implemented are in keeping with best practice.	**Review of the record of care plan audits 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	Criteria 16.2	The registered manager should ensure that an awareness of safeguarding vulnerable adult issues are included on day one of induction for all staff.	**Review of induction programmes evidenced that this recommendation has been complied with.**	**Compliant**
2	Criteria 5.3	The registered manager should ensure that an individual care plan is in place for each wound.	**Review of care records for two patients with more than one wound evidenced that individual care plans were not in place. This recommendation is assessed as moving towards compliance and is stated for a second time.**	**Moving towards compliance.**
3	Criteria 30.1	The registered manager should review the provision of registered nurses on duty from the hours of 21 00 to 22 00 daily.	**Review of staffing confirmed that there are now two registered nurses on duty between 21 00 and 22 00 hours. This recommendation has been complied with.**	**Compliant**
4	Criteria E21	The registered manager should ensure that each room is individually assessed and where possible ceiling mounted screens provided.	**The registered manager confirmed that each room had been individually assessed. However these were not reviewed on the day of inspection. Therefore this recommendation is carried forward for review at a future inspection.**	**Carried forward for review at a future inspection.**

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

Since the previous inspection on 21 May 2014, RQIA have been notified by the registered manager of ongoing investigations 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 four patients' and two residents care records evidenced that the assessment of continence needs was included in the "holistic assessment of need" tool. The outcome of these assessments was incorporated into the patients'/residents care plans on continence care. Two care records reviewed included the specific type of continence products that patients/residents' required. It is recommended that this information is included in all of the patients'/residents care plans. Discussion with staff confirmed that residential client's continence needs were also assessed by the district nursing services of the local health and social care trust. Patients/residents care records evidenced that bladder 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/residents' 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 recorded in the care plan. Care records evidenced that catheters were changed regularly and in accordance with the recommended frequency. Fluid charts to monitor patients' fluid intake and urinary output were maintained for those patients with urinary catheters. Patient's care records evidenced that patients/residents and/or their representatives were informed of changes to patient need and/or condition and the action taken.	Compliant

Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	
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 discussed the availability of best practice guidance documents within the home. None were available at the time of this inspection. It is recommended that publications on the management of bladder and bowel continence and catheter and stoma care are readily available in the home to inform and guide staff on best practice.	

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:	
Nursing 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. Currently there were a number of registered nurses who undertake male catheterisation. Review of staffing training records evidence that the registered nurses on the duty roster for the week of the inspection had all attended an update on catheterisation in the last 12 months. Staff also confirmed that there was good support, and training opportunities, from the local health and social care trust.	Compliant

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

11.0 Additional Areas Examined

11.1 Staff recruitment

A whistle blower had raised concerns with RQIA that on one occasion a member of staff worked in the home without the correct recruitment processes being completed.

In light of this concern the inspector reviewed the general recruitment procedures within the home. The policy on recruitment of staff was reflective of legislative requirements and DHSSPS guidance. Discussion with the registered manager evidenced that they were knowledgeable regarding the correct recruitment procedures to follow and the records required to be maintained.

Recruitment records of two staff currently employed in the home contained the following records:

- A recent photograph and proof of identify of the candidate.
- A full employment history, including the reason for leaving previous posts and an explanation of any gaps in employment.
- An ACCESS NI enhanced disclosure certificate, received prior to commencement of employment.
- A health declaration.
- One written reference.

The references obtained were from the candidates' most recent employers but only confirmed the date of employment. Both files contained letters requesting two written references for each employee. However the candidates had commenced employment without the second reference being obtained. All of the information required and documents specified in regulation 21, schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005 must be obtained prior to staff commencing employment. A requirement has been made.

11.2 The use of restraint within the home and restrictive practice

The whistle blower raised concerns regarding the use of tables as a form of restraint, for two named patients but also stated that this was common practice with the home. The concerns regarding the named patients were referred by RQIA to the adult safe guarding team of the relevant health and social care trust for screening under the regional protocol.

As a focus of this inspection the inspector sought to identify any form of restraint through observation and to assess staff awareness of the use of restraint and restrictive practice. On arrival in the home the inspector visited the lounge on the ground floor. There was no furniture observed to be positioned in a manner that would restrict patient movement. An inspection of the dining room, which had recently been used for breakfast, evidenced that tables and chairs were not positioned closely to the walls to inhibit patients' movement.

The inspector spoke with five members of staff regarding the use of restraint and restrictive practices within the home. Staff were aware of what constituted restraint and restrictive practice. Discussion took place with staff regarding unintentional restraint, for example the use of recliner chairs. Staff explained that this lounge was supervised by staff at all times and if a

patient was observed having difficulty getting up from a chair this would be observed by staff and assistance provided.

Review of care records evidenced that care plans were in place to manage restrictive practice, for example the management of patients' cigarettes, if the patient was unable to ration their own, and the management of the key pad on the external door into the courtyard. The existence of these care plans evidenced an awareness of the necessity to appropriately manage restrictive practice.

Following observations, discussion with staff and review of care records the inspector was satisfied that staff had an awareness of restraint and restrictive practice. Following discussion with the registered manager it was agreed that she would continue to monitor the positioning of furniture in the lounges and dining room.

11.3 Care records

The whistle blower raised concerns that registered nurses supplied by an employment agency could not record care delivery on the computerised care record system as they did not have individual log in details. The whistle blower reported that registered nurses employed by the home use their log in details to allow agency nurses to record care.

This is concerning as the authenticity of the registered nurses identity is validated through their electronic log in and password. Therefore the records entered by the agency nurse would be logged against the wrong nurse. This would compromise traceability and accountability for both the agency nurse and the nurse who had shared their log in details.

These concerns were shared with the registered manager who confirmed that there currently was no log in facility for agency nurses.

Registered nurses must be supported to meet and maintain their professional standards for record keeping. It is therefore required that a facility is created to ensure that agency nurses can record entries to patients care records and that the record of who created the entry is correctly logged.

As previously discussed in section 9 review of repositioning charts evidenced that they were not consistently completed and therefore did not evidenced that patients' were repositioned regularly.

11.4 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. Staff were observed to respond to patients' requests promptly.

On the morning of the inspection a group of children from a local school were carol singing in the home. The patients/residents joined in with the singing and enjoyed the presence of the children.

Review of bed side charts evidenced that those patients who were being nursed in bed, and unable to summon help, were attended by staff on a regular basis.

11.5 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.

11.6 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.

The registered manager confirmed in the returned questionnaire that the home have a transport policy and procedure in place and that they do provide transport services to residents. However in response to the questions "Does the home have a written transport agreement with each resident/their representative which details the arrangements for providing transport to the resident, the current charges to the resident and the method of payment? And, "Does the home maintain up to date records of all charges made to residents for the provision of transport?" the registered manager had stated "not applicable." This was discussed with the registered manager who confirmed that whilst the home does provide transport in a minibus owned by the home, there is no charge to patients for this service.

11.7 NMC Declaration

Prior to the inspection the home 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 registered nurses, including the home manager, were appropriately registered with the NMC and that the registration status of all nursing staff was checked at the time of expiry.

11.8 Patients/Residents Comments

During the inspection the inspector spoke with seven patients/residents 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, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

Examples of patients' comments were as follows:

"I count this as my home now."
"carers are very good."
"food is lovely everyday."
"no complaints, I get everything I want."

There were no concerns raised by patients during the inspection

11.9 Relatives comments

The inspector did not meet with any relatives during the inspection. One completed questionnaire was received by RQIA following the inspection. The respondent indicated that that the relative was satisfied with the care their loved one was receiving. A commented included was:
"I am always welcomed and provided with tea which I enjoy with my ….I just think at times more staff would help."

The number of staff on each shift was discussed with the registered manager and planned staffing was in accordance with RQIA "Staffing guidance for nursing homes" August 2009.

11.10 Staff Comments

During the inspection the inspector spoke with seven staff including a registered nurse, senior care assistant, care assistants and housekeeping staff. Staff spoken with commented positively in regard to the care delivery in the home, management and the support and training available. Staff were knowledgeable regarding the safe guarding vulnerable adult reporting procedures, whistle blowing and what constituted restrictive practice.

Six questionnaires were issued for staff following the inspection, two were returned. Staff responses indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus 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.

There were no concerns raised by staff during the inspection.

11.12 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients'/residents' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were clean and fresh smelling.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Liz O Rourke, 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.

Where the inspection resulted in no recommendations or requirements being made the provider/manger is asked to sign the appropriate page confirming they are assured about the factual accuracy of the content of the report.

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

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**
Prior to admission to the home and at time of admission a nurse carries out and records an initial assessment using a validated assessment tool, Information received from care management team informs this assessment A Comprehensive holistic assessment of patients care needs using a validated assessment is completed within 11 days of admission Nutritional screening is carried out with patients on admission using a validated tool such as the Malnutrition Universal Screening Tool. A pressure ulcer risk assessment tool including nutritional,pain and continence assessments combined with clinical	Compliant

judgement is carried out on all patients prior to admission where possible and on admission to the home.	

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 has responsibility for discussing,planning and agreeing nursing interventions with individual patients and their representatives Advice and recommendations from relevent Health Professionals are taken into account	Substantially compliant

where appropriate. Nursing Careplans demonstrates the promotion of maximum independence and rehabilitation There are referral arrangements to obtain advice and support from relevent health professionals Staff are aware how to contact tissue viability for advice. A documented pressure ulcer prevention and treatment programme is drawn up which meets the patients needsand comfort and agreed with relevent health professionals. Referral arrangements are in place to relevent Health Professionals who have the knowledge and expertise to diagnose treat and care for patients who have lower limb or foot ulceration. Staff are aware of referral arrangements for dietition to assess individual patients requirements, Dietitions document on Epicare system and Dietitions treatment plan and recomendations are incorperated into patients careplan and these plans are adhered to.	

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**
Re-assessment is an on going process which is carried out daily and at identified agreed time intervals Care records are re assessed monthly and or when a condition changes.	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**
All nursing interventions and procedures are supported by research evidence and guidelines. A validated pressure ulcer grading tool is used to screen patients , In Woodlodge the Braden Scale is used,and appropriate treatment plan is then implemented. Up to date nutritional guidelines are in place and are used on a daily basis these are found in Nutrition promotion pack.	Substantially compliant

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**
Contemporaneous nursing records in accordance with NMC guidelines are kept of all nursing interventions activities and procedures these records are updated in relation to each patients needs and will include outcomes. Records of patients meals is recorded a daily menu is displayed in a prominent place in the dining room and patients make their choice on a daily basis from the menu A record is maintained of their choice. Patients record of food consumed is maintained on the touchscreens for epicare A written record is also maintained for those patients who are bed bound and unable to make a choice or chooses not to eat a meal If a patient chooses not to eat a meal it is documented on daily progress report.	Moving towards complian

A written record has now been commenced where a patient is eating excessively. All such occurrences are discussed with each patient and reported to the nurse in charge and is documented, Where it is necessary a referral is made to Dietition and is fully documented on epicare system.	

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**
Daily evaluations are documented on each patient on a day to day basis , Any changes to care is updated as it happens in the patients care records and is reveiwed and evaluated on a monthly basis or more often if the need arises. Patients representatives are informed of any new developments or changes as they happen.	Moving towards complian

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**
Care reviews are arranged and held in the home they are arranged by care manager or monitering officer for the trust on a yearly basis, If deemed necessary or if a problem arises a care review can be requested to take place. The results of all reveiws and the minutes of review meetings are recorded and where required changes are made to nursing care plans with the agreement of patients and representatives. Patients and their representatives are kept informed of progress.	Substantially 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**
A varied nutritious menu is displayed on a three weekly basis meeting their individual dietry needs Full account is taken of the relevent guidance documents or guidance provided by dietition or other professionals and disciplines. The daily menu in Woodlodge offers a choice of meals all patients are given the option if they don't like choices an alternative meal is provided . A choice is also offered for specific diets.	Compliant

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**
Training has been given in house and staff have also attended training at different venues to update knowledge and skills in managing feeding techniques for patients who have swallowing difficulties and instructions drawn up by the speech and lauguage therapists are adhered to. Meals are served at conventional times Hot and cold drinks and snacks are available at customary times and or if	Moving towards complian

requested at any time of the day,Fresh drinking water is always available. All staff are fully aware risks when patients are eating or drinking eg what type of diet and if fluids required to be thickened and to which consistancy they are prescribed., Staff are aware if assistanc is required and is provided. Staff are aware of any necessary aids and equipment. if deemed necessary, Where a patient requires wound care Staff are up to date in their skills in wound management further training in General principals of wound management is scheduled for later this month and nurses are scheduled to attend.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Moving towards compliance

Quality Improvement Plan

Secondary Unannounced Care Inspection

Wood Lodge Nursing and Residential Home

18 December 2014

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 the registered manager Liz O'Rourke 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	21, schedule 2	The registered manager must ensure that all of the required records are obtained prior to staff commencing employment. **Ref section 11, 11.1**	One	All of the information and documents specified in regulation 21. A checklist has now been devised and is inserted on cover page of personal file for recruitment	Ongoing from the date of inspection.
2	25(b)	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. **Ref section 11.3**	One	A Guest login has been created and any agency nurses sign in with this,and signing their name when entry is logged.	By the end of January 2015

Recommendations

These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.6	Repositioning charts should be consistently recorded to evidence regular repositioning. **Section 9**	One	Repositioning charts are now being consistently recorded and are checked by staff nurses at end of their shift.	By the end of January 2015
2	5.3	The registered manager should ensure that an individual care plan is in place for each wound. **Ref section 9**	Two	Individual care plans are in place for each wound	By the end of January 2015
3	E21	**Carried forward for review at a future inspection** The registered manager should ensure that each room is individually assessed and where possible ceiling mounted screens provided. **Ref section 9**	One	Each room is individually assessed for mobile screens, the possibility of ceiling mounted screens will be reviewed.	Two months
4	19.1	The specific type of continence products that patients/residents' require should be included in the patients'/residents care plans.	One	Specific types of continence products are included in patients/residents careplans.	By the end of January 2015

		Ref section 10, criterion 19.1			
5	19.2	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. **Ref section 10, 19.2**	One	RCN publications on management of bladder and bowel continence and catheter and stoma care is available in the home up dated training is scheduled for staff. To guide on best practice	By the end of January 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	Liz O Rourke
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Liam Lavery

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	X	Sharon McKnight	4-03-15
Further information requested from provider			