Unannounced Care Inspection Report
31 May 2016

Wood Lodge

Address: Mill Hill, Castlewellan, BT31 9NB
Tel No: 0284377 8511
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Wood Lodge took place on 31 May 2016 from 09:35 hours to 17:00 hours.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

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.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

Areas for improvement were identified; one to ensure that the registered nurse in charge of the home in the absence of the registered manager was clearly identified on the staff duty roster; another to review the recording of competency and capability assessments to reflect greater detail. Two recommendations were made.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that the outcome of care delivery was positive for patients. A review of care records confirmed that patients were subject to a comprehensive assessment of need which was then used to develop appropriate care plans. There were arrangements in place to monitor and review the effectiveness of care delivery. Patients, relatives and staff reported that they were happy with the care they received. We examined the systems in place to promote communication between staff, patients and relatives and were assured that these systems were effective.

Areas of improvement were identified in the delivery of effective care; three relating to care records and one with regard to the frequency with which staff meetings are held. Four recommendations were made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff were also observed to be taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to the care they received.

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure and staff were aware of their roles and responsibilities. A review of care confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide. There was evidence of leadership in the home and governance arrangements.

There were no areas of improvement identified in the domain of well led.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**6**

Details of the QIP within this report were discussed with Liz O'Rourke, registered manager and Marian Kelly, deputy manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection.

Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

In May 2016 RQIA received an anonymous call via the duty inspector system raising concerns regarding how staff spoke to patients. At that time the caller was advised of the role of RQIA; the concerns were passed by RQIA to the relevant health and social care trust as a potential adult safeguarding issue.

Following discussion with RQIA senior management and the relevant health care trust, it was agreed that the focus of the inspection would subsume the alleged area of concern. The outcome of the inspection did not substantiate the concern raised. The findings of the inspection were shared with the relevant health and social care trust following the inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: G & M Lodge Care Ltd	**Registered manager:** Elizabeth O'Rourke
Person in charge of the home at the time of inspection: Elizabeth O'Rourke	**Date manager registered:** 31 March 2014
Categories of care: RC-I, RC-PH, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 49

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we met with 14 patients individually and with the majority of others generally, the deputy manager, residential care manager, one registered nurse, 2 senior care assistants, six care staff, two domestic assistants and the activity leader.

A poster indicating that the inspection was taking place was displayed in the home and invited visitors/relatives to speak with the inspector.

Ten questionnaires were also issued to relatives and staff with a request that they were returned within one week from the date of this inspection.

The following records were examined during the inspection:

- three patient care records
- staff duty roster for the week commencing 30 May 2016
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- reports of monthly visits undertaken in accordance with Regulation 29

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 18 November 2015.

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

4.2 Review of requirements and recommendations from the last care inspection dated 18 November 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 36.2 **Stated:** First time **To be Completed by:** 5 January 2016	It is recommended that when the policies on communication, palliative care, death and dying and bereavement are reviewed and issued staff should receive an induction/training on the content. **Action taken as confirmed during the inspection**: The policy entitled Palliative Care included sections of communication, care of the dying and care after death. The reviewed policy had been shared with staff who had signed to confirm that they had read and understood the content. This recommendation has been met.	**Met**
Recommendation 2 **Ref**: Standard 39 **Stated:** First time **To be Completed by:** 5 January 2016	Training/development opportunities on communicating effectively with relatives, as part of end of life care, should be provide for staff. **Action taken as confirmed during the inspection**: A review of training records evidenced that training had taken place in April 2016 entitled "Communication and the bereaved." This recommendation has been met.	**Met**

Recommendation 3 **Ref**: Standard 20.2 **Stated:** First time **To be Completed by:** 5 January 2016	Further opportunities, to discuss end of life care, should be created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that opportunities had been created to discuss end of life care and where wishes had been expressed a care plan was in place. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 30 May 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic and laundry staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients commented positively regarding the staff and care delivery.

The registered manager, registered nurses and staff spoken with were aware that a nurse was identified to be in charge of the home when the registered manager was off duty. The nurse in charge was not identified on the staffing roster. This was discussed with the registered manager and a recommendation stated.

A review of records evidenced that a competency and capability assessment had been completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessment listed the general areas for assessment; for example responds effectively in emergency situations or has sound knowledge of relevant procedures and protocols. There was no detail of what information had been discussed or what knowledge had been assessed. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home. The benefit of recording the detail of what was assessed under each heading was discussed with the registered manager and a recommendation stated.

Discussion with the registered manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed.

The registered manager was knowledgeable regarding the management of the Northern Ireland Social Care Council (NISCC) registration process for newly employed care staff.

A review of one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.

Discussion with staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The programme included a written record of the areas completed and the signature of the staff member and the person supporting the new employee. On completion of the induction programme the registered manager signed the record to confirm that the induction process had been satisfactorily completed.

Training was available via an e learning system known as “EVO training”. Training opportunities were also provided by the local health and social care trust. The registered manager had systems in place to monitor staff attendance and compliance with training. These systems included a print out of which staff had completed an e learning training, signing in sheets to evidence which staff had attended face to face training in the home and a record of staff who attended training outside of the home. A review of the print out of mandatory training evidenced good compliance with mandatory training in 2015; for example 92% of staff had completed adult safeguarding training in the past 12 months, 96% had completed the e learning programme for moving and handling. Mandatory training was ongoing for 2016.

Review of three patient care records evidenced that a range of validated risk assessments were completed to accurately identify risk and inform the patient’s individual care plans.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses, care staff and domestic staff described the types of abuse and were able to provided examples of what could be considered as abuse, for example tone of voice, rushing patient or failing to respond to patients’ requests for care. Staff were aware of whom to report concerns to within the home. Annual refresher training in adult safeguarding was considered mandatory by the home.

A general inspection of the home was undertaken to examine a random sample of patients’ bedrooms, lounges, bathrooms and toilets. A number of the patients’ bedrooms had recently been redecorated; the standard and overall appearance of the rooms was commended. The registered manager informed us that further refurbishment was planned for the corridor areas. The carpet on the back stairs was observed to be worn and stained in places; the registered manager confirmed that this carpet was due for renewal as part of the ongoing refurbishment. The majority of patients’ bedrooms were personalised with photographs, pictures and personal items. The home was clean and appropriately heated. With the exception of one area the home was fresh smelling. The management of odours in the identified area was discussed with a domestic assistant who provided a detailed account of the recent action taken in an attempt to eliminate the malodours. Following discussion with the domestic staff and the registered manager we were assured that the home was working to find a solution to the malodour. The registered manager agreed to monitor the situation closely.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for improvement

The registered nurse in charge of the home when the registered manager is off duty should be clearly identified on the staff duty rosters.

The current competency and capability assessment completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager should be further developed to include greater detail of what is assessed under each heading.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.4 Is care effective?

We reviewed three patients' care records to evaluate the admission process, the updating of care records when a patient's condition changes and the day to day maintenance of care records.

A review of one care record evidenced that a comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home. The holistic assessment contained good detail of the patient's individual needs. Initial plans of care were generated within 24 hours of admission. As previously discussed a range of validated risk assessments were also completed as part of the admission process. A direction, regarding care deliver, was recorded in the patient's care records; the direction had been agreed with the relevant health and social care trust. There was no detail of how the intervention would be managed or why it was required. It was agreed that a care plan would be put in place to include this information. A recommendation was made.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians.

A review of another care record evidenced that the holistic assessment and risk assessments had been reviewed and updated in response to a change in a patient's condition. The care plan for eating and drinking had been updated to reflect recommendations following an assessment by SALT. Care plan evaluations reflected the change to the patient's condition; however the care plan had not been updated. It was recommended that following evaluation of care plans prescribed interventions should be updated to meet the needs of the patient.

A review of a third care record evidenced that care records were regularly reviewed and updated, as required. We reviewed the completion of a repositioning chart; the review was for a period of six days. There were significant gaps in the record. A system to monitor and ensure repositioning charts were completed accurately should be introduced. A recommendation was made.

There was evidence within each of the care records that patients and/or their representatives were involved in the care planning process. There was also evidence of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust.

These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication. Observation of a handover report in the afternoon confirmed that the shift handover provided information regarding each patient's condition and any changes noted. The handover also included any administrative tasks to be completed.

The registered manager confirmed that staff meetings were held regularly with all staff teams. The most recent meeting was a management meeting held on 10 February 2016. This meeting included the registered manager, deputy manager, officer in charge of residential care and the administrator. Minutes of this meeting detailing the areas discussed were available. No other staff meetings had taken place in 2016. The most recent meetings were held in April and May 2015. Staff meetings should take place regularly and at a minimum quarterly in accordance with DHSSPS Care Standards for Nursing Homes (April 2015). A recommendation was made.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. The registered manager explained that they had regular, daily contact with the patients and visitors and were available, throughout the day, to meet with both on a one to one basis if needed. Patients spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with.

Areas for improvement

A care plan should be put in place to include why the identified intervention was required and how it would be managed.

Following evaluation of care plans prescribed interventions should be updated following to meet the needs of the patient.

A system to monitor and ensure repositioning charts are completed accurately should be introduced.

Staff meetings should take place regularly and at a minimum quarterly in accordance with DHSSPS Care Standards for Nursing Homes (April 2015).

Number of requirements	**0**	**Number of recommendations**:	**4**

4.5 Is care compassionate?

Throughout the inspection there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Patients were sitting in the lounges, or in their bedroom, as was their personal preference.

Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients' likes, dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

The provision of activities was reviewed and we spoke at length with the activity leader who explained that activities were planned on a monthly basis. They explained that patient participation varied from those who could take an active role in activities to those engaged in talking about the activity to patients who were observers. The activity leader commented that for some patients "it's not just about the activity; it's as much about the atmosphere you create." The activity leader confirmed that there was good support from staff which was vital in enabling her to do her job. Arrangements were in place to support patients with their spiritual needs. Ministers and representatives of various denominations visited regularly to attend to the patients. Patients commented that they enjoyed the activities provided.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"…she could not have better looked after (and her room was fantastic, overlooking the stable yard and all the activity that kept her entertained."

"Over the last two years…I've noted something special about Wood lodge and its simply that they care."

"…as her family we have been treated with the utmost kindness and respect…"

Ten relative questionnaires were issued; three were returned prior to the issue of this report. All of the respondents were very satisfied or satisfied with the care delivered in the home. One of the respondents commented:
"I am 100% confident in the safety and effectiveness of the care provided to my mother…"
"…they make time to sit with my mother, or other residents when they are feeling a bit low and quickly bring a smile to their faces…"
"There is a wonderful atmosphere in the home which is the secret of a well led home…"

Ten questionnaires were issued to nursing, care and ancillary staff; two were returned prior to the issue of this report. The responses were all positive. There were no additional comments provided by staff.

Areas for improvement

No areas for improvement were identified in the delivery of compassionate care

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

Staff spoken with were knowledgeable regarding line management and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there was good team work and the registered manager was responsive to any suggestions or concerns raised. Discussion took place regarding senior care staff overseeing residential care and duties such as medication administration and record keeping. We identified the need for protected time as was afforded to the registered nurses for these tasks. These comments were shared with the registered manager who agreed to review the issue further.

Patients were aware of who the registered manager was and confirmed that if they had a complaint to make they would make it to a member of staff or the registered manager. They were confident that staff and/or management would address any concern raised by them appropriately.

A record of complaints was maintained electronically. The record included the date the complaint was received, the nature of the complaint, details of the investigation and how the registered manager had concluded that the complainant was satisfied. There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was in place. Areas for audit included care records, accidents and the admission process.

As previously discussed there were systems in place to ensure that notifiable events were investigated as appropriate and reported to the relevant bodies. The registered manager completed a regular analysis of falls to identify any trends or patterns.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. A copy of the report was maintained and available in the home; the report included an action plan to address any identified areas for improvement. There was evidence in the reports that the action plan was reviewed during the next visit.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the 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 by the registered manager. 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 service. 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 service.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 28 June 2016	It is recommended that the registered nurse in charge of the home when the registered manager is off duty should be clearly identified on the staff duty roster in the nursing and residential units. **Ref: section 4.3**
	Response by registered person detailing the actions taken: The Registered Nurse who is in charge of the home when registered manager is off duty is highlighted on Duty Rota.
Recommendation 2 **Ref**: Standard 41.7 **Stated:** First time **To be completed by:** 28 June 2016	It is recommended that the record of the competency and capability assessment completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager is further developed to include greater detail of what is assessed under each heading. **Ref: section 4.3**
	Response by registered person detailing the actions taken: Competency and Capability assessments are being further developed to ensure S/N in charge fully understands and recoqnises what is expected of them whilst registered/deputy manager is off duty.
Recommendation 3 **Ref**: Standard 4.4 **Stated:** First time **To be completed by:** 28 June 2016	It is recommended that a care plan should be put in place to include why the identified intervention was required and how it would be managed. **Ref: section 4.4**
	Response by registered person detailing the actions taken: Care plan has been put in place detailing how the intervention is managed and why it is required.
Recommendation 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 28 June 2016	It is recommended that following evaluation of care plans prescribed interventions are updated to meet the needs of the patient. **Ref: section 4.4**
	Response by registered person detailing the actions taken: When care plans are updated staff have been instructed to ensure a meaningful evaluation which is meeting the needs of patients.

Recommendation 5 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 28 June 2016	It is recommended that a system to monitor and ensure repositioning charts are completed accurately is introduced. **Ref: section 4.4**
	Response by registered person detailing the actions taken: A system has been put in place whereby S/N check and sign repositioning charts to ensure they are completed accurately
Recommendation 6 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 28 June 2016	It is recommended that staff meetings take place regularly and at a minimum quarterly in accordance with DHSSPS Care Standards for Nursing Homes (April 2015). **Ref section 4.4**
	Response by registered person detailing the actions taken: Staff meetings will now resume on a quartarly basis with Managagement meetings taking place weekly.

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address

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