The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
16 March 2017

Wood Lodge

Type of Service: Nursing Home
Address: Mill Hill, Castlewellan, BT31 9NB
Tel no: 0284377 8511
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Wood Lodge took place on 16 March 2017 from 11:00 to 15:45.

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

Is care safe?

A review of the staffing provision and a general inspection of the home indicated that the delivery of care was safe.

No areas for improvement were identified with the domain of safe care.

Is care effective?

We reviewed the care records of three patients. A comprehensive assessment of need and a range of validated risk assessments were completed for each patient and reviewed as required and as a minimum monthly. A range of care plans were in place, however there were needs identified in the assessments that did not have accompanying care plans in place to direct the care required. A recommendation was made.

We reviewed the management of wound care for two patients. Care records contained details of the prescribed regimes and evidenced that generally dressings were renewed regularly. There was no consistency to the recording of wound care. A recommendation was made that the recording of wound care should be reviewed to ensure the detail of care delivered is consistently recorded and in keeping with best practice guidance.

A total of two recommendations were made in the domain of effective care. Compliance with these recommendations will further drive improvements in the standard of record keeping.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and one relative commented positively regarding the care they received and staff attitude. A number of their comments are included in the report.

No areas for improvement were identified with the domain of safe care.

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Discussions with staff confirmed that there were good working relationships between all grades of staff.

No areas for improvement were identified with the well led domain.

The term ‘patients’ is used to describe those living in Wood Lodge which provides both nursing and residential care.

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**	**3***

*The total number of recommendations includes one recommendation which has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Liz O'Rourke, registered 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 medicines management inspection undertaken on 14 March 2017. There were no further actions required to be taken following the most recent inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, 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 Mr Liam Lavery	**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 eight patients, one registered nurse, one senior care assistant, two care assistants, two housekeeping staff and one patient's relative.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Ten, staff and patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- Staffing rota for week commencing 10 and 17 February 2017
- three patients' care records
- record of staff meetings
- nurse in charge competency and capability assessments

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 March 2017

The most recent inspection of the home was an unannounced medicines management inspection. There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

4.2 Review of requirements and recommendations from the last care inspection dated 31 May 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 41 **Stated:** First time	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.	**Met**

	Action taken as confirmed during the inspection: The registered nurse in charge of the home when the registered manager is off duty was clearly identified on the staff duty roster. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 41.7 **Stated:** First time	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	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that the competency and capability assessment had been reviewed and updated to include greater detail of what is assessed. A review of the records evidenced that this recommendation has been met.	
Recommendation 3 **Ref**: Standard 4.4 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that at that time a care plan had been created to include the identified intervention. This recommendation has been assessed as met.	
Recommendation 4 **Ref**: Standard 4 **Stated:** First time	It is recommended that following evaluation of care plans prescribed interventions are updated to meet the needs of the patient.	**Met**
	Action taken as confirmed during the inspection: A review of three care records evidenced that this recommendation has been met.	

Recommendation 5 **Ref**: Standard 35.6 **Stated:** First time	It is recommended that a system to monitor and ensure repositioning charts are completed accurately is introduced	**Not Met**
	Action taken as confirmed during the inspection: One repositioning chart reviewed did not evidence that the patient was repositioned as recommended in their care plan. This recommendation is assessed as not met and is stated for a second time.	
Recommendation 6 **Ref**: Standard 41 **Stated:** First time	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).	**Met**
	Action taken as confirmed during the inspection: A review of the minutes of staffing meetings held since the previous inspection evidenced that this recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home. A review of the staffing roster for week commencing 15 March 2017 evidenced that planned staffing levels were adhered to. In addition to nursing and care staff, the registered manager confirmed that administrative, catering, domestic and laundry staff were also on duty daily. No concerns regarding staffing provision within the home were raised during discussions with patients, relatives and staff.

We also sought relatives and staff opinion on staffing via questionnaires. None were returned prior to the issue of this report.

A general inspection of the home was undertaken to examine a number of patients' bedrooms, lounges, bathrooms and toilets. The home was fresh smelling, clean and appropriately heated. A number of bedrooms have recently been refurbished and the choice and standard of décor was commended. There were no issues identified with infection prevention and control practice.

Areas for improvement

No areas for improvement were identified with the delivery of safe care.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

A review of three patient care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient and reviewed as required and at minimum monthly. A range of care plans were in place, however there were needs identified in the assessments that did not have accompanying care plans in place to direct the care required. A recommendation was made.

We reviewed the management of wound care for two patients. Care records contained details of the prescribed regimes and evidenced that generally dressings were renewed regularly. In one care record we reviewed the delivery of wound care for the period 6 – 16 March 2017. There was one occasion during this period when we could not evidence that the dressing had been renewed within the prescribed timescale. We noted that there was a lack of consistency with where in the care records the recording of wound care and assessment of the wounds was recorded. The second care record evidenced that the dressing had been renewed within the prescribed timescale; again there was no consistency to the recording of wound care. Following discussion with the registered manager it was recommended that the recording of wound care should be reviewed to ensure the detail of care delivered is consistently recorded and in keeping with best practice guidance.

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. Care records were regularly reviewed and updated, as required, in response to patient need.

We discussed how patient and care needs were communicated between staff. Staff advised that they received a handover report at the start of each shift. Staff were of the opinion that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with patients, relatives and their colleagues.

Areas for improvement

A detailed plan of care for all assessed needs should be drawn up.

The recording of wound care should be reviewed to ensure the detail of care delivered is consistently recorded and in keeping with best practice guidance.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

We arrived in the home at 11:00. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were sitting in the lounges or their bedrooms as was their personal preferences. Staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preference to sit throughout the day.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:

"Staff are very caring."
"I can't praise the staff enough."
"The staff can't do enough for me."
"the food is great."

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

Ten questionnaires were issued to staff and relatives, none were returned prior to the issue of this report.

Areas for improvement

No areas for improvement were identified with the delivery of compassionate care.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the registered manager, a review of care records and observations confirmed that the home was operating within the categories of care registered.

The registered manager confirmed that the responsible person was in the home regularly to provide support and assistance as required.

Areas for improvement

No areas for improvement were identified within the domain of well led.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the 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 provider/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 provider 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 the nursing home. The registration is not transferable so that in the event of any

future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The 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 provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements: No statutory requirements were made as a result of this inspection.	
Recommendations	
Recommendation 1 **Ref**: Standard 35.6 **Stated:** Second time **To be completed by:** 13 April 2017	It is recommended that a system to monitor and ensure repositioning charts are completed accurately is introduced **Ref section 4.2**
	Response by registered provider detailing the actions taken: Each day a staff member is delegated to ensure repositioning charts are completed during morning and afternoon shift, Night Nurses will delegate night staff to ensure completion.
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 13 April 2017	The registered provider should ensure that a detailed plan of care for all assessed needs is drawn up. **Ref section 4.4**
	Response by registered provider detailing the actions taken: A detailed plan of care will be drawn up when needs are assessed.
Recommendation 3 **Ref**: Standard 4.8 **Stated:** First time **To be completed by:** 13 April 2017	**The registered provider should** review the recording of wound care to ensure the detail of care delivered is consistently recorded and in keeping with best practice guidance. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Meeting with Staff Nurses and all staff nurses are aware of correct recording of wound care to ensure the detail of care delivered is consistantly recorded and in keeping with best practice.

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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