Unannounced Care Inspection Report
3,9 and 16 July 2019

Rosevale Lodge

Type of Service: Nursing Home
Address: 173 Moira Road, Lisburn, BT28 1RW
Tel no: 028 9260 4433
Inspectors: Dermot Walsh, Catherine Glover and Joseph McRandle

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 30 patients with dementia.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individuals:** Dr. Maureen Claire Royston	**Registered Manager and date registered:** Mayvelyn Talag 28 December 2012
Person in charge at the time of inspection: Mayvelyn Talag	**Number of registered places:** 30 The home is also approved to provide care on a day basis only to 1 person.
Categories of care: Nursing Home (NH) DE – Dementia	**Number of patients accommodated in the nursing home on the day of this inspection:** 30

4.0 Inspection summary

An unannounced care inspection took place on 9 July 2019 from 10.00 hours to 17.45 hours. This inspection was undertaken by the care inspector. The pharmacist inspector conducted an unannounced inspection on 3 July 2019 from 10.20 to 12.15 hours and the finance inspector conducted an unannounced inspection on 16 July from 10.15 hours to 13.15 hours.

The inspection assessed progress with areas for improvement identified in the home since the last care, finance and medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staffing arrangements, staff recruitment, training, adult safeguarding, infection prevention and control, the home's environment, staff handover and record keeping. Further good practice was found in relation to incidents management, quality improvement, maintaining good working relationships, regular checks of money and valuables held on behalf of patients, recording of transactions undertaken on behalf of patients, retaining records of fees charged to patients and records of fees received on behalf of patients and issuing receipts to individuals depositing monies on behalf of patients.

In relation to medicines management, evidence of good practice was found in the administration of medicines, medicine records, the storage of medicines and the management of controlled drugs.

An area for improvement in relation to the moving and handling of patients has been stated for a second time. One area for improvement was identified from the finance inspection in relation to updating patients' written agreements.

Patients described living in the home in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*1	1

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mayvelyn Talag, 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.

4.2 Action/enforcement taken following the most recent inspection dated 6 December 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 6 December 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including medicines management and finance issues, registration information, and any other written or verbal information received. For example serious adverse incidents.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff week commencing 1 July 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment file
- three patient care records
- a sample of governance audits/records
- complaints record
- compliments received
- RQIA registration certificate
- three patients' finance files including copies of written agreements
- a sample of records of monies and valuables held on behalf of patients
- a sample of records from purchases undertaken on behalf of patients
- a sample of payments to the hairdresser and podiatrist
- a sample of statements from patients' bank account
- a sample of records of monies deposited on behalf of patients
- a sample of records of patients' monies forwarded from the Health and Social Care Trust

The following areas/records were reviewed during the medicines management inspection:

- staff training and competency
- management of medicines on admission and discharge
- management of distressed reactions and controlled drugs
- personal medication records, medicine administration records, medicines requested, received and transferred/disposed
- medicines management audits
- storage of medicines

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of outstanding areas for improvement from previous inspections

Areas of improvement identified at previous care inspection have been reviewed. Of the total number of areas for improvement four were met and one not met has been included in the QIP at the back of this report.

There were no areas for improvement identified as a result of the last finance inspection.
There were no areas of improvement from the last medicines management inspection.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The manager confirmed that the number of staff and the skill mix of staff on duty at any given time was determined through regular monitoring of patient dependency levels in the home. A review of the duty rota for week commencing 1 July 2019 confirmed that the planned staffing level and skill mix was adhered too. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff. Patients' needs and requests for assistance were observed to have been met in a timely and caring manner. Patients and their visitors consulted spoke positively in relation to the care provision in the home. Staff consulted confirmed that they were satisfied the staffing arrangements in the home were suitable to meet patients' needs.

A review of a recently employed staff member's recruitment records confirmed that the appropriate pre-employment checks had been completed prior to the staff member commencing in post. References had been obtained and records indicated that AccessNI checks had been conducted.

Checks were evidenced to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC). Similar checks were made on care workers to ensure that they were registered on the Northern Ireland Social Care Council (NISCC) register and that no restrictions to their employment had been identified.

A record of any training that staff had completed was maintained in the home. Staff spoke positively in relation to the provision of training in the home. Compliance with training was monitored monthly on a training matrix. A system was in place to communicate with staff whose training was about to lapse to ensure completion. There was evidence that recent face to face training on dementia care and on continence management had been conducted.

The manager confirmed that staff were also mentored and coached through staff supervisions and appraisals. Records were maintained of completed supervisions and appraisals and a planner was evident to ensure staff received at minimum two recorded supervisions per year and one annual appraisal.

There was evidence that any nurse given responsibility of taking charge of the home in the absence of the manager had first completed a competency and capability assessment to assure the manager of their competence prior to taking charge. In addition, registered nurse competencies were conducted in relation to wound care and medicines management.

An adult safeguarding champion had been identified to manage any potential safeguarding incidents. Discussion with the manager confirmed that they were aware of the regional safeguarding policy and procedures. A monthly safeguarding log was maintained in preparation for the completion of an annual position report. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

Falls in the home had been monitored monthly for pattern and trend. A review of accident records evidenced that these had been completed appropriately and that the correct actions had been taken following the accident.

We reviewed the home's environment undertaking observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Fire exits, corridors and stairwells were observed to be clear of clutter and obstruction. Bedrooms and communal rooms were clean and tidy. Compliance with best practice on infection prevention and control had been well maintained. There were no malodours detected in the home. Appropriate doors had been locked to promote patient safety. An area for improvement in this regard has now been met. However, during the review of the environment we observed staff using inappropriate moving and handling techniques. This was discussed with the manager and an area for improvement in this regard has been stated for the second time.

Patients' medicines were well managed. The administration of medicines was undertaken by trained and competent staff. All aspects of the management of medicines were regularly audited by staff in the home.

Systems were in place to ensure the safe management of medicines when a patient arrives at the home and to ensure that patients have a regular supply of their medicines so that they do not run out. The sample of medicines that were audited during the inspection had been administered correctly.

Medicines records complied with legislative requirements, professional standards and guidelines. Medicine records were legible and accurately maintained. Where medicines were prescribed on a 'when required' basis, there were clear instructions for use in the patient's records.

Medicines were safely and securely stored. Medicine storage areas were clean, tidy and well organised.

The management of medicines prescribed to manage pain, distressed reactions and thickened fluids was examined and found to be satisfactory. All of the appropriate care records had been completed.

Controlled drugs were safely managed. The receipt, administration and disposal of Schedule 2 and 3 controlled drugs were maintained in a controlled drug record book. Controlled drugs were safely stored and stock balances were checked on each occasion when the responsibility for secure storage was transferred.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, staff recruitment, training, adult safeguarding, infection prevention and control and the home's environment.

Areas of good practice were also identified in relation to the management of medicines on admission, medicines prescribed for distressed reactions and controlled drugs.

Areas for improvement

No new areas for improvement were identified during the inspection in this domain. An area for improvement in relation to moving and handling has been stated for the second time.

	Regulations	Standards
Total number of areas for improvement	0	0

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

Dietary requirements, such as the need for a diabetic diet, were communicated through staff handovers. Information also included the consistency of patients' food and fluids. Staff confirmed that the shift handover provided them with all necessary information to provide care to patients. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/management.

Training in using new International Dysphagia Diet Standardisation Initiative (IDDSI) indicators to ensure that patients were safely given the correct foods and fluids was implemented. Patients had been weighed regularly and a nutritional screening tool known as Malnutrition Universal Screening Tool (MUST) was utilised to determine the risk of weight loss or weight gain. Patients and staff confirmed that they had 24 hour access to food and fluids. Patients commented positively on the food provision in the home.

We reviewed the lunchtime meal experience during the inspection. Patients dined in the main dining room or at their preferred dining area such as their bedroom or the lounge. The menu offered a choice of meal for lunch. It was noted that the menu was in a written format and that the previous monthly monitoring visit, conducted by a senior manager within Four Seasons Health Care, had identified that a pictorial menu would be better suited for the patients in the home to aid in their choice of meal. Food was served from heated trolleys which maintained the temperature of food prior to serving. The plates had been labelled with the IDDSI descriptor of the consistency of the food to ensure that the food served was served to the correct patients. Patients' drinks were thickened, where appropriate, with the patient's own individual thickener. An area for improvement in this regard has now been met. Food taken outside of the dining room was covered on transfer. The food served appeared nutritious and appetising. Staff were knowledgeable in relation to patients' dietary requirements. Patients wore clothing protectors where required and staff wore aprons when serving or assisting with meals. Staff were observed chatting with patients when assisting with meals and patients were assisted in an unhurried manner. Patients consulted confirmed that they enjoyed the meal.

Patients' risk of pressure related skin damage was assessed on their admission and reviewed on a monthly basis. When a risk was identified, such as immobility, poor diet or incontinence, a care plan was developed to guide staff in measures to prevent skin breakdown. Wound care records had been maintained appropriately. An initial wound assessment had been completed and a care plan drafted to guide on the wound management. Wound observation charts had been completed at the time of wound dressing to monitor the progress of the wound treatment. An area for improvement in this regard has now been met. Records of repositioning had been maintained.

Falls in the home were monitored on a monthly basis for any patterns and trends in times or locations of the fall. This would be to review the pattern to proactively plan measures to reduce the incidences of falls where possible. Falls risk assessments and care plans had been developed and updated monthly or following a fall. Accident records had been maintained indicating that the appropriate persons had been notified of the fall.

When a restrictive practice, such as the use of bedrails had been implemented, there was evidence within the patient's care records of an initial assessment completed to ensure safe use. This assessment was reviewed regularly. The continued use of this restrictive practice was monitored at the evaluation of the patients' care plans.

Each staff member was aware of their roles and responsibilities within the team. Staff spoke positively in relation to the teamwork in the home. Staff also confirmed that if they had any concerns, they could raise these with the manager or the nurse in charge.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, shift handover and teamwork

Areas for improvement

No new areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff were aware of individual patients' wishes, likes and dislikes. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were given choice, privacy, dignity and respect. Staff were also aware of patient confidentiality regarding the handling and use of patient information.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences.

Consultation with ten patients individually, and with others in smaller groups, confirmed that living in Rosevale was a positive experience. Ten patient questionnaires were left for completion. None were returned within the timeframe.

Patient comments:

- "There is nothing wrong here. Staff are very nice."
- "It is nice enough here."
- "It's alright here."

Three patient representatives were consulted during the inspection. Patient representatives' questionnaires were left for completion. Three were returned. Patient representatives commented:

- "Staff are very pleasant. The home is very clean. Would like to see more stimulation for patients."
- "I find the home very good. Staff are very good."
- "Overall impression is that staff are very caring."

Staff were asked to complete an online survey; we had no responses within the timescale specified. Comments from seven staff consulted during the inspection included:

- "I really enjoy working here."
- "It's ok, nice to work with older people."
- "There are good days and bad days."
- "I love it. Made to feel part of the team."
- "In general it is ok."

Two questionnaires were returned which did not indicate if they were from relatives or patients. Both respondents indicated that they were satisfied or very satisfied that the home was providing safe, effective and compassionate care and that the home was well led.

Any comments from patients, patient representatives and staff in returned questionnaires or online responses received after the return date will be shared with the registered manager for their information and action, as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the delivery of compassionate care and with staff interactions with patients.

Areas for improvement

No areas for improvement were identified during the inspection in the compassionate domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. This certificate identifies the management arrangements for the home and the maximum number of patients allowed to be accommodated in the home. Since the last care inspection, the management arrangements in the home had not changed.

A system was in place to record any complaints received including all actions taken in response to the complaint. Patients and their visitors consulted during the inspection confirmed that they would have no issues in raising any identified concern with the home's staff or management.

Discussion with the manager and review of auditing records evidenced that a number of monthly audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, care records, wound care and infection prevention and control. We reviewed the wound care audits. Auditing records evidenced that all wound care documentation was reviewed as part of the analysis. No shortfalls were identified.

Monthly monitoring visits to the home were conducted by the responsible individual. Reports from the visit were available for review by patients and their visitors, staff, Trust staff and other healthcare professionals.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Management of service users monies

A finance inspection was conducted on 16 July 2019. Financial systems in place at the home were reviewed and found to be satisfactory. These included the system for recording transactions undertaken on behalf of patients, the system for recording the reconciliations of patients' monies and valuables, the recording of fees charged to patients and retaining records of the amount received on behalf of patients for fees.

A review of three patients' files evidenced that copies of signed written agreements were retained within all three files. The agreements in place did not show the current weekly fee paid by, or on behalf of, the patients. One of the agreements reviewed did not show the amount of the third party contribution paid on behalf of the patient. This was discussed with the registered manager and identified as an area for improvement under the standards.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of incidents, quality improvement, maintaining good working relationships, regular checks of monies and valuables held on behalf of patients, recording of transactions undertaken on behalf of patients, retaining records of fees charged to patients and records of fees received on behalf of patients and issuing receipts to individuals depositing monies on behalf of patients.

Areas for improvement

One area for improvement was identified in relation to updating patients' written agreements to show the current fee.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mayvelyn Talag, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (3) **Stated:** Second time **To be completed by:** 9 August 2019	The registered person shall make suitable arrangements to ensure staff effectively communicate with patients when assisting them to transfer from a sit to stand position and that correct moving and handling techniques are embedded into practice. Ref: 6.1 and 6.3
	Response by registered person detailing the actions taken: Moving and handling training is regularly updated for all staff, supervisions are carried out to reinforce and remind staff and to ensure correct moving and handling techniques are embedded into practice. Trained staff and Home Manager to monitor.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 2.2 **Stated:** First time **To be completed by:** 13 September 2019	The registered person shall ensure that patients' written agreements are updated to show the current fee paid by, or on behalf of, patients. The agreements should also show the current amount of the third party contribution (where relevant). Ref: 6.6
	Response by registered person detailing the actions taken: All written agreements are already in place showing the total to paid, by whom this is payable, and the amount of the third party contribution if applicable. These are updated yearly. The new forms this year are currently being reviewed and updated with current CMA regulations.

Please ensure this document is completed in full and returned via Web Portal

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