Rosevale Lodge
RQIA ID: 1850
Garden/Rose/Vale Suites
173 Moira Road
Lisburn
BT28 1RW

Inspector: Dermot Walsh
Inspection ID: IN021714

Tel: 028 9260 4433
Email: rosevale.lodge@fshc.co.uk

Unannounced Care Inspection
of
Rosevale Lodge

27 – 28 January 2016

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

1. Summary of Inspection

An unannounced care inspection took place on 27 January 2016 from 10.10 to 16.30 and 28 January 2016 from 10.40 to 15.00.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

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

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Please also refer to sections 5.2 and 6.2 of this report.

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

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 4 August 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2*	5

*The total number of requirements includes one requirement stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Registered Manager, Mayvelyn Talag, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care Dr Maureen Claire Royston	**Registered Manager:** Mayvelyn Talag
Person in Charge of the Home at the Time of Inspection: Mayvelyn Talag	**Date Manager Registered:** 28 December 2012
Categories of Care: RC-I, NH-DE, RC-DE	**Number of Registered Places:** 66
Number of Patients Accommodated on Day of Inspection: 63	**Weekly Tariff at Time of Inspection:** £470 - £616

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIP) from inspections undertaken in the previous inspection year
- the previous care inspection report

During the inspection, the inspector met with 24 patients, six care staff, two registered nurses, one ancillary staff and four patient representatives.

The following records were examined during the inspection:

- a sample of staff duty rotas
- six patient care records
- accident/notifiable events records
- staff training records
- staff induction records
- policy documentation in respect of communicating effectively, palliative and end of life care
- complaints
- compliments
- best practice guidelines for palliative care and communication

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 4 August 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref:** Regulation14 (3) **Stated:** First time	The registered person must evidently ensure that staff carry out the moving and handling of patients in line with training provided and best practice.	**Not Met**
	Action taken as confirmed during the inspection: During a tour of the premises, on two separate occasions, patients were observed to be transferred on a wheelchair without the safety lap belt fastened.	
Requirement 2 **Ref:** Regulation 27 (2) (c) **Stated:** First time	The registered person must ensure that all equipment in the home including commodes are only used for the purpose designed for.	**Met**
	Action taken as confirmed during the inspection: All equipment observed on the day of inspection was being used for the purpose it was designed for.	
Requirement 3 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person must ensure that infection control audits are completed on a regular basis, verified by the registered manager and with evidence of the action taken to address any identified shortfalls. Records should also evidence improvement with validation of the outcomes by the registered manager.	**Met**
	Action taken as confirmed during the inspection: Infection control audits had been completed on a monthly basis. A responsibility and comments section is completed to address shortfalls identified within the audit. The infection control audits are reviewed within the regulation 29 monthly monitoring visits by the registered person. Discussion with the registered manager confirmed issues on infection control are also addressed during the registered manager's daily walk around the home.	

Requirement 4 **Ref:** Regulation 27 (2) (b) **Stated:** First time	The registered person must ensure that an action plan for the upgrading of bathrooms and shower rooms including the time frame for completion is submitted to RQIA by 30 September 2015.	**Met**
	Action taken as confirmed during the inspection: The action plan for the upgrading of bathrooms and shower rooms, dated September 2015, was received by RQIA.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref:** Standard 5.3 **Stated:** Second time	**I**t is recommended that a continence assessment is maintained in patients' care records.	**Met**
	Action taken as confirmed during the inspection: A review of six patient care records evidenced continence assessments were present and maintained within them all.	
Recommendation 2 **Ref:** Standard 12 **Stated:** First time	The registered person should ensure that meals and mealtimes for the patients in the nursing include: • Condiments deemed as appropriate at the patients' table during mealtimes Appropriate music in the background during mealtimes. **Ref: 5.4.4**	**Met**
	Action taken as confirmed during the inspection: Condiments were observed on dining tables during lunch. Appropriate music could be heard in the background.	

Recommendation 3 **Ref:** Standard 4 (5) (9) **Stated:** First time	The registered person should review care records to ensure: • evidence is provided of patient and/or relative involvement in the records around the assessment and care planning process • care plans and assessments reflect the current care provided to patients and the care plan has the correct patient name to which the care is being provided	**Met**
	Action taken as confirmed during the inspection: Six care records reviewed evidenced patient/representative involvement within the assessment/care planning process. Care plans and assessments reviewed reflected current care provided. All records reviewed were reflective of the named patient on the record.	
Recommendation 4 **Ref:** Standard 46.2 **Stated:** First time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection. **Ref: 5.4.9**	**Met**
	Action taken as confirmed during the inspection: Infection control audits had been completed on a monthly basis. The registered manager confirmed they carried out a daily walk around to ensure compliance with infection control practice.	
Recommendation 5 **Ref:** Standard 21.11 **Stated:** First time	In line with current best practice guidelines, the registered person should ensure that any patient with a long term catheter insitu should have a catheter diary in place to monitor changes and to plan ongoing management. **Ref: 5.4.7**	**Met**
	Action taken as confirmed during the inspection: Two patient care records, where the patient requires a catheter to maintain continence, were reviewed. Both care records included a catheter diary which had been appropriately recorded and updated.	

Recommendation 6 **Ref:** Standard 28.1 **Stated:** First time	The registered person ensure the safe administration of medication were all medications prescribed for a specific time should be administered at that time or as close as possible around the time. **Ref: 5.4.4**	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager and registered nursing staff and observation on the day of inspection evidenced medications were administered within the appropriate timeframes.	
Recommendation 7 **Ref:** Standard 4 **Stated:** First time	The registered person ensure that individual patient records reflect the decision making for each patient in a person centred way, and where risks are identified such as the need to remove the call bell from the patient's room, other options enabling patients to summon staff assistance are explored and put in place.	**Met**
	Action taken as confirmed during the inspection: During a tour of the premises, one patient was noted not to have a call bell in their room. A review of the patient's care records evidenced the removal of the call bell was made in the patient's best interest. A visual check list had been maintained consistently to maintain contact with the patient to identify any needs the patient may have.	

Areas for Improvement

The registered person must evidently ensure that staff carry out the moving and handling of patients in line with training provided and best practice.

Number of Requirements:	**1**	**Number of Recommendations:**	**0**

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Policy guidance for staff was available on communicating effectively. A copy of the DHSSPS Regional guidance on breaking bad news was available in the home.

Discussion with the registered manager confirmed communicating effectively with patients and their families/representatives was incorporated within palliative care training. Palliative care training had been completed by 17 staff. Further palliative care training was identified.

Is Care Effective? (Quality of Management)

Two registered nurses consulted demonstrated their ability to communicate sensitively with patients and/or their representatives when breaking bad news. They discussed the importance of a quiet private area to speak with patients and/or their representatives and the importance of using a soft, calm tone of voice and using language which was appropriate to the listener. Staff also described the importance of providing reassurance and allowing time for questions or concerns to be voiced**.**

Care staff were also knowledgeable on breaking bad news and offered similar examples when they have supported patients when delivering bad news. A best practice guideline on 'Breaking Bad News' was available in the Home.

Is Care Compassionate? (Quality of Care)

Having observed the delivery of care and staff interactions with patients, it was evident that effective communication was well maintained and patients were observed to be treated with dignity and respect.

The inspection process allowed for consultation with 24 patients both individually and with others in small groups. All patients spoken with stated they were very happy with the care they were receiving in Rosevale Lodge Nursing Home. They confirmed that staff were polite and courteous and they felt safe in the home.

Four patient representatives confirmed that they were very satisfied with the care and the staff. Patient representatives' comments are recorded in section 5.5.1 below.

Areas for Improvement

There were no areas of improvement identified for the home in respect of communication.

Number of Requirements:	**0**	**Number of Recommendations**:	**0**

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

A policy and procedures on the management of palliative and end of life care with care of the dying included were available in the home.

A copy of GAIN Guidelines For End Of Life Palliative Care and End Of Life Care In Nursing and Residential Homes (November 2013) was available to staff in the home. A palliative care reference file was maintained in the home and along with guidance documentation contained the minutes of previous palliative care link nurse meetings.

Patient / representative information leaflets were available at reception. These included Four Seasons Health Care (FSHC) 'Advice on Palliative Care' and 'Advice on bereavement'. A range of 'Dying Matters' information leaflets were available along with information on local hospice and palliative care services.

Training records evidenced that 17 staff were trained in the management of death, dying and bereavement. Training included RQIA standards, breaking bad news, GAIN guidelines, advance care planning, nutrition, hydration, pain, mouth care, breathing, nausea, constipation, spirituality and care after death. Palliative and end of life care is incorporated within the home's induction programme

Discussion with two registered nurses and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the registered manager, eight staff and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or drugs was in place and discussion with two staff confirmed their knowledge of the protocol.

A palliative care link nurse had been identified for the home. The palliative care link nurse took responsibility in maintaining the palliative care reference file.

Is Care Effective? (Quality of Management)

Discussion with the registered manager and staff evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/ representatives to be with patients who had been ill or were dying. A quiet room has been identified for family/friends to have a private conversation or a rest. Staff consulted with were aware of the importance of providing refreshments at this time.

On the day of inspection, there was one patient in receipt of palliative and end of life care. Symptom management care plans, for example pain and elimination, were in place. Where palliative care advice had been given, there was evidence within the care records that these directions had been followed.

A review of notifications of death to RQIA during the previous inspection year evidenced that these were reported appropriately.

Is Care Compassionate? (Quality of Care)

Arrangements were in place in the home to facilitate, as far as possible, and in accordance with the persons wishes, for family/friends to spend as much time as they wished with the person. From discussion with the registered manager and staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time.

Some compliments are detailed below:
'We will always be grateful that …… spent his final days in such a caring environment.'
'For the kindness shown to ……. during his stay at Rosevale, the family send their deep appreciation and thanks.'
'The support and comfort you provided to us was amazing and without this we do not know how we would have coped at such an emotional time.'
'Thank you all so much for the care ……. received and your kindness to us all.'

All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death.

Areas for Improvement

There were no areas for improvement in relation to palliative care/death and dying.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.5 Additional Areas Examined

5.5.1. Consultation with patients, their representatives and staff

During the inspection process, 24 patients, nine staff, and four patient representatives were consulted with to ascertain their personal view of life in Rosevale. The feedback from the patients, representatives and staff indicated that safe, effective and compassionate care was being delivered in Rosevale.

A few patient comments are detailed below:
'I'm very happy here.'
'I find it a very good home.'
'The accommodation is excellent and the nurses are lovely.'
'I'm happy. I like it here.'

The patient representatives consulted with were very positive about the care provided. Some of their views are detailed below:
'We are very satisfied. We're always kept well informed of what's happening.'
'We find everything ok here.'

The general view from staff during conversations was that they took pride in delivering safe, effective and compassionate care to patients.

A few staff comments are detailed below:
'It's hard work but really good. I enjoy it.'
'I'm very happy here.'
'It's dead on here.'
'I really like it here.'

5.5.2. Premises

During a tour of the premises it was evident that a refurbishment programme for communal toilets, bathrooms and shower rooms was in progress. However, during the tour of the premises, some identified patient bedrooms were observed to be in a state of disrepair and in need of re-painting. Areas in the rooms including doors, skirting boards and walls were in need of redecoration. Bare wood was observed to be exposed. A recommendation was made for all bedrooms in the home to be reviewed to identify rooms in need of redecoration and an action plan developed to address this need.

5.5.3. Mealtimes

During the inspection, the lunchtime meal experience was observed in two identified dining areas. The dining areas were supervised adequately. Condiments were on the tables and patients were wearing appropriate clothing protectors. The food looked nutritious and menus indicating food choices had been displayed. However, there was a strong malodour in one of the dining areas. When this was brought to staffs attention from the inspector, the cause of the malodour was neutralised.

One patient's meal was served on a chipped plate. Meals were not covered when being transferred to patients rooms. Food which had been plated had been left on top of a trolley uncovered for an identified period of time. A recommendation was made for the mealtime experience to be reviewed to ensure that the mealtime experience is in accordance with the care standards for nursing homes and best practice guidelines.

5.5.4. Documentation

Bowel assessments had been completed in six patient care records reviewed. Records relating to the management of bowels were reviewed which evidenced that staff made reference to the Bristol Stool Score. However, in one patient record there was no recorded bowel movement in eleven days. A recommendation is made that records relating to the management of bowels are recorded accurately and consistently. A recommendation is also made to identify and record the specific type of continence product the patient required to meet their continence needs within their continence assessment and care plan.

Six food intake charts were recorded. In three of the food intake charts the actual food product was recorded. However, the amount of food consumed had not been recorded. A recommendation was made.

During the review of six patient care records it was noted that annual re-assessments had not been completed on two patients. One patient was last assessed on 2 November 2014 and one patient was last assessed on 14 June 2014. A requirement was made.

Areas for Improvement

Bedrooms should be reviewed to identify which rooms require redecoration and an action plan should be made to plan for the completion of redecoration.

The mealtime experience should be reviewed to ensure care standards are met.

Records relating to the management of bowels should be recorded accurately and consistently.

The specific continence product required to meet the needs of the patients should be identified within the patients' continence assessment and continence care plan.

Food intake charts should include the amount of food consumed by the patient.

The assessments of patients' needs are revised as required but not less than annually.

Number of Requirements:	**1**	**Number of Recommendations:**	**5**

6. Quality Improvement Plan

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

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

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/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 provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref**: Regulation14 (3) **Stated:** Second time **To be Completed by:** 31 March 2016	The registered person must evidently ensure that staff carry out the moving and handling of patients in line with training provided and best practice. **Ref: Section 5.3** **Response by Registered Person(s) Detailing the Actions Taken:** All Staff have received updated training with regards to Safe Moving and Handling. This will be reinforced by carrying out observation sessions to ensure staff are carrying out the moving and handling of patients in line with training provided and for best practice. Compliance of staff will be monitored by Home Manager, RGN and Regional Manager.
Requirement 2 **Ref:** Regulation 15 (2)(b) **Stated:** First time **To be Completed by:** 14 March 2016	It is required that the assessments of patients' needs are revised as required but not less than annually. **Ref: Section 5.5.4** **Response by Registered Person(s) Detailing the Actions Taken:** Named nurses/ senior care assistants will ensure that annual assessments are carried out when due for revision and at any time when the assessed needs have changed. The Monitoring of completion will take place through the internal auditing system.
Recommendations	
Recommendation 1 **Ref**: Standard 44 **Stated:** First time **To be Completed by:** 30 April 2016	It is recommended that all bedrooms in the home are reviewed and an action plan developed to address bedrooms in need of redecoration. **Ref: Section 5.5.2** **Response by Registered Person(s) Detailing the Actions Taken:** All bedrooms will be reviewed and an action plan will be developed to address bedrooms in need of redecoration. Action plan to be forwarded on completion of review and before 30th April.

Recommendation 2 **Ref**: Standard 12 **Stated:** First time **To be Completed by:** 14 March 2016	The mealtime experience of patients should be reviewed to ensure that the mealtime experience is in accordance with the care standards for nursing homes and current best practice guidelines. Particular attention should focus on the areas identified on inspection. **Ref: Section 5.5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Home manager has discussed with the cook manager to resolve any identified issues and new items/equipments will be sourced and purchased to ensure mealtime experience conforms with the care standards for nursing homes and current best practice guidelines.THe dining audit will be undertaken 6 monthly and actions identified addressed. Last dining audit was completed on 6 March for Nursing unit and 29 February for Residential unit.
Recommendation 3 **Ref:** Standard 4.9 **Stated:** First time **To be Completed by:** 14 March 2016	It is recommended that bowel function, reflective of the Bristol Stool Chart is recorded accurately and consistently in the patients' daily progress records. **Ref: Section 5.5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Bowel function is recorded in the bowel chart using the Bristol Stool. Home manager and Nursing sister/Team leader to monitor that this is documented in the daily progress records by trained staff and senior care assistants when required.
Recommendation 4 **Ref:** Standard 4 Criteria (1) (7) **Stated:** First time **To be Completed by:** 31 March 2016	It is recommended that patients' continence assessments and care plans are fully completed and include the specific continence products required by the patient. **Ref: Section 5.5.4**
	Response by Registered Person(s) Detailing the Actions Taken: The continence assessments are in place and the type of continence product required by the patients has now been recorded in the residents' care plans. This will continue to be monitored by the Nursing sister and team leader.
Recommendation 5 **Ref**: Standard 12 Criteria (27) **Stated:** First time **To be Completed by:** 31 March 2016	Food intake charts should include the amount of food consumed along with the actual food product. **Ref: Section 5.5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Amount of food consumed along with the actual food product will be recorded accurately in the food and fluid chart by care staff. Key persons have been allocated to ensure the charts are appropriately completed. Home manager to monitor compliance by staff.

Registered Manager Completing QIP	Mayvelyn Talag	**Date Completed**	16/03/2016
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	05.04.16
RQIA Inspector Assessing Response	Dermot Walsh	**Date Approved**	06/04/2016

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