Unannounced Care Inspection Report
2 - 5 September 2019

Orchard Lodge Care Home

Type of Service: Nursing Home
Address: Desart Lane South, Armagh BT61 8BF
Tel No: 028 3752 6462
Inspectors: Julie Palmer, Joseph McRandle and Catherine Glover

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 55 patients.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Gavin O'Hare-Connolly	**Registered Manager and date registered:** Leanne McGaffin 20 August 2019
Person in charge at the time of inspection: Leanne McGaffin - 2, 3 and 5 September 2019	**Number of registered places:** 55
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 53 A maximum of 40 patients in category NH-DE accommodated in the Orchard and Cathedral Units and a maximum of 15 patients in categories NH-I, NH-PH, NH-PH(E) accommodated in the Bard Unit

4.0 Inspection summary

An unannounced care inspection took place on 2 September 2019 from 09.35 to 18.10 hours. An unannounced finance inspection took place on 3 September 2019 from 11.00 to 15.00 hours. An unannounced medicines management inspection took place on 5 September 2019 from 10.30 to 14.00 hours.

The inspection assessed progress with all areas for improvement identified in the home since the last finance inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led. Areas for improvement in respect of the last premises inspection have also been reviewed.

Evidence of good practice was found in relation to staffing, training, risk assessment, communication, providing dignity and privacy, the culture and ethos and governance arrangements. Further areas of good practice were also highlighted in regard to the standard of maintenance of the personal medication records, the management of medicines on admission, the management of pain, the management of patients' monies and valuables and general financial arrangements.

Areas requiring improvement were identified in relation to infection prevention and control measures, wound care recording and updating the relevant care records in the event of a fall.

Patients described living in the home as being a good experience. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

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	2

Details of the Quality Improvement Plan (QIP) were discussed with Leanne McGaffin, 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 25 February 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 25 February 2019. No further actions were required to be taken following 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 finance and estates issues, registration information, and any other written or verbal information received.

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 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 from 26 August to 8 September 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records and registered nurse competency and capability assessments
- incident and accident records
- two staff recruitment and induction files
- four patients' care records including food and fluid intake charts and repositioning charts
- staff supervision and appraisal schedule
- a sample of governance audits/records and fire risk assessment records
- complaints and compliments records
- 2018/19 annual quality report
- a sample of monthly monitoring reports from February 2019
- RQIA registration certificate
- two patients' finance files including copies of written agreements
- a sample of various financial records including, patients' personal allowance and valuables, fees charged to patients, payments to the hairdresser and podiatrist and purchases undertaken on behalf of patients
- a sample of records of monies deposited on behalf of patients, records of the safe contents and reconciliations of patients monies and valuables
- a sample of records from the patients' comfort fund, statements from patients' bank account and a sample of records of patients' personal property
- a sample of records of patients' monies received from the Health and Social Care Trust
- personal medication records, medicine administration records, medicines requested, received and transferred/disposed
- management of medicines on admission and medication changes
- management of controlled drugs, antibiotics and insulin
- care planning in relation to distressed reactions, pain and thickening agents
- medicine management audits, storage of medicines and stock control

Areas for improvement identified at the last finance 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 person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspections

There were no areas for improvement identified as a result of the last care inspection carried out on 25 February 2019 or the last medicines management inspection carried out on 31 July 2018.

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 registered manager confirmed that planned staffing levels for the home were subject to at least monthly review to ensure the assessed needs of patients were met. The duty rotas reviewed reflected that the planned daily staffing levels were adhered to. Staff spoken with were satisfied with staffing levels.

We also sought staff opinion on staffing via the online survey; no responses were received.

Patients spoken with were satisfied with staffing levels in the home. The majority of patients' visitors spoken with were also satisfied with staffing levels. However, one visitor felt that there were occasional issues and commented that there were "not enough staff at any one time, especially at turnover times" and that "staffing levels and communication are the two flaws". These comments were brought to the attention of the registered manager for consideration and action as appropriate. Comments received from other visitors included:

- "We know they are well looked after."
- "It's very good."
- "Overall quite happy, no issues with staff."

We also sought the opinion of patients and patients' visitors on staffing levels via questionnaires; one response was received from a relative who indicated that they were very satisfied with staffing levels and all other aspects of care provided in the home.

We reviewed two staff recruitment and induction files and these evidenced that staff had been vetted prior to commencing employment to ensure they were suitable to work with patients in the home. All staff spoken with stated they had completed, or were in the process of completing, a period of induction and review of records confirmed this.

A staff appraisal and supervision schedule was in place and a record of supervisions and appraisals was maintained.

There was a system in place to monitor the registration status of registered nurses with the NMC and care staff with NISCC and this clearly identified the registration status of all staff.

Staff spoken with demonstrated their knowledge of how to deal with a safeguarding issue; they were also aware of their duty to report concerns. Staff were knowledgeable regarding their own roles and responsibilities and were familiar with the home's whistleblowing policy.

Review of care records evidenced that a range of validated risk assessments were completed and informed the care planning process for patients.

Where practices were in use that could potentially restrict a patient's choice and control, for example, bedrails or alarm mats, the appropriate risk assessments and care plans had been completed. A rationale for use and consultation with the patient or their relative and/or key worker was recorded; consent was obtained where appropriate.

We looked at the home's environment and entered a selection of bedrooms, bathrooms, shower rooms, storage rooms, sluices, dining rooms and lounges. The home was found to be warm, well decorated, clean and tidy throughout. We did, however, observe various infection prevention and control shortfalls which we brought to the attention of the registered manager. These included, for example, identified wheelchairs, shower and sink drains, soap dispensers and shower chairs which required more effective cleaning. We also observed worn bedrail bumpers in use in one identified patient's bedroom. A robust system should be in place to monitor IPC measures in the home and an action plan developed as required; an area for improvement was made.

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

Staff were observed to wear personal protective equipment (PPE), for example aprons and gloves, when required and PPE was readily available throughout the home.

We observed that staff were responsive to patients' needs, assistance was provided in a timely manner and call bells were answered promptly.

The registered manager confirmed that staff compliance with mandatory training was monitored and that they were prompted when training was due. Staff told us they were satisfied their training needs were met.

Findings of Medicines Management Inspection

Good systems were in place for the following areas of the management of medicines: medicine records, the management of the medicines on admission, controlled drugs, antibiotics and care planning in relation to pain, distressed reactions and thickening agents.

The audits completed at the inspection indicated that medicines had been administered as prescribed.

The home has recently introduced a new medicines system. Staff were reminded that the date of opening should be recorded on all medicine containers to facilitate audit. It was acknowledged that this issue had been identified in the management audits and that progress was being closely monitored.

The management of distressed reactions was discussed with the registered manager and it was agreed that when applicable, the first and second line medicines would be clearly recorded on the medicine records.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, providing timely assistance to patients, the standard of maintenance of the personal medication records, the management of medicines on admission and the management of pain.

Areas for improvement

An area for improvement was identified in this domain in relation to infection prevention and control measures.

	Regulations	Standards
Total number of areas for improvement	1	0

6.4 Is care effective?

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

We observed the daily routine and the care given to patients in the home and were satisfied that patients received the right care at the right time. Patients spoken with felt that their care needs were met, they commented that:

- "It's great here."
- "The care is very good."
- "If you say something to staff, or ask for something, they see to it."

Staff confirmed they received a handover when they came on duty which provided them with an update on the patients' care needs and any changes to these. Staff spoken with were knowledgeable about the patients' care needs and confirmed these were regularly reviewed to determine the effectiveness of care delivered and if the patients' needs had changed. The nurses also attended a daily 'flash' meeting with the registered manager or nurse in charge in order to discuss identified issues and ensure appropriate action was taken.

We reviewed the care records for four patients and evidenced that a range of validated risk assessments had been completed to inform care planning for the individual patients.

Patients' weights were monitored on at least a monthly basis and their nutritional needs had been identified. There was evidence of referrals having been made to relevant health care professionals, such as the dietician or speech and language therapist (SALT), where necessary. Patients care plans included recommendations from the dietician and/or SALT if required and were regularly reviewed.

Measures to prevent pressure ulceration, such as the use of pressure relieving mattresses and repositioning schedules, were in place for those patients who required them.

We reviewed the management of wounds and observed that care plans and wound charts were in place to direct the care required. However, while we were assured that patients' wounds had been attended to as required, we observed 'gaps' in the recording of wound care in one of the care records reviewed. In another care record reviewed the care plan did not contain information about the type of dressing required, the date the care plan had been created or was due for evaluation. Up to date wound care records should be maintained in accordance with NMC guidelines; an area for improvement was made.

A monthly falls analysis was completed to determine if there were any trends or patterns emerging and an action plan was devised if necessary. Staff were knowledgeable regarding the actions to take to help prevent falls and how to manage a patient who had a fall. However, we observed that the relevant risk assessments and care plans were not always updated in the event of a fall; an area for improvement was made.

We observed the serving of lunch in the Cathedral Unit dining room. The menu was on display and a selection of drinks and condiments were available. Patients were offered clothing protectors and staff were wearing aprons. Staff demonstrated their knowledge of how to thicken fluids if necessary and which patients required a modified diet. A registered nurse was overseeing the meal and the atmosphere was calm, unhurried and relaxed. The food smelled appetising and was well presented. It was obvious that staff knew the patients well and were aware of their likes and dislikes; alternative choices were available and offered if required. Staff assisted patients as required and independent eating was encouraged if appropriate.

Patients told us they enjoyed the food on offer, comments included:

- “It’s nice and tasty.”
- “The food is excellent.”

Food and fluid intake charts were maintained and the records reviewed were up to date.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to risk assessment, monitoring of weights and nutritional needs and the meal time experience.

Areas for improvement

Areas for improvement were identified in this domain in relation to wound care recording and updating the relevant care records in the event of a fall.

	Regulations	Standards
Total number of areas for improvement	0	2

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.

During the inspection we spoke with ten patients about their experience of living in Orchard Lodge. Patients appeared to be settled and content in their surroundings and told us that:

- “It’s a home from home.”
- “I have absolutely no problems.”

Patients' visitors also expressed their satisfaction that care was compassionate; comments included:

- "I'm very content."
- "The nurses are really good."
- "Staff are helpful."

Patients and patients' visitors spoken with said that if they had a concern they knew whom to talk to and felt that they were listened to.

Observation of care delivery evidenced that staff treated patients with dignity and respect. We observed that staff knocked on bedroom and bathroom doors before entering and ensured doors were closed when delivering care to preserve patients' privacy. Patients were offered choice and the daily routine appeared to be flexible.

We looked at the activities on offer in the home. The registered manager informed us that, following a review of how activities were provided within the home, a well-being lead had been recruited but had yet to commence their post. Three members of staff were assisting with activities in the interim; they ensured that the activities provided were suitable and meaningful for the patients. Patients' views had been sought on the design and layout of the garden. Staff and patients told us that a recent ladies day had been a great success. The home had introduced a 'forget-me-not' scheme for patients who remained in their bedrooms to ensure they did not feel isolated; all staff were encouraged to call in to visit these patients and a record of visits was maintained.

A 'resident of the day' scheme was also in operation. This involved a member of staff from each area within the home, for example, nursing and care staff, the cook, domestic and maintenance man, calling to see the patient and discussing any issues or concerns the patient had within their particular remit. The registered manager explained that this had resulted in all staff getting to know the patients very well. It had also driven improvement within the home; changes had been made, for example, to the menu, as the cook had taken the views of patients on board and had altered the menu to suit their preferences.

A relatives' meeting was held in August 2019 and staff meetings were held on a quarterly basis. Patients and relatives views were sought through dining and feedback surveys. The annual quality report was available to view and this included the views of patients and their relatives.

We observed that staff treated patients with care and kindness; they knew when to provide comfort, there was a positive culture and ethos throughout the home. Staff communicated effectively with patients and with each other throughout the day. They were mindful of any barriers to communication and demonstrated their understanding of appropriate methods of communicating effectively with individual patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to providing dignity and privacy, listening to and valuing patients and their representatives, taking account of the views of patients, the culture and ethos of the home and communication.

Areas for improvement

No areas for improvement were identified during the inspection.

	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.

There had been no change in management arrangements since the last inspection. A review of the duty rota evidenced that the registered manager's hours and the capacity in which these were worked were clearly recorded. Patients, visitors and staff spoken with were all on first name terms with the manager and told us that she was accessible and approachable.

The certificate of registration issued by RQIA was displayed in the entrance hall of the home. Discussions with staff and observations confirmed that the home was operating within the categories of care registered.

Discussion with the registered manager and review of a selection of governance audits evidenced that systems were in place to monitor and evaluate the quality of nursing care and other services provided in the home and to ensure action was taken as a result of any deficits identified to drive quality improvement. Audits were completed to review areas such as accidents/incidents, use of restrictive practices, complaints and care plans.

Review of the complaints record evidenced that systems were in place to ensure complaints were appropriately managed. The complaints procedure was displayed in the home and patients and patients' visitors spoken with were aware of the process.

We reviewed the system in place to ensure notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. We discussed notifiable events with the registered manager in order to clarify what should or should not be reported. A record of any notifiable events reported to RQIA or other relevant bodies was maintained.

Monthly quality monitoring reports were available to view; we found these to be comprehensive, informative and to include an action plan.

Review of the home's fire risk assessment following the inspection confirmed that an area for improvement which had been identified during the last premises inspection was met.

Findings of Finance Inspection

A finance inspection was conducted on 3 September 2019. A review of a sample of patients' records was taken to validate compliance with the areas for improvement identified from the last finance inspection; these included copies of patients' written agreements, records of purchases undertaken on behalf of patients, records of patients' items held in the safe place, records of

patients' personal property, bank account statements, records from patients' comfort fund, records of the reconciliations of monies and valuables held on behalf of patients and records of payments to the hairdresser and podiatrist.

A review of a sample of purchases undertaken on behalf of patients showed that in line with the Care Standards for Nursing Homes (April 2015), the details of the purchases were recorded, two signatures were recorded against each entry in the patients' transaction sheets and receipts were available from each of the purchases.

A review of two patients' files evidenced that copies of signed written agreements were retained within both files. The agreements in place showed the current weekly fee paid by, or on behalf of, the patients and a list of the services provided to patients as part of their weekly fee. The agreements also included a list of items members of staff were authorised to purchase on behalf of patients e.g. toiletries and the additional services authorised to be paid on behalf of patients e.g. hairdressing.

Discussion with staff confirmed that since the last finance inspection a bank account was operated at the home for the retention of monies belonging to a number of patients. A review of a sample of bank statements confirmed that the name of the bank account did not indicate that the monies held in the account belonged to patients. Discussions also confirmed that the bank account was used in connection with the carrying on or management of the home. It was noticed however, that in line with good practice the patients' monies were transferred out of the business bank account within four weeks of being paid into the account.

A review of a sample of property records for two patients evidenced that the records had been updated since the last finance inspection with items belonging to the patients. There was evidence that the records had been reconciled and signed by two members of staff at least quarterly as in line with the Care Standards for Nursing Homes, April 2015.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships, the management of patients' monies and valuables and general financial arrangements.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Leanne McGaffin, 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 13 (7) **Stated:** First time **To be completed by:** 9 September 2019	The registered person shall ensure that the identified infection prevention and control shortfalls are resolved and that effective cleaning is carried out to minimise the risk and spread of infection in the home. The system in place to monitor IPC measures should be robust and an action plan should be developed as required. Ref: 6.3
	Response by registered person detailing the actions taken: All staff have attended COSHH training and elearning on infection prevention and control. All areas of the home were deep cleaned and an ongoing daily programme to ensure all areas are maintained. New shower chairs are being introduced on a weekly basis to replace existing ones. Infection control audit completed monthly by manager/deputy manager. Cleaning records audited and signed on daily basis by housekeeper.
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 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that wound care recording is up to date, care plans should be detailed, the date of creation and when evaluation is due should be recorded. Ref: 6.4
	Response by registered person detailing the actions taken: Wound care pathway formulated and displayed in treatment rooms for all staff to ensure robust recording of all wound care. Deputy manager completing audits on all care files of residents with wounds on a monthly basis.
Area for improvement 2 **Ref**: Standard 22 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the relevant risk assessments and care plans in the individual patients' care records are updated in the event of a fall. Ref: 6.4
	Response by registered person detailing the actions taken: Falls pathway displayed in all treatment rooms and incident books to ensure robust recording in event of fall. Manager auditing all paperwork for falls to ensure appropriate documentation of same.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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