Unannounced Follow Up Care Inspection Report
25 February 2019

Orchard Lodge Care Home

Type of Service: Nursing Home (NH)
Address: Desart Lane South, Armagh BT61 8BF
Tel No: 02837526462
Inspector: Julie Palmer

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

1.0 What we look for

2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 55 persons.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Gavin O'Hare-Connolly	**Registered Manager:** Leanne McGaffin-see below
Person in charge at the time of inspection: Mary McKee-Deputy Manager	**Date manager registered:** Leanne McGaffin- application received - "registration pending".
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)	**Number of registered places:** 55 comprising: 40 – NH-DE in the Orchard and Cathedral Units. 15 -- NH-I, NH-PH and NH-PH(E) in the Bard Unit.

4.0 Inspection summary

An unannounced inspection took place on 25 February 2019 from 09.35 to 15.50 hours.

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.

The inspection sought to assess progress with issues identified for improvement at the previous care inspection on 10 April 2018.

The following areas were examined during the inspection:

- staffing arrangements
- environment
- governance arrangements
- care records.

We spoke with patients individually and in small groups, one patient commented "there is a lovely feeling of oneness with patients, staff and managers."

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	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mary McKee, deputy manager, and Caron McKay, regional operations director, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 31 July 2018. No further actions were required to be taken following the most recent inspection on 31 July 2018.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- 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 QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with 14 patients, eight patients' relatives and nine staff. Questionnaires were also left in the home to obtain feedback from patients and patients' relatives. Ten patients' questionnaires and ten patients' relatives' questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision**.**

A poster informing visitors to the home that an inspection was being conducted was displayed in the entrance hallway.

The following records were examined during the inspection:

- duty rota for registered nursing and care staff from 25 February to 10 March 2019
- incident/accident records from 10 April 2018
- a sample of governance audits
- six patient care records
- six patient care charts including food and fluid intake records, repositioning charts and wound care charts
- a sample of the monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 the most recent inspection dated 10 April 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 10 April 2018

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation12 (4) (a)

Stated: First time

To be completed by:
Immediate from the date of inspection</td><td>The registered person shall ensure that food and fluids are provided in adequate quantities and at appropriate intervals. Records should be maintained in accordance with best practice guidelines and reviewed by registered nurses to ensure that the nutritional needs of patients are being appropriately met.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Discussion with staff and review of supplemental care records evidenced that this area for improvement had been met.</td></tr>
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Area for improvement 2 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** Immediate form the date of inspection	The registered person shall ensure that patients are repositioned in accordance with their care plan to maintain and prevent pressure damage. Records should be maintained in accordance with best practice guidelines. **Action taken as confirmed during the inspection**: Discussion with staff and review of repositioning records evidenced these were contemporaneously maintained and repositioning was carried out at the intervals recommended in individual patient care plans.	**Met**
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 30 June 2018	The registered person shall ensure that risk assessments and care plans are reviewed following a patients discharge from hospital. A body map and an assessment of all wounds and pressure damage should be completed and any relevant documentation updated accordingly. **Action taken as confirmed during the inspection**: Discussion with staff and review of care records evidenced that risk assessments, wound assessments and care plans were reviewed and body maps completed on hospital discharge.	**Met**
Area for improvement 2 **Ref**: Standard 4 Criteria 9 **Stated:** First time **To be completed by:** 30 June 2018	The registered person shall ensure that in accordance with NMC guidelines, contemporaneous nursing records are kept of all nursing interventions. This relates specifically to wound management. **Action taken as confirmed during the inspection**: Review of care records and wound charts evidenced that record keeping in relation to wound care was contemporaneous.	**Met**

6.3 Inspection findings

6.3.1 Staffing Arrangements

A review of the registered nursing and care staff rota from 25 February to 10 March 2019 confirmed the planned daily staffing levels were adhered to. Discussion with the manager confirmed staffing levels were subject to regular review to ensure the assessed needs of the patients were met.

Staff spoken with were generally satisfied that there was sufficient staff on duty to meet the needs of patients. Staff said on occasions staffing levels were affected by short notice leave although this happened infrequently and shifts were generally 'covered'.

The manager confirmed agency staff were presently used to cover shifts if necessary. However, four registered nurses had recently been recruited and were due to commence employment in the next few weeks.

We also sought opinion of staff on staffing levels via an online survey; no responses were returned.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients' needs in a caring and timely manner.

One patient spoken with remarked "staff are good but a bit rushed." One relative spoken with commented that they felt there were "no issues, staffing levels are good".

We also sought the opinion of patients and patients' relatives on staffing via questionnaires. Four questionnaires were returned by patients, all indicated they were very satisfied with staffing levels and the care they received. Comments included:

- "I'm fond of the staff."
- "They take good care of you."
- "The girls are good to me."

One relative spoken with commented positively about communication, consultation and how approachable staff were; she also remarked that Orchard Lodge was "a great place, mum was really well looked after".

Areas of good practice

Areas of good practice were identified in relation to ensuring the assessed needs of patients were met.

6.3.2 The Environment

A review of the home's environment was undertaken, this included observations of a sample of bedrooms, bathrooms, lounges, dining rooms, sluices, storage areas and treatment rooms. The home was found to be warm, well decorated, fresh smelling and clean throughout. Bedrooms were found to be personalised and in good decorative order. Bathrooms were found to be clean and in good condition. Isolated environmental issues noted during the inspection and brought to the attention of the manager were resolved on the day. Fire exits and corridors were observed to be clear of obstruction.

In each of the three units reviewed, a notice board was prominently displayed with information that was relevant; this included staff on duty, planned weekly activities and also the dates arranged for relatives' meetings throughout 2019. The group activities available were suitable for the needs of the patients. There were alternative options, such as puzzle books and colouring books, for patients who preferred one to one or solo activities. Patients and their relatives commented that the activities were varied and enjoyable and included bingo, arts and crafts and carpet bowls. Patients in one of the units were being entertained by a singer during the inspection and appeared to be really enjoying themselves.

Patients, patients' relatives and staff spoken with were complimentary in respect of the home's environment. One patient commented on how much she liked her bedroom and that she had "really been encouraged to make it feel like her own home".

Comments received from relatives included:

- "Perfection."
- "No complaints at all."
- "Nothing negative to say."
- "It's alright."

Areas of good practice

Areas of good practice were identified in relation to maintaining a pleasant environment and provision of suitable activities.

6.3.3 Governance Arrangements

There had been a change in management arrangements since the last care inspection and RQIA were notified accordingly.

Review of a selection of monthly governance audits including, for example, falls analysis, dining experience, infection prevention and control and wound analysis, evidenced that systems and processes were in place to review and monitor the quality of nursing and other services provided in the home.

A review of records evidenced that monthly quality monitoring visits were undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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

Discussion with staff confirmed there were good working relationships and communication within the home; staff commented that managers were approachable and supportive.

Areas of good practice

Areas of good practice were identified in relation to governance arrangements.

6.3.4 Care Records

We reviewed care records and supplemental care charts for six patients in relation to management of wounds, food and fluid intake, repositioning and review following hospital discharge.

Discussion with staff and review of supplemental care charts evidenced that food and fluid intake was consistently and contemporaneously recorded, this had been embedded into practice.

Repositioning records reviewed were noted to be consistently and contemporaneously updated and to reflect the repositioning schedules recommended in individual patient care plans; this had also been embedded into practice.

Review of record keeping evidenced that, on discharge from hospital, patients were reviewed appropriately; body maps were completed and risk assessments and care plans were updated as required. However, a hospital discharge checklist that had been developed for registered nursing staff to complete was noted to not have been done in two of the four files reviewed where there had been a recent hospital discharge. This was discussed with the manager as there should be a consistent approach to record keeping; it was agreed that the manager would arrange supervision sessions, within the next week, for registered nursing staff in order to address this deficit.

Review of wound charts evidenced that record keeping was contemporaneous and reflected the care, treatment and interval between dressings recommended in the individual patients' care plan.

Areas of good practice

Areas of good practice were identified in relation to contemporaneous record keeping.

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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