Unannounced Care Inspection Report
18 July 2016

Rose Lodge

Type of Service: Nursing
Address: 185 Belsize Road, Lisburn, BT27 4LA
Tel No: 02892676301
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Rose Lodge took place on 18 July from 09:35 hours to 17:30 hours.

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

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

There were no areas of improvement identified in the delivery of safe care.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that that the outcome of care delivery was positive for patients. A review of care records confirmed that a range of risk assessments were completed. Care plans were created to prescribe care. There were arrangements in place to monitor and review the effectiveness of care delivery.

We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Patients and staff were of the opinion that the care delivered provided positive outcomes.

One area for improvement was identified to ensure that all patients had a comprehensive assessment of need completed at the time of their admission. A recommendation was made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Staff were also observed to be taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to the care they received.

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure evidenced within Rose Lodge and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

There was evidence of good leadership in the home and effective governance arrangements. Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. A requirement was made that monthly monitoring visits must be undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

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 Department of Health, Social Services and Public Safety(DHSSPS) Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**1**	**1**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ed Warnock, responsible person and Hilary Clarke, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 27 April 2016. Other than those actions detailed in the previous QIP there were no further actions required. This QIP will be validated during the next medicines management inspection.

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

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered provider: Rose Lodge Care Homes Ltd Mr Ed Warnock, responsible person	**Registered manager:** Hilary Clarke
Person in charge of the home at the time of inspection: Hilary Clarke	**Date manager registered:** 18 December 2012
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 48

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection we met with ten patients individually and with the majority of others in small groups, two registered nurses, the general manager, three care staff, one domestic assistant, the activity co-ordinator and two patients' relatives.

Ten questionnaires were issued to relatives and staff with a request that they were returned within one week from the date of this inspection.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

The following information was examined during the inspection:

- five patient care records
- staff duty roster for week commencing 18 July 2016
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records

- records of audit
- records of staff meetings
- annual quality report
- reports of the monthly quality monitoring visits.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 27 April 2016.

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

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of recommendations from the last care inspection dated 10 November 2015.

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 36.2 **Stated:** First time	It is recommended that when the draft policies on communication, palliative care, death and dying and bereavement are issued staff should receive an induction/ training on the content.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that when identified policies had been reissued they were displayed for staff to read. A record of signatures had been maintained to evidence that staff had read and understood the information. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 20.1 **Stated:** First time	Further opportunities, to discuss end of life care, should be created by the registered nurses. Any expressed wishes of patients and/ or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that this recommendation had been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. There was evidence of review in the minutes of the staff meeting held on 25 February 2016; following discussion with staff, a restructuring of shift patterns was agreed in response to service need. The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 18 July 2016 evidenced that the planned staffing levels were adhered to.

In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic and laundry staff were on duty daily. There was also an activity co-ordinator. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Some anxieties were discussed when care staff, in the absence of a senior care assistant, were asked to co-ordinate other care staff during a shift. This was discussed with the responsible person and registered manager who agreed to discuss this further with staff and the registered nurses in an attempt to clarify the role and allay anxieties. We also sought staff opinion on staffing via questionnaires; four completed questionnaire was returned following the inspection. All of the staff responded that there were sufficient staff to meet the needs of the needs of the patient and assessed the domain of safe as either excellent or good.

Patients and relatives commented positively regarding the staff and care delivery. Ten questionnaires were issued to relatives; two were returned in time for inclusion in this report. The relatives responded that they were satisfied that staff had enough time to care for their relative.

The registered manager and registered nurses spoken with were aware of who was in charge of the home when the registered manager was off duty. The nurse in charge was clearly identified on the staffing roster for the week of the inspection. A review of records evidenced that a competency and capability assessment had been completed with all nurses who were given the responsibility of being in charge of the home in the absence of the registered manager. The assessments were signed by the registered manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

Discussion with the registered manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed. The registered manager was knowledgeable regarding the management of the Northern Ireland Social Care Council (NISCC) registration process for newly employed care staff and confirmed that newly appointed staff were supported to complete their application as part of the induction process.

A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. The record maintained of Access NI checks was reviewed. The records included the registration number of the certificate and that date the certificate was checked by the home. Records evidenced that the outcome of the Access NI check had been confirmed prior to the candidate commencing employment.

Discussion with the registered manager and staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Two completed induction programme were reviewed. The programmes included a written record of the areas completed and the signature of the person supporting the new employees. On completion of the induction programme the registered manager signed the record to confirm that the induction process had been satisfactorily completed.

Mandatory training was provided by the home in classroom based sessions. Mandatory training was delivered over a three day period. An annual training plan was completed. This planner identified five sessions of mandatory training; each session consisted of three days. Staff were required to attend a full session once a year. The dates were displayed at the beginning of the year to allow staff sufficient time to plan which session they would attend. Training delivered during these sessions included safeguarding, manual handling, (theory and practice), infection prevention and control and fire safety. The registered manager explained that an e learning programme was available and use in the interim for newly employed staff as part of their induction. These staff would attend the next available three day training. Staff were required to completed a reflective account following completion of training. The reflective account asked staff to consider what they had learned and how they would use it to improve their practice. The use of reflection was commended.

The registered manager had systems in place to monitor staff attendance and compliance with training. These systems included a training matrix to facilitate an over view and the signing in sheets from each training to evidence staff attendance. A review of the print out of mandatory training evidenced good compliance with mandatory training over the past twelve months; for example 90% of staff attended fire safety, 90% attended infection prevention and control and 89% attended safeguarding. Training records included staff who were on extended sick leave and maternity leave; this has an impact on statistical reporting.

Training opportunities were also provided by the local health and social care trust. The registered manager explained that dates and details of the planned training were provided to the home regularly and staff were supported to attend.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. There were comprehensive records of referrals to safeguarding within the local health and social care trust. The registered manager maintained a time line of events.

The records include confirmation from the relevant health and social care trust when the issues were closed. We noted that the registered manager had completed a root cause analysis following an investigation and held a debriefing meeting with the registered nurses to discuss the conclusion of the issues and lessons learned. This follow-up and approach to minimise the risk of the issues occurring again was commended. The registered manager was knowledgeable regarding the recent guidance “Adult Safeguarding: Prevention and Protection in Partnership 2015” and confirmed that the home have identified a safeguarding champion in accordance with the new guidance.

The registered nurses care and domestic staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient’s individual care plans.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of accidents to identify any trends or patterns.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. All of the responses we received in the returned questionnaires confirmed that this was normal for the home.

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

There were no issues identified with infection prevention and control practice.

Areas for improvement

No areas for improvement were identified in the assessment of safe care.

Number of requirements:	**0**	**Number of recommendations**:	**0**

4.4 Is care effective?

We reviewed five patients' care records with regard to the admission process, the management of wound care and the day to day maintenance and review of care records.

A review of two care records evidenced that a comprehensive assessment of patients' nursing needs had not been commenced at the time of admission to the home. A recommendation was made.

As previously discussed a range of validated risk assessments were completed as part of the admission process. Initial plans of care were generated within 24 hours of admission.

A review of wound care records evidenced that details of the wounds and the recommended dressing were recorded in the patient's care plan. The care record contained an initial assessment of the wound and an assessment following each dressing renewal. Review of completed records evidenced that prescribed dressing regimes were adhered to. The importance of recording the frequency with which dressing should be renewed was discussed with the registered manager.

Repositioning charts were maintained for patients who required assistance with postural changes; charts for one patient evidenced that positional changes were carried out regularly.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Care records were regularly reviewed and updated, as required, in response to patient need. Evaluation of care plans included a meaningful statement of the patient's condition since the previous review.

The registered manager informed us that a physiotherapist, employed by the home, was available weekly. They provided patients with assessments in regard to moving and handling needs and the provision of appropriate equipment. They also complete post falls evaluation and support with mobility needs following a fall. The addition of this role and patient access to physiotherapist input was commended.

There was evidence within the care records of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Observations evidenced that call bells were answered promptly and patients requesting assistance in the lounge areas or their bedrooms were responded to appropriately. Patients were confident of the ability of staff to meet their need effectively and in a timely manner. Patients were satisfied that staff responded to call bells promptly.

The serving of lunch was observed in the dining room on the ground floor. Tables were nicely set with cutlery, condiments and napkins. Patients who had their lunch in the lounge or bedroom were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. There was a choice of two dishes; both were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. The registered manager explained the nurses commenced their shift 30 minutes prior to care staff. They received the full nursing report. The nurse provided care staff with a handover report of the relevant information. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided relevant information regarding each patient's condition and any changes noted.

The registered manager confirmed that staff meetings were held regularly. The dates of the meeting were arranged on an annual basis and displayed in the home. This allowed staff sufficient time to make arrangements to attend. In addition if a staff member could not attend one date they were aware, in advance, of the date of the next meeting. Records of the issues discussed and agreed outcomes were maintained. Meetings with staff teams, for example registered nurses, care staff, kitchen and housekeeping staff were held on a number of dates in February, March, May and June 2016. Minutes of these meetings, detailing attendees, and the areas discussed, were available. It was good to note that the responsible person attended a number of staff meetings in May and June 2016.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff confirmed that if they had any concerns, they would raise these with the registered manager.

Areas for improvement

A comprehensive assessment to identify patient need should be initiated for all patients on admission and completed within five days of admission to the home.

Number of requirements:	**0**	**Number of recommendations**:	**1**

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:
"I'm very happy with me care."
"Everyone does a great job."
"Things are as good as ever."

Patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. As previously discussed in section 4.4 observation of care delivery confirmed that patients were assisted in a timely manner.

We spoke with the relatives of two patients. Both commented positively with regard to the standard of care and communication in the home.

They confirmed that they were made to feel welcome when visiting and were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. The registered manager has regular, daily contact with the patients and visitors and was available, throughout the day, to meet with both on a one to one basis if needed. The registered manager explained that they structure their working week over 7 days to ensure they are available to meet with relatives who visit at the weekends. Patients spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with.

The registered manager explained that quality assurance questionnaires were sent out annually to relatives. The results of the questionnaires sent in 2015 were included in the Annual Quality report for the period January – December 2015. We discussed the importance of including the action taken by the responsible person in response to the comments made, how this report could be shared with relatives and visitors and the benefits of doing so.

The provision of activities was reviewed and we spoke at length with activity co-ordinator who explained that activities were planned on both a group and one to one basis. They explained that, following admission, they visited each patient, introduced themselves, explained their role and discussed with patients and/ or relatives what their past interests were and how they liked to spend their day. In addition to displaying the activity programme in the home all of the patients were informed each morning of what activities would be taking place and if they wish to participate; while we were talking with patients we heard the activity co-ordinator informing patients and checking who wished to attend. The activity co-ordinator confirmed that there

was good support from staff which was vital in enabling him to do his job. Arrangements were in place to support patients with their spiritual needs. Ministers and representatives of various denominations visited regularly to attend to the patients. Patients commented that they enjoyed the activities provided. Those patients who chose not to attend were aware that activities were available and that they could participate if they wished.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"There are not enough words to express my thanks for all your kindness and care to both … and myself especially through the last week of her life."

"Dad was only with you for a short while; however I can gladly say he could not have been better cared for."

"From the day dad arrived at Rose Lodge you showed him affection, attention, respect, dignity and most of all fun."

Ten relative questionnaires were issued; two were returned within the timescale for inclusion in this report. The respondents were very satisfied with all aspects of care. No additional comments were provided.

Ten questionnaires were issued to staff; four were returned within the timescale for inclusion in this report. Staff responded positively to all of the questions asked. No additional comments were provided.

Areas for improvement

No areas for improvement were identified in the assessment of compassionate care.

Number of requirements:	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were displayed and available in the reception area of the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home.

Staff spoken with were knowledgeable regarding the line management arrangements and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships; staff stated that management were responsive to any suggestions or concerns raised.

Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients and their representatives confirmed that they were confident that staff and/or management would address any concern raised by them appropriately. Patients were aware of who the responsible person and registered manager were and reported that they would have daily contact.

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint, details of the investigation and action taken, if any. The record also indicated how the registered manager had concluded that the complaint was closed. There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included care records and the occurrence of accidents and incidents. Discussion with the registered manager confirmed that where an area for improvement was identified there was evidence of re-audit to check that the required improvement had been completed.

The arrangements for the unannounced monthly visits required in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were reviewed.

An annual schedule was available and detailed the responsible person, or one of the company directors, to undertake a visit monthly; a focus /theme was identified for each month. A review of the reports available evidenced that monthly quality monitoring visits had only been undertaken on three occasions in 2016. The visits had not been undertaken in a timely manner. For example the visit to evaluate the care in January 2016 was undertaken in April and the report issued in June 2016. Prior to us reviewing the reports the responsible person had acknowledged that improvements where required in this area. The responsible person must ensure that an unannounced visit is undertaken monthly to monitor the quality of services provided. A requirement was made.

Areas for improvement

The responsible person must ensure that an unannounced visit is undertaken monthly to monitor the quality of services provided.

Number of requirements:	**1**	**Number of recommendations**:	**0**

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ed Warnock, Responsible Person and Hilary Clarke, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of

the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions taken by the Registered Provider

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

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 29(2) & (3) **Stated:** First time **To be completed by:** 15 August 2016.	The registered provider must ensure that an unannounced visit is undertaken monthly to monitor the quality of services provided. **Ref section 4.6** **Response by registered provider detailing the actions taken:** The backlog of reports that were due have now been completed and Regulation 29 monitoring reports are being carried out on a more timely basis.
Recommendations	
Recommendation 1 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** 15 August 2016	It is recommended that a comprehensive assessment to identify patient need should be commenced for all patients on admission and completed within five days of admission to the home. **Ref section 4.4** **Response by registered provider detailing the actions taken:** All recent admissions either before the inspection or since have been reviewed and a comprehensive needs assessment has been carried out using the Epic Care template. All nursing staff have been informed of Standard 4.1 and the necessity of completing a needs assessment within five days of admission. Admission doccumentation will be audited on day five to ensure compliance by the nurse manager or her deputy until compliance is fully established.

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

The Regulation and Quality Improvement Authority

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