Unannounced Care Inspection Report
9 March 2017

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 9 March 2017 from 10:15 to 16:15.

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

Is care safe?

A review of the staffing provision and a general inspection of the home indicated that the delivery of care was safe.

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

Is care effective?

A review of five care records evidenced that a range of risk assessments had been commenced at the time of admission to the home. Care plans were in place to direct the care required. The assessments and care plans were reviewed regularly. A comprehensive assessment of need had not been commenced for all patients at the time of admission and a recommendation was made.

In one of the care records reviewed the information contained in the assessments did not accurately identify the needs of the patients. The information contained in assessments and care plans should accurately and consistently identify the needs of the patients and provide clear direction for staff. A recommendation was made.

We discussed how patient and care needs were communicated between staff. Staff advised that they received a handover report at the start of each shift. Staff were of the opinion that there was effective teamwork; each staff member knew their role, function and responsibilities.

A total of two recommendations were made within the domain of effective care. Compliance with these recommendations will further drive improvements in this delivery of effective care.

Is care compassionate?

We arrived in the home at 10:15. The majority of patients were sitting in the lounges and reception area beside the front door. The level of noise and conversation created a great sense of community on arrival into the home. Patients sitting in the reception area commented that sitting in that area provided them with a view of “all the comings and goings” of the home. It was evident that the patients were comfortable in their surroundings.

There was evidence of good communication in the home between staff and patients. Patients were very praiseworthy of staff and a number of their comments are included in the report.

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

Is the service well led?

Patients, relative and staff commented positively regarding the registered manager and her role within the home. Staff reported that they were well supported in their role and that management were approachable. The registered manager confirmed that the responsible person was in the home daily to provide support and assistance as required.

There were no areas of improvement identified within the domain of well led.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**2***

*The total number of recommendations includes one recommendation which has been stated for the second time.

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 estates inspection undertaken on 7 October 2016. There were no further actions required to be taken following the most recent 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 2015
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:

- 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 15 patients, two registered nurses, five care staff and the relatives of four patients.

Questionnaires were also left in the home to facilitate feedback from patients' representatives and staff not on duty. Ten, staff and patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- Staffing rota for week commencing 6 March 2017
- five patients' care records
- record of complaints
- record of quality monitoring visits carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 07October 2016

The most recent inspection of the home was an unannounced estates inspection. There were no issues identified during this inspection, and a QIP was neither required, nor included, as part of this inspection report.

4.2 Review of requirements and recommendations from the last care inspection dated 18 July 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 29(2) & (3) **Stated:** First time	The registered provider must ensure that an unannounced visit is undertaken monthly to monitor the quality of services provided.	**Met**
	Action taken as confirmed during the inspection: A review of the completed reports for the period August 2016 to January 2017 evidenced that an unannounced visit was undertaken monthly to monitor the quality of services provided. This requirement has been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 4.1 **Stated:** First time	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.	**Partially Met**
	Action taken as confirmed during the inspection: A review of five care records evidenced that one patient had a comprehensive assessment to identify patient need commenced on admission to the home. Three patients had an assessment completed a number of weeks after admission and one patient had not have a comprehensive assessment completed at the time of the inspection. This recommendation is assessed as partially met and is stated for a second time.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home. A review of the staffing roster for week commencing 6 March 2017 evidenced that planned staffing levels were adhered to. In addition to nursing and care staff, the registered manager confirmed that administrative, catering, domestic and laundry staff were also on duty daily. No concerns regarding staffing provision within the home were raised during discussions with patients or relatives.

We also sought relatives and staff opinion on staffing via questionnaires. Seven were returned from relatives prior to the issue of this report. Five of the respondents responded “yes” to the question “Are you satisfied that staff have enough time to care for your relative?”; two relatives

replied “no” to this question. One respondent commented that shortage of staff or facilities impacted on the length of time visits to the toilet can take. All of the respondents indicated that they were very satisfied or satisfied that care was safe.

Staff spoken with discussed working patterns and the impact patient dependency has on staffing. One staff member returned a questionnaire. The staff member was satisfied that there were sufficient staff to meet the needs of the patients.

A general inspection of the home was undertaken to examine a number of patients’ bedrooms, lounges, bathrooms and toilets. The home was fresh smelling, clean and appropriately heated. There were no issues identified with infection prevention and control practice.

There were no requirements or recommendations made for this domain.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

A review of five care records evidenced that a range of risk assessments had been commenced at the time of admission to the home. Care plans were in place to direct the care required. The assessments and care plans were reviewed regularly. A comprehensive assessment of need had not been commenced for all patients at the time of admission.

As previously discussed one patient had a comprehensive assessment to identify patient need commenced on admission to the home, three patients had an assessment completed a number of weeks after admission and one patient had not had a comprehensive assessment completed at the time of the inspection. A recommendation made as a result of the previous care inspection is now stated for a second time.

In one of the care records reviewed the information contained in the assessments did not consistently identify the needs of the patients. For example in the patient’s activity of daily living assessment the patient was assessed as being independently mobile. They were also assessed as being unable to weight bear. Staff confirmed that the patient was able to walk without the assistance of staff. There was also conflicting information in the assessment of the patients continence needs. A review of the care plans for mobility and continence evidenced that the patient’s needs, as confirmed by staff, were accurately recorded however the prescribed interventions were not consistent. For example the care plan for mobility stated the patient was able to mobilise without assistance, should be assisted and supervised at all times when mobilising and was able to mobilise with the assistance of a walking aid. The assessments and care plans did not accurately or consistently identify the needs of the patients and failed to provide clear direction for staff. A recommendation was made.

We discussed how patient and care needs were communicated between staff. Staff advised that they received a handover report at the start of each shift. Staff were of the opinion 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 patients, relatives and their colleagues.

Areas for improvement

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.

The information contained in assessments and care plans should accurately and consistently identify the needs of the patients and provide clear direction for staff.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

We arrived in the home at 10:15 hours. The majority of patients were sitting in the lounges and reception area beside the front door. The level of noise and conversation created a great sense of community on arrival into the home. Patients sitting in the reception area commented that sitting in that area provided them with a view of "all the comings and goings" of the home. It was evident that the patients were comfortable in their surroundings.

Patients spoken with commented positively in regard to care delivery and staff with in the home. The following comments were provided:

"If I can't be at home here is the next best place."
"After all this time they are still taking good care of me."
"The care is exemplary."

We spoke with the relatives of four patients. The relatives commented positively with regard to the care provided and the kindness and support they received from staff. The following comment was provided:

"The home is always clean and fresh smelling."
"Staff are wonderful, so loving."

Staff spoken with were knowledgeable regarding patients' likes, dislikes and individual preferences. Observation of interactions between staff evidenced that there was good team work and respect for the various roles within the home.

Ten relative questionnaires were issued; seven were returned within the timescale for inclusion in this report. All of the respondents were very satisfied or satisfed that care was safe, effective, compassionate and well led. The following comments were provided:
"The service provides a well organised management team with excellent staff and facilities."
"Sometimes when I visit … is at the bathroom and at times it can take quite a long time which means I have less time with her but I am very fond of the home."

Comments with regard to staffing are discussed in section 4.3.

Ten questionnaires were issued to staff; one was returned within the timescale for inclusion in this report. The staff member was satisfied that care was safe, effective, compassionate and well led. No additional comments were provided.

There were no requirements or recommendations made for this domain.

Areas for improvement

No areas for improvement were identified with the delivery of compassionate care.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Patients, relative and staff commented positively regarding the registered manager and her role within the home. Staff reported that they were well supported in their role and that management were approachable. The registered manager confirmed that the responsible person was in the home daily to provide support and assistance as required.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The compliments received from the relatives of former and current patients were also reviewed and evidenced that numerous compliments had been received since the previous inspection.

Review of reports and discussion with the registered manager evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement.

There were no requirements or recommendations made for this domain.

Areas for improvement

No areas for improvement were identified within the domain of well led.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the 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/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment 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: There were no requirements made as a result of this inspection.

Recommendations

Recommendation 1 **Ref**: Standard 4.1 **Stated:** Second time	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 4.2 and 4.4**
To be completed by: 6 April 2017	**Response by registered provider detailing the actions taken:** A discussion has taken place with the Nursing Team and nurses informed of the inspection recommendation. In order to meet this standard the whole team must be involved with information gathering for the first five days. Nurses must inform management if they experience obstacles to information gathering so support can be provided. Management will conduct an audit on days one to five of all new admissions to monitor progress and provide support in order to ensure the standard is met. Visual Alerts are posted in the diary on days one to five of the admission process and also on Outlook. Protected time is being given to nurses in a designated area in order to work on the admission process as needed.
Recommendation 2 **Ref**: Standard 4 **Stated:** First time	The registered provider should ensure that the information contained patient assessments and care plans accurately and consistently identifies the needs of the patients and provides clear direction for staff. **Ref section 4.4**
To be completed by: 6 April 2017	**Response by registered provider detailing the actions taken:** A discussion with Nursing Staff has taken place since the inspection and feedback sought as to difficulties the team and individual nurses experience in maintaining care plans and assessements. A full audit has taken place since the inspection of all care plans and assessments. Inconsistencies have been identified and each primary nurse has been informed and deadlines given to update care plans and assessments. Nurses have been assigned protected time daily to work on care plans and assessments and this is being recorded.

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