Unannounced Care Inspection Report
28 September 2017

Rose Lodge

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

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 48 persons.

3.0 Service details

Organisation/Registered Provider: Rose Lodge Care Homes Ltd **Responsible Individual:** Mr Ed Warnock	**Registered Manager:** Hilary Clarke
Person in charge at the time of inspection: Hilary Clarke	**Date manager registered:** 18 December 2015
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill. Residential Care (RC) I – Old age not falling within any other category.	**Number of registered places:** 48 Category RC-I for 1 named individual only. The home is also approved to provide care on a day basis to 1 person in the Dowling Wing and 1 person in the Warnock Wing.

4.0 Inspection summary

An unannounced inspection took place on 26 September 2017 from 09:15 to 16:30.

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 term ‘patients’ is used to describe those living in Rose Lodge which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to the provision of staffing, staff relations, the development of staff, adult safeguarding and the home’s environment.

The assessments of patients’ needs and care plans were well maintained and contained good details of patients’ individual needs and preferences. There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, activities and the caring and compassionate manner in which staff delivered care.

Areas requiring improvement under the care standards were identified in relation to the effectiveness of the systems to confirm nurses NMC registration at the time of renewing their registration and the recording of enteral feeding.

Patients said:
“They go out of their way to help you.”
“If you can’t be at home here is the next best place.”
“The staff are wonderful.”

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	2

Details of the Quality Improvement Plan (QIP) were discussed with Ed Warnock, responsible person and Hilary Clark, 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 27 April 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 27 April 2017. There were no further actions required to be taken following the most recent inspection.

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
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI’s), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with seven patients individually and with others in small groups and nine staff. Questionnaires were also left in the home to obtain feedback from patients’ representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives were left for distribution.

The following records were examined during the inspection:

- duty rota for all staff for week commencing 25 September 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction file
- three patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- 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 27 April 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 09 March 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 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.	**Met**
	Action taken as confirmed during the inspection: Care records reviewed contained a comprehensive assessment to identify patient need. A review of a patient record admitted since the previous inspection evidenced that the assessment had been commenced within five days of admission to the home. This area for improvement has been met.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered provider should ensure that the information contained in patient assessments and care plans accurately and consistently identifies the needs of the patients and provides clear direction for staff.	**Met**
	Action taken as confirmed during the inspection: In the three patients' care records reviewed the information with regard to patient need was consistently recorded. This recommendation has been met.	

6.3 Inspection findings

6.4 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 the planned daily staffing levels for the home and that staffing was subject to regular review to ensure the assessed needs of the patients were met.

The registered manager discussed at length recent changes made to the staffing in response to issues raised by staff; further review by the registered manager was planned to ensure staffing was appropriate to meet the morning routine of patients. Staff spoken with were aware of the registered manager's ongoing review of staffing and were of the opinion that their views were listened to by the management of the home.

A review of the staffing rota for week commencing 25 September 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Observation of the delivery of care and discussion with patients evidenced that their needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; four were returned following the inspection. All of the respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?".

Patients spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in timely manner. We sought relatives' opinion on staffing via questionnaires; six were returned in time for inclusion in the report. The relatives were very satisfied or satisfied that there was sufficient staff to meet the needs of their loved one.

The registered manager confirmed that a nurse was identified to take charge of the home when the registered manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the 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.

A review of two staff recruitment records evidenced that they were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records confirmed that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager and the administrator. A review of the records of NMC registration evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The records showed that there where nurses whose registration expired on 30 September 2017; this date was over a weekend and, the administrator confirmed, prior to the next check being completed. Following discussion with the registered manager and administrator it was agreed that the systems in place would be reviewed they are effective in confirming registration at the time of renewal. This was identified as area for approval under the care standards.

The registered manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe.

We discussed the provision of mandatory training with staff. The registered manager explained that an annual training plan, detailing which mandatory training was required to be completed each month was arranged and shared with staff at the beginning of each year. A review of the training records for 2017 evidenced good compliance; for example 97% of staff had completed training in safeguarding, 96% fire awareness and 97% in moving and handling. Mandatory training compliance was monitored by the registered manager.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. The registered manager confirmed that they were aware of the new regional operational safeguarding policy and procedure and that the safeguarding policy had been updated to reflect the new guidance. Records were in place of the information required for the completion of the annual position report.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA between 1 May – 26 September 2017 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, clean and fresh smelling. The standard of cleanliness and maintenance of the environment observed was commended. Patients spoken with were complimentary in respect of the home's environment. Infection prevention and control measures were adhered to. We spoke with two members of housekeeping staff who were knowledgeable regarding the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths and the management of the environment for patients with a healthcare associated infection. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately.

We discussed the management of fire safety with the assistant manager who confirmed that fire checks were completed weekly. Fire exits and corridors were observed to be clear of clutter and obstruction. The weekly testing of the fire alarm was completed during the inspection. It was good to note that patients, staff and visitors were made aware that the fire alarms were being tested prior to the alarms being activated.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to provision of staffing, staff relations, the development of staff, adult safeguarding and the home's environment.

Areas for improvement

An area for improvement made under the care standards was identified in relation to the effectiveness of the systems to confirm nurses NMC registration at the time of renewing their registration.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

A review of three patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

We examined the management of enteral feeding for one patient. The dietetic report which detailed the prescribed nutritional regime was available in the patient's care records. The administration of the prescribed enteral feed was recorded on a fluid chart. We reviewed the fluids charts completed for the four days prior to the inspection. The records were inconsistently recorded; for example some staff recorded the time the feed commenced but there was no record to confirm the administration had concluded; on one occasion the feed was not included on the fluid chart. The records of the administration of water were not accurately totalled for one day. Following discussion with staff and examination of the care records of the monthly review by the dietician and the patient's weight we concluded that the patient's nutrition needs were being met. However improvements were required with the recording of the enteral feed. The registered manager agreed that they would review the recording of prescribed enteral feeding regimes to ensure that it is in accordance with best practice and evidenced care delivery. This was identified as an area for improvement under the care standards.

We reviewed the management of catheter care for one patient. A care plans was in place which detailed the frequency with which the catheter was due to be changed and systems were in place to alert staff to when the next change was due. Care records evidenced that the catheter was changed in accordance with the prescribed frequency. Records evidenced that staff were monitoring the patient's urinary output.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as TVN, SALT and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

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. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

The registered manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meetings were held on 20 September 2017 with the registered nurses and 23 August 2017 with senior care staff.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This registered provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the assessment of patient need and care planning, care delivery and the communication of patients' needs.

Areas for improvement

An area for improvement was made under the care standards in relation to the recording of enteral feeding.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 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.

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. 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 were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. The staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day.

There was evidence that patients were involved in decision making about their care. Patients were consulted with regarding meal choices and were offered a choice of meals, snacks and drinks throughout the day. Staff encouraged those patients who could express their preference to do so and demonstrated a detailed knowledge of patients' likes and dislikes for those patients who were unable to express their opinion.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Discussion with patients individually and with others in smaller groups, confirmed that they were content living in the home. These are examples of some of the comments received:
"They go out of their way to help you."
"If you can't be at home here is the next best place."
"The staff are wonderful."

We reviewed the provision of activities and were informed by patients that they looked forward to the different events that were planned throughout the day. We spoke with the activity co-ordinator who continues to be enthusiastic regarding their role in the home. They confirmed that there was wide a variety of activities planned on a weekly and monthly basis. A copy of the activity programme was displayed and included events to meet the patients' religious wishes. In the afternoon of the inspection a musician visited to provide entertainment. Staff joined in with the musician and encouraged the patients to sing along. There was a lovely atmosphere and it was evident that the patients enjoyed the entertainment. Patients commented that whilst they didn't join in with all of the activities there were certain events they enjoyed and the monthly visit by the musician was one of them.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. They explained that they had regular, daily contact with the patients and any visitors and was available, throughout the day, to meet with both on a one to one basis if needed. Patients spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with.

Quality assurance questionnaires were also issued annually to relatives; there were last issued on October 2016 and the results were included in the annual report for 2016. The responses were all positive with 100% of the respondents strongly agreeing, or agreeing that they were happy with the overall care provided.

We issued ten relative questionnaires; six were returned within the timescale for inclusion in this report. All of the relatives were either very satisfied or satisfied with the care provided across the four domains.

We issued ten questionnaires to nursing, care and ancillary staff; four were returned prior to the issue of this report. Staff were either very satisfied or satisfied with the care provided across the four domains.

Any comments from relatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, activities and the caring and compassionate manner in which staff delivered care.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 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.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its' registered categories of care. The most recent certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. In discussion patients and relatives were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The registered manager's hours were clearly recorded in the home. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them contact as required. The registered manager was supported in her role by the operational manager, who was in the home daily. They were also supported by an administration team who were well informed and provided good support throughout the inspection.

Discussion with the registered manager and review of the home's complaints records evidenced that systems were in place to ensure 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 complaints record was well maintained with information of the action taken in response to complaints and a detailed response to the complainant.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. The following are examples received on thank you cards:

"Thank you for looking after …He loved the staff taking him for walks around the home and sitting at the front watching the birds."
"Dad settled in remarkable well and we know that was greatly due to the genuine warmth, friendship and professionalism of the many staff."
"I couldn't help but notice the loving care shown to all ….. and always with a kind word."

The registered manager confirmed that monthly audits were completed, for example care records. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

The responsible person undertakes the role of operational manager within the home, and as previously discussed, is in the home daily. Review of records evidenced that a monthly report to review the quality of the services delivered was completed. The monthly reported included discussion with patients, relatives and staff and a summary on the service delivered. A copy of the monthly reports was available in the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management support and the maintenance of good working relationships between staff.

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 Ed Warnock, responsible person and Hilary Clark, 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 Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that the systems in place to monitor the registration status of nurses with the NMC are effective in confirming registration at the time of renewal. Ref: Section 6.4
To be completed by: 26 October 2017	**Response by registered person detailing the actions taken:** The registration status of nurses is now checked by the end of the 3rd week of each calendar month. Reminders are now set for each registrant prior to expiration of registration
Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First time	The registered person shall review the recording of prescribed enteral feeding regimes to ensure that it is in accordance with best practice and evidences care delivery Ref: Section 6.5
To be completed by: 26 October 2017	**Response by registered person detailing the actions taken:** The documentation for recording prescribed enteral feeding has been reviewed and adjusted to improve clarity. The start and stop time for enteral feeding and water hydration infusions is now included. There are now three columns : feed, water hydration, flushes and medication, each with a subtotal and then a 24hr total. This improved form is now being used and completed accurately each day.

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

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