The Regulation and Quality Improvement Authority

Inspection Report

14 and 28 May 2024

Woodlawn House

Type of service: Nursing Home
Address: Quarry Lane, Dungannon, BT70 1HX
Telephone number: 028 3756 6380

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Southern Health and Social Care Trust **Responsible Individual:** Dr Maria O'Kane	**Registered Manager:** Mrs Chanelle Crawford **Date registered:** 1 June 2022
Person in charge at the time of inspection: Mrs Chanelle Crawford, Manager	**Number of registered places:** 9
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 7
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 9 patients. The home is divided in two units in which care is provided for people living with a learning disability. The service is used to provide a short break service to patients and their families.	

2.0 Inspection summary

An unannounced inspection took place on 14 May 2024 from 9.30am until 4.30pm by a care inspector, followed by an unannounced inspection on the 28 May 2024 from 11.35am to 11.50am by an estates inspector.

The purpose of the inspections was to assess progress with all areas for improvement identified in the home 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.

Patients told us that they felt well looked after. Patients who were less able to communicate their views were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report.

Areas for improvement were identified during the inspection as detailed throughout this report and within the Quality Improvement Plan (QIP) in section 6.0.

The findings of this report will provide the management team with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the management team at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "I really enjoy staying here", "It's very homily here", "The care is second to none" and "The staff are very good". There was no response to questionnaires from patients or relatives.

Staff said that the management team were very approachable, teamwork was great and that they felt well supported in their role. Comments included: "The manager is brilliant", "I really enjoy working here" and "We have a good team and are supportive of each other". There was no feedback from the staff online survey.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 23rd June 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall implement a robust auditing system to ensure that all medicines are administered as prescribed and medication administration records are accurately maintained. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref:** Regulation 27 (4) (b) **Stated:** First time	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that fire doors are not propped open. **Action taken as confirmed during the inspection**: Observation of the environment evidenced that this area for improvement had been met.	**Met**
Area for improvement 3 **Ref:** Regulation (27) (2) (b) (c) **Stated:** First time	The registered person shall ensure that all windows are reviewed and fitted where necessary with robust tamper proof fixings which can only be overridden or removed with the use of a special tool to ensure that window openings are controlled to a safe point of opening of not more than 100mm. **Action taken as confirmed during the inspection**: Review of a sample of windows on the 14 May 2024, evidenced that some windows were required to be fitted with tamper proof fixtures. This was discussed with the manager who agreed to have these fitted.	**Met**

	During the unannounced inspection on the 28 May 2024, the estates inspector reviewed a sample of windows which evidenced that relevant action had been taken and this area for improvement had been met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 38.3 **Stated:** First time	The registered person shall ensure that the manager has oversight of the recruitment process including pre-employment checks.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of recruitment records and discussion with the manager evidenced that this area for improvement had been met.	
Area for improvement 2 **Ref:** Standard 44 **Stated:** First time	The registered person shall ensure that the environmental issues identified during this inspection are addressed.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment and discussion with the manager evidenced that this area for improvement had been met.	
Area for improvement 3 **Ref:** Standard 48.8 **Stated:** First time	The registered person shall ensure that all staff participate in a fire evacuation drill at least once a year.	**Met**
	Action taken as confirmed during the inspection: Review of relevant records evidenced that this area for improvement had been met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics including fire safety and adult safeguarding.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC).

Review of a sample of staff recruitment files evidenced that not all relevant pre-employment information had been obtained for one staff member prior to commencing work in the home. Details were discussed with the manager and following the inspection, written assurances were received that relevant action had been taken to address this.

Staff said they felt supported in their roles and that there was good team work with effective communication between staff and management. Staff also said that, whilst they were kept busy, the number of staff on duty was generally satisfactory to meet the needs of the patients.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the manager was not on duty.

Review of a sample of registered nurses' competency and capability assessments for taking charge of the home in the absence of the manager found these to have been completed.

A matrix system was in place for staff supervision and appraisals to record staff names and the date that the supervision/appraisal had taken place.

5.2.2 Care Delivery and Record Keeping

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was seen to be a pleasant opportunity for patients to socialise and the atmosphere was calm and relaxed. A pictorial menu was displayed outside the dining room.

There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, staff recognised that patients may need a range of support with meals and were seen to helpfully encourage and assist patients as required. One staff member was observed standing when assisting a patient with their meal and staff did not wear aprons during the provision of meals. This was discussed with the manager and following the inspection written confirmation was received that relevant action had been taken to address these issues.

Staff described how they were made aware of patients' individual nutritional and support needs based on recommendations made by the Speech and Language Therapist (SALT). Whilst staff were providing the correct diet as recommended by SALT, review of one patient's care records evidenced that the care plan had not been updated to reflect the most recent SALT recommendations and two further patients care plans were not consistent with the International Dysphagia Diet Standardisation Initiative (IDDSI) terminology. This was discussed in detail with the manager and an area for improvement was identified.

Review of two patients care records evidenced that care plans and risk assessments were reviewed as part of the admission process. Whilst most risk assessments had been reviewed, the Malnutrition Universal Screening Tool (MUST) had not been completed. The manager agreed to have this reviewed and to discuss with relevant staff. Following the inspection written confirmation was received that relevant action had been taken to address this with ongoing monitoring to ensure sustained compliance.

A number of patients had a Deprivation of Liberty Safeguards (DoLS) in place and some patients required enhanced supervision by staff. Review of two patients care records evidenced that a care plan had not been implemented for DoLS and there was insufficient detail within one patient's care plan regarding the duration and level of enhanced supervision required. Specific details were discussed with the manager and an area for improvement was identified.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from and consultations with any healthcare professional was also recorded.

The door to the nurses' office was observed open and unattended with access to patient confidential information, this was brought to the attention of the manager who immediately addressed this with relevant staff. The door remained locked when not occupied by staff for the remainder of the inspection.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean, neat and tidy. The manager confirmed that an audit of the environment is completed on a monthly basis and an action plan implemented where deficits are identified to ensure the home is well maintained.

Surface damage was identified to a number of walls and floor coverings requiring either repair, replacement or redecoration. A malodour was also evident within an identified en-suite. Details were discussed with the manager and following the inspection written confirmation was received that relevant action had been taken to address these issues.

Corridors and fire exits were clear of clutter and obstruction. The most recent fire risk assessment was completed on 25 January 2024 with confirmation from the manager that relevant action had been taken to address any recommendations stated.

There was evidence that fire evacuation drills had been completed with the names of the staff members who took part in the drill.

The staff room door was observed open with access to staff belongings and food. This was brought to the attention of a nurse who immediately locked the door and confirmed that this

door is normally kept locked. This was later discussed with the manager who agreed to monitor this during her daily walk around of the home. The door remained locked for the remainder of the inspection.

There was a good supply of personal protective equipment (PPE) and hand sanitising gel in the home. Staff use of PPE and hand hygiene was regularly monitored by management and records were kept. Observation of staff practices in relation to infection prevention and control (IPC) evidenced that a number of staff were not bare below the elbow and an area for improvement was identified.

5.2.4 Quality of Life for Patients

Observation of life in the home and discussion with staff and patients established that staff engaged with patients individually or in groups; patients were afforded the choice and opportunity to engage in social activities, if they wished.

During the inspection one patient was accompanied by staff to visit a local coffee shop and a further patient was observed relaxing in the multi-sensory room. Other patients were observed participating in art work with staff or engaged in their own activities such as; watching TV, resting or chatting to staff. Patients appeared to be content and settled in their surroundings and in their interactions with staff. One patient said: “Lots of activities and things to do” but also said: “(I) would like Wi-Fi to do more activities”. This was discussed with the management team to review and action as necessary.

Patients commented positively about the food provided within the home with comments such as: “The food is good here and plenty of choices” and “The food is nice.”

5.2.5 Management and Governance Arrangements

There has been no change to the management arrangements for the home since the last inspection. The manager said they felt well supported by senior management and the organisation.

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients’ next of kin, their care manager and to RQIA. It was identified that one notification had not been submitted to RQIA. This was discussed with the manager who had these submitted retrospectively.

Review of the complaints file evidenced that information regarding the action taken and/or the outcome was not available for one complaint. This was discussed with the management team and following the inspection written confirmation was received that the record of complaint had been updated with the necessary information.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Where deficits were identified the audit process included an action plan with the person responsible for completing the action, a time frame for completion and a follow up to ensure the necessary improvements had been made.

The home was visited each month by a representative of the responsible individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed and available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	1*	3

* The total number of areas for improvement includes one regulation that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed the management team, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 17 August 2021	The registered person shall implement a robust auditing system to ensure that all medicines are administered as prescribed and medication administration records are accurately maintained. Ref: 5.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 14 May 2024	The registered person shall ensure that patients care plans are reflective of the most recent Speech and Language Therapist (SALT) recommendations and documented in accordance with the International Dysphagia Diet Standardisation Initiative (IDDSI) terminology. Ref: 5.2.2

	Response by registered person detailing the actions taken: All care plans are being reviewed and updated with a focus on on ensuring that correct IDDSI levels are detailed and that correct termonoligy is used within the care plan. All service user care plans will be updated prior to their next short break admission to Woodlawn House. Care plans are being crossed referenced with PARIS and REDS to ensure consistency of information, and to ensure the most up to date and accurate information is recorded within the Woodlawn House care plan. All keyworkers have been reminded of the requirement to ensure adequate cross checking of information and to keep files up to date. This will be reinforced at team meetings on an onoing basis. Changes to eating and drinking reccommendations are included on the Woodlawn House admission checklist documentation. This has been reviewed and additional propmpts added to support admitting staff to ensure more robust information is recorded at the point of admission. Assistant Manager and Registered Manager to continue to complete a minium of 10 file audits per month. LD Nurse Consultant and LD Nurse Lead are working with Woodlawn staff and management to ensure audits of SLT recommmendations and recording of same are robust and any areas of concern are duly followed up. Woodlawn also implemented the 'mealtime matters' audit.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 14 May 2024	The registered person shall ensure that a care plan is implemented for any patient with a Deprivation of Liberty Safeguards (DoLS) and that care plans regarding enhanced supervision are reflective of the duration and level of enhanced supervision required. Ref: 5.2.2
	Response by registered person detailing the actions taken: All care plans are being reviewed to ensure they clearly detail any enhanced levels of supervision in place. All service user care plans will be updated prior to their next short break in Woodlawn House to ensure any DoLs are clearly recorded. . All nurses have been reminded of the requirement to detail any DoLs / enhanced levels of supervision in individual service user care plans.

	There is a restrictive practice section on the admission checklist. This is currently under review, prompts in relation to DoLs will be added to the checklist to support admitting staff and to ensure detailed information is included at the point of admission. The service now has a DOLs spreadsheet which details all service users attending Woodlawn House with a DoLs in place. This will be updated on an ongoing basis to ensure up to date and accurate information is held by the service. A safe today/safe tomorrow process is now in place in Woodlawn House. This process requires staff in charge to twice daily review the service and identify any areas of concern and to address these e.g. staffing levels, skill mix of staff. This process will ensure DoLs requirements are met.
Area for improvement 3 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure that staff are compliant with infection prevention and control (IPC) best practice and remain bare below the elbow. Ref: 5.2.3
To be completed by: 14 May 2024	**Response by registered person detailing the actions taken:** Hand Hyigene audits continue to form part of the regular audit programme in Woodlawn House. Frequency of these audits will increase from monthly to weekly for a period of time to improve adherence to IPC procedures. In addition management team will undertake spot checks. Any non-compliance issues will be addressed immediately. Additionally, audit findings will be reviewed by the Registered Manager on a monthly basis to ensure any issues highlighted have been are addressed with relevant staff and actioned. Dress code audit is completed monthly. These audits will be reviewed by the management team to ensure any issues of non-compliance are addressed with individual staff members and any follow up actions are completed. All staff will be reminded of the IPC, Hand Hygiene and Dress Code procedures through team meetings / supervision.

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