Lisburn Care Home
RQIA ID: 1265
119a Hillsborough Road
Lisburn
BT28 1JX

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Unannounced Care Inspection
of
Lisburn Care Home

7 January 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 7 January 2016 from 11 50 hours to 16 15 hours.

The focus of this inspection was to determine what progress had been made in addressing the recommendations made during the previous care inspection on 19 May 2015.

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 19 May 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care	**Registered Manager:** Karen Moriarty
Person in Charge of the Home at the Time of Inspection: Registered Nurse - Amy McCormick	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 36
Number of Patients Accommodated on Day of Inspection: 34	**Weekly Tariff at Time of Inspection:** £605.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the deputy manager
- discussion with the nurse in charge
- discussion with staff
- discussion with patients
- discussion with relatives
- review of records
- observations during a tour of the premises
- evaluation and feedback

The inspector met with eleven patients individually, and with the majority of others in groups, one patient's relative, two registered nurses, four care staff and the cook.

Prior to inspection the following records were analysed:

- 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

The following records were examined during the inspection:

- five patient care records
- staff training records
- complaints and compliments records
- incident and accident records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Lisburn Care Home was an unannounced care inspection dated 19 May 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 32 **Stated:** First time	It is recommended that when the updated Palliative and End of Life Care manual is issued that staff receive an induction/training on the content to ensure their knowledge and care delivery is reflective of best practice.	**Met**
	Action taken as confirmed during the inspection: A review of training records evidenced that induction and question and answer sessions on the Palliative and End of Life Care manual were held in October and November 2015. The deputy manager explained that the majority of staff had attended one session; a record of the signatures of staff who had attended was maintained. This recommendation has been met.	
Recommendation 2 **Ref:** Standard 20 **Stated:** First time	It is recommended that further opportunities, to discuss end of life care, are 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'. Requested restrictions on who information can be shared with should be recorded in a prominent location in the care records.	**Met**
	Action taken as confirmed during the inspection A review of three care records evidenced that opportunities had been created to discuss and identify end of life wishes. Where wishes had been identified these had been formulated into a care plan. Information was observed to appropriately recorded. This recommendation has been met.	

5.3 Additional Areas Examined

5.3.1 Comments of Patients, Patients' Representatives and Staff

As part of the inspection process patients, their representatives and staff were consulted and the comments received are detailed below.

Patients

Patients spoken with were very positive about their care, the kindness of the staff and the quality of the food provided. Patients were well presented and comfortable in their surroundings. Comments included:

"This is a place I would definitely recommend."
"The staff are very good, always trying to help you."
"There's always staff around for a cup of tea."

Comments made by one patient were discussed with the deputy manager who readily agreed to discuss the issues further with the patient. It was good to note that the deputy manager was aware of the patient's views prior to RQIA speaking with them.

There were processes within the home to obtain the opinion of patients and visitors on a daily basis. A review of records evidenced that for the period June – December 2015 a total of 29 patients had completed a questionnaire. All of the responses were positive. The registered manager had systems in place to review responses regularly and to address any suggestions or areas for improvement.

Patients Representatives

We spoke with one patients' representative. The relative was happy with the care their mother was receiving and was confident that her needs were being met.

Staff

Staff were observed to be responding promptly to the needs of patients. The relationships between staff and patients were friendly and relaxed. Staff commented positively about working in the home and the delivery of care. There were no concerns raised. Review of the nursing and care staff duty roster for the week of the inspection evidenced that planned staffing levels were adhered to.

5.3.2 Care Practices

A tour of the home was undertaken prior to lunchtime. There was a calm atmosphere in the home and staff were quietly attending to the patients' needs. One issue regarding continence aids and a potential impact on patient dignity was discussed with the deputy manager who agreed to discuss further with staff.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. Patients spoken with commented positively in regard to the care they received and the caring attitude of the staff. Those patients who were unable to verbally express their views were observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

Staff and patient interaction and communication demonstrated that patients were treated courteously, with dignity and respect. Good relationships were evident between staff and patients.

5.3.3 Mealtime

Lunch was served in the dining room. Twenty nine of the 34 patients came to the dining room for their meal. The tables were set with cutlery, condiments and napkins. Those patients who had their lunch in their room 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.

The lunchtime menu was homemade tomato soup followed by a choice of Irish stew or pork casserole, brussel sprouts and creamed potatoes. Patients chose which dish they preferred at the point of service. This is good practice. The meals were served by the kitchen staff. The serving of the lunch was observed to be well organised with all of the patients being attended to in a timely manner. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch

5.3.4 Complaints and Compliments

A review of the record of complaints and compliments evidenced that the registered manager had a robust system in place for the management of complaints. The complaints record included the nature of the complaint, the action taken and if the complainant was satisfied with the outcome. An analysis to identify trends and patterns was completed monthly by the registered manager. Compliments were generally received in the form of cards. These were displayed in the home and a record of their receipt recorded by the registered manager.

5.3.5 Accidents and Incidents

Accidents and incidents were maintained electronically with a paper copy retained in the home for inspection. A review of accidents recorded for the period 1 June 2015 to 31 December 2015 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 to identify any trends or patterns.

5.3.6 Staff training

Training opportunities were available via an e learning system, internal face to face training arranged by Four Seasons Health Care and training provided by the local health and social care Trust. A review of staff training records evidenced that there was good compliance with mandatory training; for example 98% of staff had completed training in safeguarding vulnerable adult in the past 12 month, 100% of staff were trained in basic life support, 93% in first aid awareness and 95% in moving and handling. Records also evidenced that staff had availed of training provided by the South Eastern Health and Social Care Trust (SEHSCT); for example swallowing awareness, stoma management and infection prevention and control link nurse training.

5.3.7 General Environment

A general inspection of the home was undertaken to examine a number of patients' bedrooms, lounges, bathrooms and toilets at random. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling throughout, clean and appropriately heated.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations.

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Karen Moriarty	**Date Completed**	15/2/16
Registered Person	Dr Claire Royston	**Date Approved**	22.02.16
RQIA Inspector Assessing Response	Sharon McKnight	**Date Approved**	23-02-16

Please provide any additional comments or observations you may wish to make below:

It was lovely to receive a positive inspection and outcomes and comments will be communicated with staff and relatives.

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