Unannounced Care Inspection Report
25 October 2016

Lisburn Care Home

Type of Service: Nursing Home
Address: 119 Hillsborough Road, Lisburn, BT28 1JX
Tel no: 02892666763
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Lisburn Care Home took place on 25 October 2016 from 09.15 to 15.30 hours.

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?

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.

A requirement has been made that RQIA is notified of any serious injury to a patient in the home.

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.

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

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 the home 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.

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	1	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with the 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 finance inspection undertaken on 09 August 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. 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 person: Four Seasons Healthcare Maureen Claire Royston	**Registered manager:** Karen Moriarty
Person in charge of the home at the time of inspection: Karen Moriarty	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI The home is approved to provide care on a day basis only to 1 person.	**Number of registered places:** 38

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- notifiable events submitted 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 plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with five patients, four care staff, two registered nurse, two domestic staff and five patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- seven patient care records
- staff training records for 2015/2016
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 09 August 2016

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance 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 finance inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 13 January 2016

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 17 October 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The manager had also signed the record to confirm that the induction process had been satisfactorily completed. Records were also maintained in relation to the induction and profile of agency staff members.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. The records reviewed confirmed that 97% of staff had, so far this year, completed mandatory training; this was commended by the inspector.

Observation of the delivery of care evidenced that training had been embedded into practice.

Review of records and discussion with the registered manager confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home. Staff confirmed that there were support systems in place to guide their practice. A matrix had been developed which provided clear information to enable the registered manager to see when staff supervisions and appraisals were due.

There were safe systems in place for the recruitment and selection of staff. Discussion with staff and a review of one personnel file, evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.

Where nurses and carers were employed, their PIN numbers were checked on a regular basis, with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that their registrations were valid. The registered manager explained how an electronic reminder was utilised, to help her monitor the registrations of nurses, whose registration renewal dates occurred between checks.

Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with Access NI and a record was maintained which included the reference number and date received.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. Although there had not been any safeguarding incidents reported since the last inspection, the registered manager was aware of the regional safeguarding protocols and was knowledgeable about how to report safeguarding incidents. A review of the minutes of the last staff meeting dated 11 August 2016 also evidenced that the home's whistleblowing procedures had been discussed with staff.

Validated risk assessments were completed as part of the admission process and were reviewed as required. These risk assessments informed the care planning process.

Choke risk assessments were completed for patients, as required. The home was also trialling the use of 'choke tent cards', which were aimed at increasing visitors' awareness of the risks to the patients' health safety and welfare; this was commended by the inspector.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident, care management and patients' representatives were notified appropriately. However, the review of the accidents records identified that an incident had occurred, wherein a patient had sustained a head injury, RQIA had not been notified. A requirement has been made in this regard.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. The areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Infection prevention and control measures were adhered to and equipment was stored appropriately

Fire exits and corridors were maintained clear from clutter and obstruction. Personal evacuation plans had been completed for each patient taking into account their mobility and assistance level. These plans were reviewed monthly to ensure that they were up to date. These plans are to assist in the event of the building needing to be evacuated in an emergency.

Areas for improvement

A requirement has been made that RQIA is notified of any serious injury to a patient in the home.

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

4.4 Is care effective?

A review of seven patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. The review evidenced that risk assessments were completed as part of the admission process and were reviewed as required. There was also evidence that risk assessments informed the care planning process.

The care records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer a care plan was in place to direct staff on the management of this risk. Where applicable, tissue viability nurse specialists (TVN) were involved in prescribing care in relation to the management of wounds.

There was evidence that regular wound assessments were completed and that care plan evaluations included detail regarding the progress of the wound. Wound dressings had been changed according to the care plan and the care records were supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, speech and language therapists (SALT) or dieticians for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Patients who were identified as requiring a modified diet had the relevant choke risk and malnutrition risk assessments completed and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records.

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.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent general staff meeting was held on 11 August 2016.

Staff also confirmed that if they had any concerns, they could raise these with their line manager and /or the registered manager. Information on advocacy services was not available to patients. Advocates can represent the views for patients/patients' representatives who are unable or not confident in expressing their wishes. However, registered nursing staff confirmed that advocacy services could be accessed via the patients' care management process, if required.

The registered manager explained that relatives' and patients' meetings were not held formally due to historically poor attendance. There was an effective system in place to ascertain patients' and relatives' views, though the Quality of Life system (QOL). Refer to section 4.5 for further detail. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management.

A notice board displaying information for relatives was provided at the front entrance to the home. This included the home's mission statement; aims and objectives; ethos of care; and how to make a complaint.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients stated that they were involved in decision making about their own care. Patients were offered a choice of meals, snacks and drinks throughout the day.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

We observed the lunch time being served in the dining room. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set in advance of the patients entering the dining room. Staff consulted with stated that there was sufficient specialist cutlery and plate guards available to help patients who were able to maintain some level of independence as they ate their meal.

The menus were displayed at the front entrance to the home, to assist patients in making choices and to provide an awareness of the meal to be served. The lunch served appeared very appetising and patients spoken with stated that it was always very nice

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

There was evidence of a variety of activities in the home and discussion with patients confirmed that they were given a choice with regards to what they wanted to participate in. There were various photographs displayed around the home of patients' participation in recent activities. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. For example, patients, relatives, visitors to the home and staff were invited to provide feedback on an ongoing basis. Questions asked were in relation to satisfaction levels with the care and general services provided. Views and comments recorded were analysed and if required an action plan was developed and shared with staff, patients and relatives. For example, the registered manager viewed feedback recorded on the QOL system on a daily or month by month basis and was able to compare and contrast outcomes over various timeframes. If required, responses could be addressed with the individual or through a meeting with patients, relatives or staff. The electronic system also requires the registered manager to confirm the action taken to responses. If a response is not recorded in a timely manner then the system provides an alert to the registered manager and/or their line manager.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives.

One comment included praise for the staff, stating that they 'would have no hesitation placing (a relative) in the caring hands of the staff in Lisburn Care Home'. Discussion with the registered manager and a review of records also confirmed that patients' representatives had nominated eight staff members, within a three month period, for a 'ROCK' award, which acknowledges staff' kindness.

During the inspection, we met with five patients, four care staff, two registered nurse, two domestic staff and five patients' representatives. Some comments received are detailed below:

Staff

"I love it here and wouldn't work anywhere else".
"Fantastic, no problems at all".
"I love it here, enjoy the ones I work with and all the residents".
"This is a good home with a good reputation".

Patients

"You couldn't get better".
"They are very good to me; the food they do very well".
"I couldn't be better".
"It is all lovely here, it is very nice".

Patients' representatives

"The staff are very good".
"I rate them exceptionally high".
"It's as good as it gets here; they take time to listen to you".
"They are great".
"They are very attentive and it is just so nice to hear my mother say, how happy she is here".
"I am happy enough".

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. No patients' questionnaires were returned. Eight staff and three relatives returned their questionnaires, within the timeframe for inclusion in this report. All respondents confirmed that they were 'very satisfied' that the home was delivering safe, effective and compassionate care and that the home was well led.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

The registered manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis. Staff had access to the home's policies and procedures in hard copy, in addition to electronic versions that were available. The registered manager explained that there was a system in place to notify staff regarding new/updated policies, via the home's electronic system. This system would enable the registered manager to view the names of staff who had read the policies. Policies and procedures were also distributed during staff meetings.

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. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff consulted with, were very praiseworthy regarding the support they received from the registered manager and from the deputy manager. Two staff members described the registered manager's management style as being 'amazing'. One patients' representative described how they never visited the home, without the registered manager acknowledging them. Through discussion with the registered manager, it was evident that she had a good knowledge of the needs of the patients and also of the needs of their relatives.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis. Although an action plan was in place to address any deficits identified, the audit of accidents failed to identify that one serious injury had not been reported to RQIA in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. All other accidents and incidents had been appropriately managed. Refer to section 4.3 for further detail.

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. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives.

The monthly quality monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required. An action plan was generated to address any areas for improvement. Discussion with the registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas for improvement

No areas for improvement were identified during the inspection.

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 the 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	
Requirement 1 **Ref**: Regulation 30 (1) (c) **Stated:** First time **To be completed by:** 21 December 2016	The registered persons must ensure that RQIA is notified of any serious injury to a patient in the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The Home Manager has met with the Deputy Manager and all Registered Nurses to refresh and inform them of the Incidents which should be reported to RQIA. This has been addressed with immediate effect from the day of inspection 25 October 2016. The Home Manager will continue to monitor and review.

Please ensure this document is completed in full and returned via web portal

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