Unannounced Care Inspection Report
16 &17 December 2019

Laganvale Care Home

Type of Service: Nursing Home
Address: 37 Laganvale Mews, Moira, BT67 0RE
Tel No: 028 9261 9899
Inspector: Gillian Dowds

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.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 72 patients. The home is divided in to two units, each containing 36 beds, one for general nursing and one for dementia nursing care.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual:** Maureen Claire Royston	**Registered Manager and date registered:** Sherly Mathai Acting Manager – No application required
Person in charge at the time of inspection: Sherly Mathai	**Number of registered places:** 72 A maximum of 36 patients in categories NH-I and NH-PH and a maximum of 36 patients in category NH-DE
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 65

4.0 Inspection summary

An unannounced inspection took place on 16 December 2019 from 10.00 hours to 17.00 hours and 17 December 2019 from 10.00 hours to 17.00 hours

This inspection was undertaken by the care inspector.

The inspection assessed 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.

Evidence of good practice was found in relation to planned activities over the Christmas period, staff interaction with patients, recruitment and falls management.

Areas requiring improvement were identified in regard to infection prevention and control (IPC), malodours in identified flooring, wound care records, management of lap belts, and oversight of supplementary care

Patients described living in the home in positive terms. Residents unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

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	2	6*

*The total number of areas for improvement includes two which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Sherly Mathai, 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 25 June 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 25 June 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from 2 December 2019 to 29 December 2019
- 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 files
- five patients' care records
- eight patients' care charts including food and fluid intake charts and repositioning charts
- a sample of governance audits/records
- complaints record
- compliments received
- a sample of monthly monitoring reports from June 2019
- RQIA registration certificate

Areas for improvement identified at the last 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 previous inspection(s)

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 **Stated:** First time	The registered person shall ensure that chemicals are not accessible to patients in any area within the home. **Action taken as confirmed during the inspection**: Observation of the environment confirmed that sluices were appropriately locked and that chemicals were securely stored.	**Met**
Area for improvement 2 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure that all parts of the home that patients have access are free from hazards and unnecessary risks are as far as possible eliminated: • Building supplies stored appropriately • Fire extinguisher storage boxes are clean and free from debris • Charging of batteries in the patients lounge	**Met**

	Action taken as confirmed during the inspection: Observation of the environment confirmed that no building supplies were being inappropriately stored. Fire extinguisher boxes were noted to be free from debris and no batteries were being charged in the lounge.	
Area for improvement 3 **Ref:** Regulation 14 (2) (c) **Stated:** First time	The registered person shall ensure that best practice guidance is adhered to for post falls management in regard to unwitnessed falls	**Met**
	Action taken as confirmed during the inspection: A review of two patients' care records evidenced best practice guidance in relation to post falls management, had been adhered to by staff.	
Area for improvement 4 **Ref:** Regulation 30 **Stated:** First time	The registered person shall give notice to RQIA without delay of any notifiable event.	**Met**
	Action taken as confirmed during the inspection: A review of notifications prior to the inspection and feedback from the manager evidenced that statutory notifications had been submitted to RQIA within expected timescales since the previous care inspection.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 23 **Stated:** First time	The registered person shall ensure that the flooring on the communal identified room is repaired /replaced as appropriate.	**Met**
	Action taken as confirmed during the inspection: The inspector confirmed that the flooring to the identified room had been replaced.	
Area for improvement 2 **Ref**: Standard 44 **Stated:** First time	The registered person shall ensure that the malodours in the identified areas are managed appropriately.	**Partially met**
	Action taken as confirmed during the inspection: The inspector noted improvement in one area of the home previously identified but a malodour remained evident in other areas.	

	This area for improvement has been partially met and is stated for a second time.	
Area for improvement 3 **Ref:** Standard 5 **Stated:** First time	The registered person shall ensure when lap belts are in use there is appropriate documentation in place to evidence consultation with Trust personnel and are reflected in the daily evaluation of care.	**Not met**
	Action taken as confirmed during the inspection: The care records for one patient were reviewed in regard to the use of lap belts. There was no evidence of any consultation with Trust personnel having taken place and the use of this restrictive practice was not reflected in the daily evaluation of care. This area for improvement has not been met and is stated for a second time.	
Area for improvement 4 **Ref:** Standard 6.3 **Stated:** First time	The registered person shall ensure there is a robust system in place to ensure that the gender mix of care staff is regularly and effectively reviewed.	**Met**
	Action taken as confirmed during the inspection: A review of the duty rota evidenced that this area for improvement was met.	
Area for improvement 5 **Ref**: Standard 41 **Stated:** First time	The registered person shall ensure there is a robust system in place to ensure staffing levels are kept under review to meet the needs of the patients.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager confirmed that staffing levels are kept under review to meet the assessed needs of patients.	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The manager confirmed the staffing levels for the home and that these were reviewed subject to patient dependency levels. A review of the staff rota from 2 to 29 December 2019 confirmed that these levels were generally adhered to. The manager also discussed ongoing recruitment and skill mix in the home. During the inspection, staff were observed assisting patients in a calm, friendly manner and provided a relaxed atmosphere within the home. Patients spoken with felt that the staffing levels were satisfactory.

Staff spoken with stated that they felt the staffing levels were satisfactory unless there were short notice absences. Staff did confirm that there were systems in place to manage this and that management did endeavour to cover the shifts.

No feedback was received from patients/relatives or staff via questionnaires in regard to staffing levels. We observed staff attending to patients' needs. Staff demonstrated a good understanding of patients' needs as well as their likes, dislikes and preferences.

Review of records confirmed there was a system in place to monitor the registration status of care staff with the NMC and NISCC and this clearly identified the registration status of all staff.

Discussion with staff confirmed they were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding. Review of training records confirmed staff had completed mandatory training in this area.

Infection prevention and control measures were observed and shortfalls were identified throughout the environment including various sluice rooms. We observed ineffective cleaning of tables and chairs and decontamination of equipment, despite there being cleaning schedules in place to direct staff on the cleaning required. In addition, staff were observed not following best practice guidance in regard to hand washing. A lack of shelving in an identified pad store was also identified.

While a malodour identified at the last care inspection was no longer present, a malodour was still evident in identified lounges on the ground floor. This was discussed with the manager who advised us that new flooring had been ordered for the lounge on the ground floor and that she would review the other areas highlighted.

A review of governance records and feedback from the manager evidenced that the malodour in one of the lounge areas had already been identified and actions were being taken to address the deficits. Due to these shortfalls, an action plan was requested by RQIA from the senior management team of Laganvale in order to provide assurance to RQIA as to how any outstanding issues would be addressed.

An area for improvement in relation to IPC has been identified and an area for improvement in regard to the malodour has been stated for a second time.

Discussion with staff and a review of records confirmed that post falls management of patients was in keeping with best practice guidance. In addition, an analysis is performed by the manager to identify any patterns or trends.

Areas for improvement

An area for improvement was highlighted in relation to infection prevention and control.

	Regulations	Standards
Total number of areas for improvement	1	0

6.4 Is care effective?

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

We observed the delivery of care to patients and were assured that staff had a good understanding of their assessed care needs. Staff demonstrated effective communication skills when communicating with patients and were seen to attend to patients in a caring and compassionate manner.

We reviewed five patients' care records and these evidenced that there were care plans in place to direct staff in meeting the patients' assessed needs. Relevant risk assessments were also in place.

Patients' nutritional needs had been identified and validated risk assessments were completed to inform care planning. Patients' weights were monitored on at least a monthly basis and there was evidence of referral to the dietician and the speech and language therapist (SALT) where required. We reviewed the care plan for a patient requiring an enteral feed. The care plan contained the relevant information required for staff. However, we identified that the evaluation of the care being provided lacked detail and did not fully reflect the care being given. An area for improvement was identified.

We reviewed the documentation for two patients who had had an identified wound. We noted that there was no documentation in relation to one patient's wound. This wound was confirmed as healed by the nurse. The care records for a second patient who had more than one wound were reviewed; this patient's wound care plan was inaccurate in regard to the required dressing regime and there was a lack of detail in the evaluation of the wound. We discussed these findings with the nurse in charge and the care plans were updated immediately. An area for improvement was identified.

We also reviewed supplementary care documentation, namely, fluid charts for those patients who required fluid monitoring. We observed that although the fluid intakes for these patients were recorded, there was no daily evaluation of the total fluid intake. We also reviewed the documentation for bowel management and repositioning charts and identified that there was a lack of oversight by the nurses in the daily progress notes of the care provided. An area for improvement was identified. The need to ensure that nursing staff effectively monitor and manage patients' daily fluid intakes, bowel patterns and repositioning needs, was stressed.

We reviewed the management of one patient who required the use of a lap belt. While it was evidenced within the care record that there had been discussions with various members of the multi-disciplinary team, these written entries lacked sufficient detail; further development of documentation in regard to lap belt checks by staff was also required. An area for improvement was stated for a second time.

Staff confirmed that there was good and effective teamwork; each staff member knew their role, function and responsibilities. Staff told us that if they had any concerns about patients' care or a colleague's practice, they could raise these with the manager or with the nurse in charge.

Areas for improvement

Areas for improvement were identified in relation to wound care documentation; oversight of supplementary care records/care delivery by registered nurses and evaluation of enteral care provision.

	Regulations	Standards
Total number of areas for improvement	1	2

6.5 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.

When we arrived in the home patients were enjoying their morning tea/coffee or breakfast in one of the lounges, dining areas or in their own room. The menu choice sheet for the lunch time meal indicated that patients' individualised choices were reflected.

During the meal time we observed that staff were providing support to patients as they needed it. Staff interactions with patients were observed to be compassionate, caring and timely. We observed the serving of lunch in the ground floor dining room. Staff assisted patients into the dining rooms, ensuring they were comfortable.

Feedback from patients in relation to food within the home included the following comments:

- "It's good."
- "The food is good."

In the afternoon we observed some patients and their visitors in the dining area enjoying the Christmas party. There were also discussions with the staff and patients about the planned outing for Christmas lunch the following day to a local hotel.

During the inspection we spoke with 10 patients, both individually and in small groups. Patients who were unable to communicate their opinions appeared to be relaxed and well cared for. Comments from patients were positive and complimentary about life in the home; these included:

- "Get on well."
- "Love it here."
- "Very good, like it here."
- "Good place."

Ten patient/relative questionnaires were left in the home for completion; no responses were returned within the timescale for inclusion in this report.

Seven patients' relatives were consulted during the inspection. Some of the comments received were as follows:

- " ……is well looked after, lovely, can't say a bad word."
- "Staff are good."
- "Fine, nothing wrong, everyone very good."
- "Good staff."

Visitors spoken to were mostly positive about the service in Laganvale. All comments by visitors were passed to the manager to review and action as necessary.

Staff were provided with the opportunity to complete an online survey; we had no responses within the timescale specified.

Areas for improvement

No areas for improvement in this domain were identified.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 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.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last care inspection in June 2019 Sherly Mathai has been appointed as the manager of the nursing home. RQIA were notified of this management change as required. We discussed the ongoing recruitment for a permanent manager.

Discussion with the manager and review of records evidenced that systems were in place to ensure notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

We reviewed a sample of monthly monitoring reports which evidenced visits being carried out by the registered provider. These included evidence of consultation with patients, staff and visitors, and included a service improvement plan/action plan.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, IPC practices, care records, medication, wound care and bedrails.

However, it was identified that in some cases where a shortfall was identified any action taken to rectify this was not always documented and an area for improvement was identified.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Review of records confirmed the home provided mandatory training to ensure staff were adequately trained for their roles and responsibilities. A mandatory training schedule was maintained and staff were reminded when training was due. Discussion with staff confirmed that they had sufficient time to access training. However, due to the deficits identified during this inspection it was noted that further training and staff supervision in regard to IPC and hand washing formed part of the action plan subsequently submitted to RQIA. An area for improvement was identified.

Areas for improvement

Two areas for improvement were identified in relation to governance audits and staff training..

	Regulations	Standards
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Sherly Mathai, 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 Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** Immediately from the day of inspection	The registered person shall ensure suitable arrangements are in place to minimise the risk of infection and spread of infection between patients and staff. This area for improvement is in relation to ensuring the following: • that staff to adhere to hand washing in keeping with best practice guidance at all times • that robust environmental cleaning schedules are implemented and monitored • that equipment is effectively decontaminated if soiled Ref: 6.3
	Response by registered person detailing the actions taken: Supervision sessions held with Nurses,Care staff,Catering and Housekeeping staff on Infection Control and Decontamination of equipment which also included principles of hand washing in the work place. The Registered Manager conducted weekly hand hygeine and PPE audits within the Home for a period of 8 weeks and audit met compliance percentage. These will now be audited monthly and if any areas of concern then weekly audits will be recommenced. Additional Alcohol gel points have been erected within the Home for easy access to staff. The Decontamination folders and Housekeeping Cleaning Schedules have been reviewed and updated within the Home and being monitored for compliance by the Interim Manager.
Area for improvement 2 **Ref:** Regulation 12 (1) (a) **Stated:** First time **To be completed by:** Immediately from the day of inspection	The registered person shall ensure that record keeping in relation to wound management is maintained in accordance with legislative requirements, minimum standards and professional guidance. Ref: 6.4
	Response by registered person detailing the actions taken: Supervision sessions held in relation to Wound Care, documentation and record keeping for all RGN staff. Wound Care TRaCa completed on all wounds within the Home at time of inspection and monthly Wound Analysis reviewed and verified by Interim Home Manager. All RGN staff in the Home have an up to date Wound care competency held on file.

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 44 **Stated:** Second time **To be completed by:** 2 March 2020	The registered person shall ensure that the malodours in the identified areas are managed appropriately. This is in relation to the identified area in this report. Ref: 6.1 and 6.3
	Response by registered person detailing the actions taken: Awaiting replacement of new vinyl flooring in both communal lounge areas of the dementia Unit to address the malodour. Housekeeeping staff washing and cleaning floors on regular basis using urine neutriliser cleaning product to assist in reducing any malodours along with use of air freshners .
Area for improvement 2 **Ref**: Standard 5 **Stated:** Second time **To be completed by:** 16 February 2020	The registered person shall ensure when lap belts are in use there is appropriate documentation in place to evidence consultation with Trust personnel and are reflected in the daily evaluation of care. Ref: 6.1 and 6.4
	Response by registered person detailing the actions taken: Supervison Session held with Registered Nurses on Restraint Management. Also going forward any restraint being used will be discussed with Trust personnel and referenced in the daily evaluation progress notes and reviewed at annual care review meetings. Currently there are no lap belts in use within the Home.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 14 February 2020	The registered person shall ensure that contemporaneous nursing records are kept of all nursing interventions and procedures carried out in relation to each patient, in accordance with NMC guidelines. Registered nurses should have effective oversight of the supplementary care records of patients, specifically: fluid balance charts, bowel monitoring and repositioning records. Ref: 6.4
	Response by registered person detailing the actions taken: Supervison session held with RGN staff on completion of food and fluid booklets and also regarding accountability for clear and accurate records as per NISCC Code of Practice 2002 and NMC Record keeping. This supervison is now being delivered to care staff also. RGN staff will review supplementary booklets on a daily basis. Interim HM will spot check and record on the daily walk around on QOL

Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 27 February 2020	The registered person shall ensure that the care a patient receives in regard to their enteral feeding is reflected fully in the daily and monthly evaluation of care. Ref: 6.4
	Response by registered person detailing the actions taken: RGN staff informed to ensure enteral feeding is reflected in daily progress notes and also informative evaluation in the monthly care plan evaluations. This will be spot checked by Interim Registered Manager
Area for improvement 5 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 27 February 2020	The registered person shall ensure that action plans are developed to address the shortfalls identified within auditing records and that these action plans are reviewed to ensure completion. Ref: 6.6
	Response by registered person detailing the actions taken: Interim Registered Manager addresses and completes all linked actions generated from Audits on QOL. Also other monthly audits ie Hand hygeine ,PPE action plans would be devised where applicable and communicated with staff.
Area for improvement 6 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 1 March 2020	The registered person shall ensure there are systems in place to monitor the effectiveness of training received by staff and that such training is embedded into practice. This in relation to IPC practices and hand washing. Ref: 6.3 and 6.6
	Response by registered person detailing the actions taken: Supervision held on infection control and handwashing with all staff. The hand hygeine and PPE audits evidence staff compliance following supervison. Staff also completing mandatory module of Infection control on SOAR and current compliance is 87%.

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

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