Inspection Report

11 December 2022

Lansdowne Care Home

Type of service: Nursing Home
Address: 41-43 Somerton Road, Belfast BT15 3LG
Telephone number: 028 9037 0911

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

1.0 Service information

Organisation: Beaumont Care Homes Limited **Responsible Individual:** Mrs Ruth Burrows	**Registered Manager:** Mrs Cara Parker **Date registered:** 14 December 2018
Person in charge at the time of inspection: Mrs Nicola McMurray – nurse in charge	**Number of registered places:** 86 A maximum of 17 patients in category NH-DE to be accommodated in the Dementia Unit.
Categories of care: Nursing Home (NH) DE – Dementia I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 49
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 86 patients. The home is divided in three units over three floors. The Annabelle unit on the ground floor provides care for people with dementia. The Innisfayle and Cavehill units on the first floor and second floor provide general nursing care.	

2.0 Inspection summary

An unannounced inspection took place on 10 November 2022 from 9.00 am to 5.15 pm by a care inspector. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

New areas requiring improvement were identified during this inspection and are discussed within the main body of the report and Section 6.0. Review of areas for improvement from the previous care inspection noted that one was met; one area for improvement was partially met and has been stated for a second time.

Patients were happy to engage with the inspector and share their experiences of living in the home. Patients expressed positive opinions about the home and the care provided. Patients said that staff members were helpful and pleasant in their interactions with them.

Patients who could not verbally communicate were well presented in their appearance and appeared to be comfortable and settled in their surroundings.

RQIA were assured that the delivery of care and service provided in Lansdowne Care Home was provided in a compassionate manner by staff that knew and understood the needs of the patients.

The findings of this report will provide the manager 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.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in the 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 and 'Tell Us' cards 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 manager at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect and that they would have no issues in raising any concerns with staff. One patient said, "It is absolutely unbelievable; the staff are second to none" while another patient said, "I am more than happy with the care. Everyone has been good, kind, pleasant and helpful. I have a lovely room and the food is great. I couldn't say a bad word".

Relatives were complimentary of the care provided in the home and spoke positively about communication with the home.

Staff spoken with said that Lansdowne Care Home was a good place to work. Staff commented positively about the manager and described them as supportive, approachable and always available for guidance. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

No questionnaires were returned by residents or relatives and no responses were received 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 21 October 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that nursing staff carry out clinical/neurological observations, as appropriate, for all patients following a fall and that all such observations/actions taken post fall are appropriately recorded in the patient's care record.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for Improvement 2 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the following: • donning and doffing of personal protective equipment • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene.	**Partially met**
	Action taken as confirmed during the inspection: Although some improvements were noted, observation of staff practice evidenced continued shortfalls in infection prevention and control knowledge and practice. This is discussed further in section 5.2.3. This area for improvement is partially met and is stated for a second time.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

A review of staff selection and recruitment records evidenced that staff members were recruited safely ensuring that all pre-employment checks had been completed prior to each staff member commencing in post. Staff members were provided with a comprehensive induction programme to prepare them for providing care to patients.

Checks were made to ensure that staff maintained their registrations with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

The staff duty rota accurately reflected the staff working in the home on a daily basis. This rota identified the person in charge when the manager was not on duty. Review of records confirmed staff who take charge of the home in the absence of the manager had completed a competency and capability assessment to be able to do so.

There were systems in place to ensure that staff were trained and supported to do their job. Examination of training records and consultation with staff confirmed that they received regular training in a range of topics such as moving and handling, infection prevention and control (IPC) and fire safety.

Review of records confirmed that improvements were required to achieve compliance with mandatory training. The manager confirmed that there had been a change of provider recently and examination of monthly monitoring reports evidenced of a high level of compliance on the previous training platform used. The manager agreed to update RQIA on a monthly basis regarding the training statistics on the new platform.

Staff members were required to complete adult safeguarding training on an annual basis. Staff members were able to correctly describe their roles and responsibilities regarding adult safeguarding.

Staff said they felt well supported in their role and were satisfied with the level of communication between staff and management. Staff reported good team work and had no concerns regarding the staffing levels.

Patients spoke positively about the care that they received and confirmed that staff attended to them in a timely manner; patients also said that they would have no issue with raising any concerns to staff. It was observed that staff responded to patients' requests for assistance in a prompt, caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff members were knowledgeable of patients' needs, their daily routine, wishes and preferences. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly. Staff members were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff members were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

Medication was observed on a bedside table of an identified patient on two occasions and was later observed to be removed by a member of staff. Discussions with staff and review of records confirmed the medication had been administered to the patient that morning, although they had not taken it. This was discussed with the manager who gave assurances that medicine administration competencies would be addressed with the identified staff. This information was shared with the aligned pharmacy inspector. An area for improvement was identified.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. Examination of the recording of repositioning evidenced these were well completed.

Management of wound care was examined. Review of one identified patient's care records confirmed that wound care was managed in keeping with best practice guidance. It was noted that the patient's plan of care had not been updated to reflect the recommendations of the Podiatrist. This was discussed with staff who arranged for this to be addressed immediately.

Falls in the home were monitored monthly to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring. There was a system in place to ensure that accidents and incidents were notified to patients' next of kin, their care manager and to RQIA, as required.

Review of the management falls evidenced appropriate actions were taken following the fall in keeping with best practice guidance.

At times, some patients may be required to use equipment that can be considered to be restrictive, for example, bed rails. Review of patients' records and discussion with the manager and staff confirmed that the correct procedures were followed if restrictive equipment was used. It was good to note that, where possible, patients were actively involved in the consultation process associated with the use of restrictive interventions and their informed consent was obtained.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Lunch was a pleasant and unhurried experience for the patients. The food served was attractively presented and smelled appetising and portions were generous. A variety of drinks were served with the meal. Patients may need support with meals ranging from simple encouragement to full assistance from staff. Staff attended to patients' dining needs in a caring and compassionate manner while maintaining written records of what patients had to eat and drink, as necessary. Patients spoke positively in relation to the quality of the meals provided.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake were in place to direct staff. Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of food and fluids.

Examination of menu choice records confirmed conflicting information regarding the consistency levels of food and fluid recommended for at least four patients was recorded when compared to information retained in the patients care files. In addition, menu choice records did not contain patients' full name; this had the potential to cause confusion in relation to the delivery of patient care. Discussion with kitchen staff and review of records evidenced they had access to accurate information for patients who required their diet to be modified. This was discussed with the manager who updated the menu choice records before the end of the inspection. Assurances were provided that a system would be implemented to review these records of a regular basis. Areas for improvement were identified.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans should be developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Review of one identified patient's care records evidenced that care plans had been developed within a timely manner to accurately reflect their assessed needs. However, review of records for a further patient and discussion with staff confirmed that risk assessments and care plans were not consistently reviewed following readmission to the home after a period of time in hospital. This was 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.

Examination of daily evaluations of care confirmed that while some entries were patient centred, there was evidence that some nursing staff were using repetitive statements to evaluate patient care. In addition, care plans did not consistently evidence they were developed in consultation with the patient or their representative. Assurances were provided by the manager that this would be discussed with staff and monitored through their audit systems. This will be reviewed at a future care inspection.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment evidenced the home was warm, clean and comfortable. Ensuite bathrooms were observed to have no pedal bins. This was discussed with the manager who agreed to address this.

Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished and tidy. However, some beds had been 'made up' with stained bed linen. Staff spoken with said there was insufficient bed linen available that morning while other staff said that they were short staffed in one of the units affected.

This was discussed with the manager who confirmed that there was sufficient clean bed linen in the home and arranged for the identified bed linen to be changed immediately. The manager advised that they had placed a number of large orders for bed linen and they were actively monitoring availability of clean linen in the home. An area for improvement was identified.

Shortfalls were identified in regard to the effective management of potential risk to patients' health and wellbeing. Cleaning chemicals on domestic cleaning trolleys were found to be inappropriately supervised on three occasions. This was discussed with identified staff who ensured that the risks were reduced immediately. Assurances were provided by the manager that further action would be taken to reduce risks to residents in the home. An area for improvement was identified.

Fire safety measures were in place to ensure that patients, staff and visitors to the home were safe. Staff members were aware of their training in these areas and how to respond to any concerns or risks. A fire risk assessment had been completed on 13 October 2022. In correspondence received by RQIA following the inspection, the manager confirmed that all actions identified by the fire risk assessor had been addressed with the exception of one. The outstanding action is being addressed by external contractors. This will be reviewed at a future care inspection.

Staff members were aware of the systems and processes that were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. Any outbreak of infection was reported to the Public Health Authority (PHA).

There were laminated posters displayed throughout the home to remind staff of good hand washing procedures and the correct method for applying and removing of personal protective equipment (PPE). There was an adequate supply of PPE and hand sanitisers were always readily available throughout the home.

Discussion with staff confirmed that training on infection prevention and control (IPC) measures and the use of PPE had been provided. Some staff members were observed to carry out hand hygiene at appropriate times and to use PPE correctly; other staff did not. Some staff members were not familiar with the correct procedure for the donning and doffing of PPE, while other staff members were not bare below the elbow. This was discussed with the manager who agreed to address these matters with staff and ensure the nurse in charge monitors compliance on their daily walk about. An area for improvement identified at the previous care inspection has been stated for a second time.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. Patients were observed enjoying listening to music, reading and watching TV, while others enjoyed a visit from relatives. Patient's told us there was a lack of activity provision in the home. One patient said, "There is a girl who does some knitting and painting with us in a group but there is not a lot of activities." Another patient said, "It can be hard to put the day in."

An activity planner displayed in the home highlighted upcoming patient birthdays, with plans in place to do word searches and for a Christmas jumper week. Staff said there were plans in place to celebrate Christmas; with Christmas trees and many decorations displayed throughout the home.

Review of the staff duty rota evidenced that no staff had been allocated as an activity champion in the absence of the activity co-ordinator. Discussion with the manager confirmed recruitment for a new activity co-ordinator was ongoing and assurances were given that they would review the provision of activities in the absence of the activity co-ordinator. Activities should be planned and delivered in each unit to ensure that patients have a meaningful and fulfilled day. An area for improvement to review the provision of activities was identified.

Staff recognised the importance of maintaining good communication with families. Visiting arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

Staff members were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

There has been no change in the management of the home since the last inspection. Mrs Cara Parker has been the Registered Manager in this home since 14 December 2018.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. The manager or delegated staff members completed regular audits to quality assure care delivery and service provision within the home. The quality of the audits was generally good. Shortfalls identified following review of the IPC and complaint audits were discussed with the manager who agreed to review how to improve the governance of these areas. This will be reviewed at a future care inspection.

There was a system in place to manage complaints. Examination of one complaint confirmed that although a complaints log was in place to monitor complaints received, there were no records available detailing the nature of the complaint, actions taken and the complainant's level of satisfaction regarding the outcome of the complaint. This was discussed with the manager who agreed to complete the records retrospectively and review current systems to ensure complaints were recorded correctly and that accurate records are maintained. Given these assurances additional areas for improvement were not identified on this occasion. This will be reviewed at a future care inspection.

Staff commented positively about the manager and described them as supportive, approachable and always available for guidance. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

Review of accidents and incidents records found that these were generally well managed and reported appropriately. However, review of records identified two notifiable events which had not been reported. These were submitted retrospectively.

The home was visited each month by a representative of the registered provider 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 in detail. These are 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 were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	5*	2

*The total number of areas for improvement includes one that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Cara Parker, Registered Manager, 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 (7) **Stated:** Second time **To be completed by:** Immediate action required (11 December 2022)	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the following: • donning and doffing of personal protective equipment • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: Supervision with all staff commenced following the day of inspection, covering the areas for improvement identified: Sequence of donning/doffing PPE, Appropriate use of PPE, Hand hygiene. This supervision topic will also form part of induction process for new staff. The Domestic team supervisions were completed on Tues 12th January 2023. All nursing care and care staff will be completed by the 10th February 2023. There is weekly Home Manager oversight ongoing. Hand washing and PPE compliance audit tool has been reviewed by HM and now includes the compliance of sequence of donning/doffing, PPE and the Moments for handwashing in order to ensure learning is embedded into practice and potential training needs. PPE & hand hygiene audits have been increased to a minimum of twice weekly. Compliance will be monitored through the completion of the monthly Regulation 29 Report

Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate action required (11 December 2022)	The registered person shall ensure that staff adhere to safe practice for the administration of medicines. Ref: 5.2.2
	Response by registered person detailing the actions taken: The incident identified by the Inspector on the day of the inspection is currently under investigation and was discussed with the Intermediate Care Prescribing Pharmacist. RN staff meetings were held on 9th, 20th & 21st January and this area of improvement was discussed. At these meetings RN staff accountability under their NMC Code of Conduct was discussed. 2 RN staff member competencies were repeated following this incident. All RN medication competencies are up to date and in line with matrix. Nursing staff are currently completing all eLearning modules in line with professional accountability. Compliance will be monitored through the completion of the monthly Regulation 29 Audit
Area for improvement 3 **Ref:** Regulation 16 (2) (b) **Stated:** First time **To be completed by:** Immediate action required (11 December 2022)	The registered person shall ensure risk assessments and care plans are reviewed and updated following patients admission to hospital. Ref: 5.2.2
	Response by registered person detailing the actions taken: Staff meetings were held with nursing staff on 9th 20th and 21st January and it was reinforced that all client risk assessments and care plans are updated if on social leave/ admitted to hospital. An admissions TRACA for new admissions and check process are being introduced for clients who have been on social leave or readmitted to unit will be completed by The Clinical Lead in the IC Unit. These admissions TRACA will be attached to the 24-shift report for the Home Manager attention for follow up of any outstanding actions. This will be monitored by the Regulation 29 Report

Area for improvement 4 **Ref:** Regulation 18 (2) (c) (e) **Stated:** First time **To be completed by:** (11 December 2022)	The registered person shall ensure adequate bedding is available at all times suitable to the needs of patients. Arrangements must be in place for the regular laundering of linen. Ref: 5.2.3
	Response by registered person detailing the actions taken: The availability of bedding has been reviewed and some new bedding purchased. Any laundry that is not of an acceptable standard is set aside and reviewed by the Housekeeper and disposed of as appropriate. This review of stock and disposal will inform the Housekeeper and Home Manager if additional orders are required to maintain adequate bedding is available at all times. This will be monitored through the completion of the monthly Regulation 29 Report
Area for improvement 5 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** Immediate action required (11 December 2022)	The registered person shall ensure as far as is reasonably practicable that all parts of the home to which the residents have access are free from hazards to their safety, and unnecessary risks to the health and safety of residents are identified and so far as possible eliminated. This area for improvement is made with specific reference to the safe storage and supervision of cleaning chemicals. Ref: 5.2.3
	Response by registered person detailing the actions taken: Supervisions were completed with the domestic team on 12th January 2023 and included COSHH management and trolley storage. Care Shop COSHH training is scheduled for February 2022. This is also monitored, reviewed and recorded during Home Manager/ senior staff completion of the Home Manager Daily Walkabout Audit. This will be monitored through the completion of the monthly Regulation 29 Report

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 12 **Stated:** First time **To be completed by:** Immediate action required (11 December 2022)	The registered person shall ensure that accurate and contemporaneous menu choice records for patients on modified diets are maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: The menu choice sheet identified at inspection was updated with Residents full name and IDDSI requirements on the day of the inspection. A master copy is now held and shared with the Chef Manager and will be reviewed after any changes occur. Supervisions were completed with Cook/ Cook Manager on 9th January 2023 to ensure understanding and compliance with IDDSI requirements. The Cook Manager is to ensure menu choice forms are amended once clients' needs change or following admission/discharge. Regular reviews of menu choice records are taking place by Home Manager as part of monthly Dining Experience auditing process and the completion of the Daily walkabout 3 times per week. The Cook Manager will undertake 10% of current occupancy weekly satisfaction surveys in each unit to capture client feedback and feedback will be discussed at Cook Manager and Home meetings on a monthly basis. This will be monitored through the completion of the monthly Regulation 29 Report

Area for improvement 2 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 11 January 2023	The registered person shall ensure that a structured programme of varied activities is provided for patients. Arrangements should be made for the provision of activities in the absence of the activity co-ordinator. Ref: 5.2.4
	Response by registered person detailing the actions taken: This post has been vacant for 8 months. Recruitment is ongoing to fill vacant hours. Whilst continuing with the recruitment process, we will be piloting the Oomph on Demand Service which will be accessible to all residents, relatives and grades of staff within the home. This virtual system of interactive activities, physical activities, reminiscence, lifestyle and music can be tailored to individual profiles for residents' choice of activities and is available over 24-hour period/ 7 days a week and works on any smart devices belonging to Lansdowne Care Home or individual smart devices. This launches on 14th February 2023. Beaumont will be extending an invitation to the external stakeholders the opportunity to view the platform functionality, resident and staff experience and the management reporting functions in March 2023. We will seek to redeploy care staff on a temporary basis to support the implementation of this platform and work with the current activity led to devise a plan suitable for each unit within Lansdowne any back fil of hours will be managed through Care assistant Agency. This will be monitored through the completion of the monthly Regulation 29 Report

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The Regulation and Quality Improvement Authority

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