Unannounced Primary Care Inspection

Name of establishment:	**Lisadian House**
RQIA number:	**1264**
Date of inspection:	**16 October 2014**
Inspector's name:	**Karen Scarlett and Lorraine Wilson**
Inspection number:	**17068**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Lisadian House
Address:	87 Moira Road Hillsborough BT26 6DY
Telephone number:	028 92689898
Email address:	lisadianhouse@btconnect.com
Registered organisation/ Registered provider / Responsible individual	Elim Trust Corporation Pastor Edwin Michael
Registered manager:	Mrs Sharon Meenagh
Person in charge of the home at the time of inspection:	Mrs Sharon Meenagh
Categories of care:	NH-I ,NH-PH ,NH-PH(E) ,NH-TI
Number of registered places:	45
Number of patients / residents (delete as required) accommodated on day of inspection:	44
Scale of charges (per week):	£593.00
Date and type of previous inspection:	14 November 2013, primary unannounced inspections
Date and time of inspection:	16 October 2014 09.50 – 18.25
Name of inspector:	Karen Scarlett and Lorraine Wilson

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year is required.

This is a report of an unannounced primary care inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008).

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for the preliminary assessment of achievement by the Provider of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self- declaration), pre-inspection analysis and inspection visit by the inspector.

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

- review of notifiable events submitted to RQIA, in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005, since the previous inspection

- analysis of pre-inspection information submitted by the registered person. All submissions were received except one regarding care reviews (see Section 8)
- discussion with the registered manager.
- review of the returned quality improvement plan (QIP) from the previous care inspection conducted on 14 November 2013.
- observation of care delivery and care practices
- discussion with staff on duty
- examination of records pertaining to the inspection focus
- consultation with patients individually and with others in groups
- care audits conducted by the registered manager
- monthly quality reports
- staff training records
- staff duty rotas
- tour of the premises
- evaluation and feedback.

5.0 Consultation process

During the course of the inspection, the inspectors spoke with:

Patients	8 and others in groups
Staff	9
Relatives	3
Visiting professionals	0

Questionnaires were provided by the inspectors during the inspection, to patients, their representatives and staff to seek their views regarding the quality of the service.

Issued to	Number issued	Number returned
Patients	3	3
Relatives / representatives	3	2
Staff	8	6

6.0 Inspection focus

The theme for the inspection year April 2014 – March 2015 is: 'Nursing Care'

Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regular reviewed. (Standard 5)

Under the 'Nursing Care' theme, inspection will focus on three areas of practice:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

Only selected criteria from each of the four standards will be inspected across nine areas and incorporated into the Provider's Self-Assessment.

The inspectors will also consider the management of patient's human rights during this inspection.

The inspection theme and focus for the 2014 – 2015 inspection year was outlined by RQIA at the annual Provider Roadshow in February 2014 and the self-assessment was made available on the RQIA website.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of service

Lisadian House is a purpose built facility situated in a rural setting overlooking the Lagan Valley, some two miles from Hillsborough and adjacent to Hillsborough Elim Pentecostal Church. The nursing home is owned and operated by the Elim Trust Corporation. The registered manager at the time of inspection was Mrs Sharon Meenagh but since the inspection this manager has resigned and an acting manager, Mr Daniel Cerezo is now in post, supported by the general manager for the home, Elaine Hill.

The home has 45 single bedrooms, 18 on the ground floor and 27 on the first floor. There are communal sitting rooms throughout the ground floor as well as a dining room. A quiet room is available of the first floor. There is a large conservatory overlooking the garden and countryside. A hairdressing room is also available for patients. Access to the first floor is via a passenger list and stairs. The home also provides for catering and laundry services on the ground floor.

The home is registered to provide care for a maximum of 45 persons under the following categories:

Nursing Care

NH - I	Old age not falling into any other category
NH - PH	Physical disability other than sensory impairment - under 65 years
NH - PH (E)	Physical disability other than sensory impairment – over 65 years
NH - TI	Terminal illness

The home does not provide day care facilities.

The certificate of registration was appropriately displayed in the entrance foyer of the home.

8.0 Executive summary

The unannounced inspection of Lisadian House was undertaken by Mrs Karen Scarlett and Mrs Lorraine Wilson (Nursing Inspectors) on 16 October 2014 between 09:50 and 18:25. The inspection was facilitated by the registered manager, who was present throughout the inspection and was available for verbal feedback at the conclusion of the inspection.

The theme for the 2014 – 15 inspection year is 'Nursing Care' (Standard 5) and the inspection focused on three areas of practice related to:

- management of wounds and pressure ulcers (Standard 11)
- management of nutritional needs of patients and weight loss (Standard 8 & 12)
- management of dehydration (Standard 12).

The inspectors also considered the management of patient's human rights during this inspection. The requirement and recommendations made as a result of the previous inspection were also examined.

Prior to the inspection, the registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 18 July 2014. The comments provided by the registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

Required pre-inspection documentation was returned to the RQIA on the 18 July 2014 excepting the list of care reviews undertaken but evidence of the review plan was seen on the day of inspection. The Quality Improvement Plan (QIP) was returned from the previous care inspection undertaken on the 14 November 2013. The progress made in addressing the two requirements and three recommendations was examined. On the day of inspection the inspectors were unable to evidence compliance with the two requirements and these have been re-stated for a second time. Findings indicated that the home was compliant with all three recommendations. Details of the action taken can be viewed in section 9.0.

RQIA had received a number of notifiable events; however, in the sample of accident/incident records reviewed four notifiable events had not been submitted to RQIA. The importance of submitting notifications to RQIA was discussed with the registered manager on the day of inspection and a requirement has been made in this regard.

The inspectors met with the majority of patients during the inspection and spoke with eight patients individually and with others in groups. Three patients also completed questionnaires assisted by one of the inspectors. The comments from patients were largely positive regarding their care and their interactions with staff. See section 11.7.2 for more information.

The patients presented as clean, well groomed and looked well cared for. There were no concerns raised to the inspectors by patients or by three relatives consulted. The inspectors can confirm that the delivery of care to patients was evidenced to be of a satisfactory standard and patients were observed to be treated by staff with dignity and respect.

The inspectors spoke to the majority of staff on the day of inspection and interviewed five members of staff individually. Six members of staff also completed questionnaires. Some concerns were raised by staff and these were discussed with the registered manager on the day of inspection. Refer to section 11.7.1 for more information.

An examination of the duty rota evidenced that staffing was in line with the RQIA staffing guidelines for nursing homes. However, concerns were raised by some staff regarding staffing levels and the inspectors observed that at least five patients were being nursed in bed. The inspectors, therefore, requested an updated list of the dependency levels of the patients within the home which was submitted post inspection. The staffing levels were found to be in line with RQIA guidelines. See section 11.7.1 for more information.

An examination of staff training records could not evidence that staff had up to date mandatory training and a training matrix was requested to be submitted within two weeks following the inspection. A recommendation has been made. There was insufficient evidence that an appropriate induction had been completed for a newly appointed staff nurse. A recommendation has been made. There was also insufficient evidence of competency and capability assessments being completed for registered nurses. A requirement has been made.

There were a number of issues identified with record keeping and two previous requirements in this regard have been restated. In addition a further two requirements and two recommendations have been made. See section 11.8 for more information.

The home was mainly well decorated and maintained on the day of inspection. However, there were a number of issues identified with the environment of the home which are detailed in section 11.9 of the report. These issues were fed back to the registered manager at the conclusion of the inspection. An environmental audit is to be conducted by the registered manager and an action plan submitted as to how the issues identified are to be addressed. A requirement has been made.

As a result of this inspection, five requirements and nine recommendations were made; two requirements were also restated for a second time.

Details can be found in section 10.0 in the report and in the quality improvement plan (QIP).

The inspectors would like to thank the patients, registered manager, registered nurses and staff for their assistance and co-operation throughout the inspection process.

The inspectors would also like to thank the patients, relatives and staff who completed questionnaires.

Post inspection

Following the inspection a number of submissions were required of the registered manager including:

- Updated patient dependency levels are to be forwarded to RQIA within one week post-inspection and this was received 29 October 2014.
- A training matrix detailing staff attendance at training is to be forwarded within two weeks post-inspection which has yet to be submitted and a recommendation has been made.
- Confirmation of completed inductions and competency and capability assessments are to be forwarded to the RQIA within two weeks post-inspection. These have yet to be submitted and one recommendation and one requirement have been made.
- Assurance that care records have been audited prior to transfer to the electronic system and shortfalls addressed within four weeks post inspection – please see QIP for more information
- An environmental audit is to be carried out and an action plan submitted as to how the issues identified will be addressed
- A policy on record keeping is to be developed and submitted to RQIA within six weeks post inspection

These submissions will help to inform the inspector regarding any actions required by RQIA in the QIP.

The inspector was contacted on the 4 November 2014 by the General Manager for the home, Ms Elaine Hill, to inform us that the registered manager had resigned. Interim management arrangements have been put in place and discussed with the RQIA. On the 5 November 2014 the inspector telephoned Elaine Hill to relay the feedback from the inspection. Elaine agreed to ensure that the requested information is forwarded to the RQIA within the timescales agreed.

9.0 Follow-up on the requirements and recommendations issued as a result of the previous primary unannounced care inspection conducted on 14 November 2013

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1.	14 (2) (c)	It is required that at the time of each patient's admission to the home, the following minimum information should be completed on the day of admission to the home. • a validated nursing assessment such as Roper, Logan and Tierney • a validated bedrail assessment • a validated pressure risk assessment such as Braden • a validated nutritional risk assessment such as MUST • a validated falls risk assessment • a validated safe moving and handling assessment. **Ref Criterion 5.1**	In one of the care records examined assessments had not been completed on admission in regards to: • manual handling • falls • pain • incontinence In another of the care records examined the pain assessment was incomplete. Risk assessments were not being reviewed on a monthly basis. **This requirement has been restated for a second time.**	Substantially compliant

2.	16 (2) (b)	It is required that care plans are kept up to date and reflect the patient's current assessment of need and the action taken to meet that need. • registered nurses must ensure there is evidence of risk assessment and individual assessment of need to show the decision making process when applying any form of restrictive practice • Risk assessments must be undertaken prior to the use of bedrails. • Bedrail risk assessments must be reviewed monthly or more often as deemed appropriate as per the home's policy. **Ref Criterion 10.7**	There was evidence that individual risk assessments were being carried out. However, the current records used do not allow staff to sufficiently demonstrate the decision making process involved. The current restraint documentation is not reflective of the human rights legislation or Deprivation of Liberty guidelines and will be required to be updated to reflect these. **This requirement has been restated for a second time.**	Substantially compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1.	25.2	It is recommended that a policy/procedure is developed which outlines the purpose, content and process of the Regulation 29 visit, the policy should be reflective of the statutory requirements. **Ref Theme 1 Section A**	There was procedure in place to address the purpose, content and process of Regulation 29 visits. This recommendation has been addressed.	Compliant
2.	11.7	It is recommended that a wound care link nurse is identified to ensure that wound management is consistent and in keeping with best practice. **Ref Criterion 5.3**	A wound care link nurse had been identified. This recommendation has been addressed.	Compliant
3.	27.5	It is recommended that in the interest of patient dignity the term 'cot side' is not used in patient records. **Ref Criterion 10.7**	The term "cot side" was not found in the records examined. This recommendation has been addressed.	Compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. Refer to section 11.4 for detail.

There had been no safeguarding issues reported to RQIA by the host trust, and no whistleblowing information had been received since the previous care inspection undertaken on 24 October 2014. On the day of the inspection the registered manager did make the inspectors aware of one ongoing safeguarding issue being managed by the SEHSCT under the regional adult protection procedures. The home's regional manager also updated the inspector on the progress of this in a telephone conversation on 4 November 2014.

RQIA is satisfied that the registered manager has dealt with SOVA issues in the appropriate manner and in accordance with regional guidelines and legislative requirements and this continues to be managed appropriately by the general manager.

10.0 Inspection findings

Section A – On admission a registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Standard criterion 5.1, 5.2, 8.1 and 11.1 examined.
Policies and procedures relating to patients' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions. Review of these policies and procedures evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. A review of three patients' care records evidenced that most of the patients' individual needs were established on the day of admission to the nursing home, through pre-admission assessments and information received from the care management team for the relevant Trust. Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), infection control and falls were also completed on admission. However, in one care record a number of risk assessments had not been completed including manual handling, falls and pain. In another record the pain assessment was incomplete. A requirement made in this regard at the previous inspection has been stated for a second time. There was also evidence to demonstrate that effective procedures were in place to manage any identified risks in two of the three records reviewed. However, in one of the records inspected there was no care plan to manage pressure ulcer risk which had been identified in the risk assessment. A requirement has been made in this regard. Review of three patients' care records evidenced that in the main, a comprehensive holistic assessment of the patients' care needs was completed within 11 days of the patient's admission to the home. In discussion with the registered manager, she demonstrated a good awareness of the patient who required wound management intervention and the number and progress of patients who were assessed as being at risk of weight loss and dehydration.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Substantially compliant**

Section B –A registered nurses assesses and plans care in relation to all care needs and in particular nutrition and pressure ulcer risk. Care records evidence involvement of the patient and /or their representative and that care planning and delivery reflect the recommendation from relevant health professionals. Referrals to healthcare professionals are made as required and in a timely manner. Standard criterion 5.3, 11.2, 11.3, 11.8 and 8.3 examined.
A named nurse and key worker system was operational in the home. The roles and responsibilities of named nurses and key workers were outlined in the statement of purpose. The named nurse's picture was posted on a notice board in each patient's bedroom. Review of three patient's care records and discussion with patients evidenced that either they or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care. There were no patients in the home with wounds or pressure ulcers on the day of inspection. It could be evidenced from discussion with the registered manager, staff and the quality reports that patients' wounds were being correctly treated and healed. In response to a recommendation made at the previous inspection in November 2013, a wound care link nurse had been appointed and the home was compliant with this recommendation. The registered manager was also involved in a forum chaired by the Trust TVN for care home managers. The registered manager and registered nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses (TVN) in the local healthcare Trust. Staff spoken with, were knowledgeable regarding the referral process. Referral arrangements were also in place to obtain advice and support from relevant health care professionals including, dietician, podiatry and speech and language therpist (SALT). In one record reviewed a completed Braden risk assessment identified the patient as medium risk of developing a pressure ulcer but no care plan was in place. A requirement has been made. A daily repositioning and skin inspection chart was reviewed by the inspectors and there was evidence of two hourly repositioning and regular skin checks for this patient. The registered manager and registered nurses confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare Trust. Staff spoken with were knowledgeable regarding the referral process. Daily records were maintained regarding the patient's daily food and fluid intake. All nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment. Overall care records were well presented and showed evidence of input from specialist staff such as physiotherapy, Occupational Therapist (OT), Speech and Language Therapist (SALT) and dietician.

Discussion with the registered manager, one registered nurse, care staff and review of the staff training records, revealed that staff had not received recent training in wound management, pressure area care and prevention or management of nutrition. The staff training records were insufficiently organised to enable the inspectors to ascertain what training had taken place this year. The registered manager is to submit a training matrix post inspection. A recommendation has been made concerning staff training.

In two of the records reviewed patients' moving and handling needs were assessed and addressed in their care plans. However, in one record reviewed there was no manual handling assessment completed. As a result a requirement has been made regarding patient care records.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Substantially compliant**

Section C - Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans. Standard criteria 5.4 examined.
Review of three patients' care records evidenced that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound care for each patient. Care plans including supplementary risk assessments were inconsistently reviewed and it could not be evidenced that these were updated on at least a monthly basis or more often if required. A requirement has been made in this regard. Monthly audits were being conducted including an audit of the care records. There was also evidence to confirm that some action had been taken to address any deficits or areas for improvement identified through the audit process. However the latest monthly audit had not been conducted. The registered manager told the inspectors that the home was to move to electronic care records in the near future. A recommendation is made that all nursing care records are reviewed and any shortfalls actioned within 4 weeks, prior to the move to the electronic system to ensure a smooth transition. This was subsequently discussed with the general manager post inspection and an assurance given that care records would be reviewed by the named nurse and that an audit was no longer required to be submitted.

Provider's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Substantially compliant**

Section D – All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations. Standard criterion 5.5, 8.4 and 11.4 examined.

The inspectors examined three patients' care records which evidenced the completion of validated assessment tools such as:

- The Roper, Logan and Tierney assessment of activities of daily living
- Braden pressure risk assessment tool
- Nutritional risk assessment such as Malnutrition Universal Screening Tool (MUST)

The inspectors confirmed the following research and guidance documents were available in the home:

- DHSSPS 'Promoting Good Nutrition' A Strategy for good nutritional care in adults in all care settings in Northern Ireland 2011-16
- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.
- A resource file from the Trust referencing The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care and The European Pressure Ulcer Advisory Panel (EPUAP)
- RCN/NMC guidance for practitioners.

Discussion with registered nursing staff found them to be knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care.

The care staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs including aids and equipment recommended to be used was held in the dining room for easy access by staff. This is commendable practice.

Review of the care records evidenced that there was discussion with the patient and family regarding restraint but that this document did not include the relevant references to Human rights legislation and Deprivation of Liberty guidance nor was it suitable to evidence the decision making process including the exploration of less restrictive options. A requirement made at the previous inspection will be restated for the second time. There was also no evidence that staff had received training in human rights and a recommendation has been made.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	Compliant
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	Substantially compliant

Section E – Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients. Standard criterion 5.6, 12.11 and 12.12 examined.

A policy and procedure relating to nursing records management was not available in the home. A recommendation has been made and the registered provider should ensure that this policy is reflective of the Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Homes Minimum Standards (2008) and NMC professional guidance. This is to be submitted to RQIA within 6 weeks post inspection. A recommendation has also been made that all new policies and procedures are to be signed and validated by the registered person.

A review of the training records could not confirm that registered nursing staff had received training on the importance of record keeping commensurate with their roles and responsibilities in the home as a result a recommendation has been made.

Review of three patients' care records revealed that entries in the notes were not consistently signed and accompanied by the designation of the signatory and a recommendation is made that this shortfall be addressed.

The inspectors reviewed a record of the three week menu plan of meals provided for patients. Records were maintained in sufficient detail to enable the inspector to judge that the diet for each patient was satisfactory. Food diaries were reviewed in the dining room which kept detailed records of each patient's dietary intake including type of food and drink and the portion consumed. It was noted that at the lunch time service soup was served followed by a hot meal and desert. There was no other choice of hot meal offered on the menu. However, in discussion with the registered manager assurances were given that an alternative hot meal would be provided on an individual basis if required.

The inspector reviewed the care records of three patients identified of being at risk of inadequate or excessive food and fluid intake. This review confirmed that:

- daily records of food and fluid intake were being maintained
- the nurse in charge had discussed with the patient/representative their dietary needs
- where necessary a referral had been made to the relevant specialist healthcare professional
- a record was made of any discussion and action taken by the registered nurse
- care plans had been devised to manage the patient's nutritional needs and were reviewed on a monthly or more often basis.

There was evidence that the patients were offered fluids on a regular basis throughout the day.

The fluid intake records for the identified patients evidenced:

- the total fluid intake for the patient over 24 hours
- an effective reconciliation of the total fluid intake against the fluid target established
- action to be taken if targets were not being achieved

However a recommendation was made that a record of reconciliation of fluid intake is included in the daily progress notes.

Staff spoken with were evidenced to be knowledgeable regarding patients' nutritional needs.

From the information provided by care assistants via questionnaires or in discussion with the inspectors all stated that they had received some form of training in the management of nutrition and dysphagia. From an examination of the training records this could not be evidenced. A recommendation was made that all staff should have training on the management of nutrition and also dysphagia.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Substantially compliant**

Section F – The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives. Standard criteria 5.7 examined.
Examination of three care records identified that the falls risk assessment was not fit for purpose and did not indicate the patient's level of risk. A previous requirement regarding the completion of a validated falls assessment is therefore, restated for the second time. Examination of the incident and accidents in the home identified one current patient and one previous patient, both of whom had experienced multiple falls in the home. It is recommended that a falls audit be conducted on at least a monthly basis to identify risks and how these can be optimally managed.

Provider's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criteria assessed	**Substantially compliant**

Section G – The management and involvement of patients and/or their representatives in review of care. Standard criterion 5.8 and 5.9 examined.
Prior to the inspection, a patients' care review questionnaire was forwarded to the home for completion by staff. This information as to how many patients had been subject to a care review by the care management team of the referring HSC Trust between 1 April 2013 and 31 March 2014 was not provided. However, the registered manager informed the inspector that patients' care reviews were held post admission and annually thereafter. The inspectors could verify that the manager updated the care reviews due each month and contacted the relevant care manager for the Trust. The manager did state that she often had difficulties contacting the Trust care managers and that it was challenging to arrange timely reviews. Care reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff preferably the patient's named nurse attends each care review. A copy of the minutes of the most recent care review was held in the patient's care record file.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

Section H – Management of nutrition including menu choice for all patients. Standard criterion 12.1 and 12.3 examined.
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. A record of the three week menu plan of meals provided for patients was examined. Records were maintained in sufficient detail to enable the inspectors to judge that the diet for each patient was satisfactory. Food diaries were reviewed in the dining room which kept detailed records of each patient's dietary intake including type of food and drink and the portion consumed. It was also noted that the menu board in the dining room had not been updated and read September instead of October. This was highlighted to the registered manager. The inspector discussed the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients with the registered manager and a number of staff. Staff spoken with were knowledgeable regarding the individual dietary needs of patients and to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals. Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals, e.g. speech and language therapist or dieticians.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	Compliant
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**

Section I – Knowledge and skills of staff employed by the nursing home in relation to the management of nutrition, weight loss, dehydration, pressure area care and wounds. Standard criterion 8.6, 11.7, 12.5 and 12.10 examined.

On discussion with the registered manager it was determined that a number of patients had swallowing difficulties.

Review of training records could not evidence that sufficient numbers of staff had attended recent training in dysphagia awareness and as a result a recommendation has been made. First aid training was ongoing for staff.

Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes. However, it was noted that some residents were just finishing their breakfast at 11:30 at which point mid-morning tea was being served and lunch was being served at 12:45. On discussion with the registered manager she explained that some residents prefer to rise later in the morning and would be able to defer their main meal until the evening meal if required.

The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times. A choice of fluids including fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. The staff consulted could identify patients who required support with eating and drinking. Information in regard to each patient's nutritional needs was held in the dining room for easy access by staff. This is commendable practice. A tissue viability link nurses was employed in the home.

On the day of the inspection, the inspector observed the lunch service. Overall the dining room experience for patients during the serving of the lunch time meal was very positive. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Staff were observed preparing the patients for their meal in caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meals and patients were offered a choice of fluids. Staff were observed assisting patients and interacting with them as they provided assistance. One staff member was respectful and apologised to a patient as she left the patient for a few minutes to assist a patient to be seated at the table.

The tables were well presented with condiments appropriate for the meal served. It is noteworthy that two care assistants were available in the mornings exclusively to assist patients with their meals. This is to be commended. For further information on the observation see section 11.3.

Provider's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard criterion assessed	**Substantially compliant**

11.0 Additional areas examined

11.1 Records required to be held in the nursing home

Prior to the inspection a check list of records required to be held in the home under Regulation 19(2) Schedule 4 of The Nursing Homes Regulations (Northern Ireland) 2005 was forwarded to the home for completion. The evidence provided in the returned questionnaire; and review of a selected sample of documents by the inspector confirmed that the required records were maintained in the home and were available for inspection.

11.2 Patients/residents under Guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection.

There were no patients accommodated at the time of inspection in the home who were subject to guardianship arrangements.

11.3 Quality of Interaction Schedule (QUIS)

The inspector undertook a period of enhanced observation in the home which lasted for thirty three minutes and took place in the dining room during lunch service.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area. A description of the coding categories of the Quality of Interaction Tool is appended to this report.

Total number of observations	
Positive interactions	8
Basic care interactions	4
Neutral interactions	3
Negative interactions	1

The inspector evidenced that the quality of interactions between staff and patients was in the main very positive.

One negative interaction was observed. This referred to a member of staff who used an inappropriate term of endearment which could be construed as demeaning to the patient. The inspectors observed three occasions when the staff member placed a meal in front of the patient without interacting with them. However, the majority of staff were observed to be very positive in their interaction with the patients.

Any issues observed were brought to the attention of the registered manager in charge during the inspection and any staff training needs identified are to be addressed by the manager.

11.4 Complaints

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were being pro-actively managed.

The management of complaints was discussed with the registered manager and the complaint record reviewed. This evidenced that complaints were managed in a timely manner and in accordance with legislative requirements.

11.5 Patient finance questionnaire

Prior to the inspection a patient financial questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.6 NMC declaration

Prior to the inspection the registered manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the registered manager, were appropriately registered with the NMC. A system is in place within the home to ensure monthly checks that NMC and NISCC registration is current.

11.7 Questionnaire findings

11.7.1 Staffing levels and staff comments

Discussion with the registered manager and review of the nursing and care staff duty roster from week commencing 6 October 2014 to week commencing 20 October 2014 evidenced that the registered nursing and care staffing levels were in line with the RQIA's recommended minimum staffing guidelines for the number of patients accommodated in the home during the inspection.

During the inspection the inspector spoke with the majority of staff including care assistants and registered nurses. Four staff were interviewed individually and six returned questionnaires. Overall, staff made positive comments about working in the home citing great team work, the excellent standard of care provided, the range of activities provided, the quality of the food and the homely environment. Some concerns raised by staff included the pressure of work on staff particularly in the mornings. Given the concerns raised by staff and the observations of the inspectors that at least five patients were being nursed in bed, the inspectors requested an updated list of the dependency levels of the patients within the home to be submitted post inspection. This was in order to determine that the staffing is reflective of the dependency levels of the patients in the home. This was submitted post inspection and staffing levels were found to be within the RQIA's guidance on the recommended minimum staffing levels for the dependency of the patients in the home.

The registered manager informed the inspectors that the home did not have any staff vacancies.

A sample of induction templates for a registered nurse and a care assistant were provided. However, following discussion with staff and a review of the personnel record of one recently employed staff nurse the inspectors were unable to evidence that an appropriate induction had taken place. A recommendation has been made. There was also insufficient evidence that competency and capability assessments for registered nurses who may take charge of the home had been completed. The inductions and competency assessments are to be completed and are to be forwarded to the RQIA two weeks post-inspection. These have yet to be received and a requirement has been made.

Some other concerns raised by staff included the lack of staff meetings, insufficient time to talk with patients and relatives and the public displaying of duty rotas on a noticeboard. These concerns were discussed with the registered manager for her consideration and discussion with the care team.

The staff training file and training information on the notice board in the office was examined. The training records were not presented in a sufficiently organised way to enable the inspectors to determine if mandatory training for staff was up to date, including but not limited to, fire training, manual handling, first aid, infection control and safeguarding training. The registered manager is required to submit a training matrix two weeks post inspection to evidence this. This has yet to be submitted and a recommendation has been made.

11.7.2 Patients/residents and relatives comments

During the inspection the inspector spoke with eight patients individually and with others in smaller groups.

Patient spoken with and the questionnaire responses confirmed that patients were treated with dignity and respect, that staff were polite and respectful, that they could call for help if required, that needs were met in a timely manner, that the food was good and plentiful and that they were happy living in the home.

Three patients completed questionnaires with one inspector as interviewer. Comments from other patient included “I am well looked after”; “the nurses are very good”. One respondent stated that staff “don’t always come right away”. This was relayed to the registered manager.

Three ladies were observed enjoying having their hair done in the hairdressing room.

The inspector spoke with three relatives during the inspection and two of these completed questionnaires at the end of the inspection. Relatives’ responses were overwhelmingly positive in regards to the care and the home manager.

11.7.2 Professionals’ comments

No professionals visited the home during the inspection.

11.8 Record keeping

In accordance with Regulation 19 (2) Schedule 4, a number of records are required to be kept in a nursing home. Prior to this inspection the registered person/s completed and returned a declaration to confirm that these documents were available in the home. If the document was not available an explanation was required. The returned declaration for Schedule 4 documents confirmed that all documents listed were available in the home. The inspector sampled a number of documents as listed in section 4.0 of this report.

Review of three patient care records evidenced that generally a good standard of record keeping was maintained. However, a number of areas for improvement were identified as follows:

- staff making entries in the notes should consistently sign and print their name and include their designation and the date and time of the entry
- fluid intake and output totals should be reconciled to the progress notes daily
- Risk assessments and care plans must be updated at least monthly or in response to any changes in the care to be provided
- Care plans must be implemented if a risk is identified from the risk assessments
- A validated falls risk assessment should be put in place
- The decision making process when applying any restrictive practice must be clearly documented

Two previous requirements in this regard to record keeping have been restated. In addition a further two requirements and two recommendation have been made.

Review of the accident and incident file evidenced that four incidents had not been reported to RQIA. A requirement has, therefore, been made. Review of the file also highlighted one current resident who has had six recorded falls in two months and one previous resident who also had multiple falls during his stay in the home. A recommendation has been made that falls auditing is carried out at least monthly and any concerns identified are actioned.

See quality improvement plan (QIP).

11.9 Environment of the Home

The inspectors conducted a tour of the home. The home was mainly well decorated and maintained on the day of inspection. However, there were a number of issues identified with the environment of the home.

Some of these issues were required to be addressed on the day of inspection including:

- Cleaning or replacement of a specified face mask in one patient's bedroom
- Disposal of a single use catheter bag left on a stand in one patient's bedroom
- Immediate removal of a broken bedside lamp in one patient's bedroom which was posing a health and safety risk.

Other identified issues will need attention in the coming weeks and a requirement will be made. These issues include:

- All light pull cords must have full length wipeable covers to enable effective cleaning
- Shelf edging in the laundry and upstairs sluice room require repair or replacement
- Cleaning of pipework and filters in the laundry room
- Malodour of all internal sluice rooms was noted and a review of the extractor fans is required to ensure the odour is sufficiently controlled
- Wall tiling in the Hallway 2 sluice requires repair or replacement and a drip tray is required for the bed pan rack to prevent cross contamination
- Ground floor sluice wall and floor damage requires repair or replacement
- The flooring in the upstairs sluice requires repair or replacement
- Rusted bin holders need to be replaced to enable effective cleaning
- In the ground floor bathroom wall tiling must be repaired or replaced, the radiator cleaned and repainted and the rusted laundry hamper replaced
- Repair of chipped furniture in patient's bedrooms
- That the stained carpet in one patient's bedroom is cleaned or replaced

Although monthly audits are carried out by the registered manager to include the environment, issues have not been identified. Following the inspection the registered manager is to conduct a full environmental audit and submit an action plan to the RQIA within a defined timescale to detail how these and any other identified issues are to be addressed.

On discussion with domestic staff it came to the attention of the inspector that proper decontamination processes for the cleaning of mop heads was not in place. A requirement has been made that a process for effective decontamination of mop heads is implemented to contribute to effective infection control.

Areas were observed to be cluttered with equipment including the reception area, outside the dining room and in other recesses. There is evidently a lack of sufficient storage for commodes, hoists, bedside tables and walking aids, with these being stored in the downstairs shower room and bathroom. In addition, the upstairs bathroom opposite room thirty-seven is not being used as a bathroom but as a storage area. Consideration needs to be given to identifying sufficient storage space for equipment and a recommendation has been made.

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Sharon Meenagh, registered manager at the time of the inspection and subsequently with Elaine Hill, general manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider is required to record comments on the quality improvement plan.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

Karen Scarlett
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.1 Before a patient is admitted to Lisadian, a pre-admission assessment is carried out by the Nurse Manager or Charge Nurse. A full assessment of the patient will also be received from the Social Worker/Care Manager detailing all information from professionals involved with the patient. From this information and in consultation with the patient and/or representative it is decided if Lisadian can offer the patient the correct care. On admission a care plan is then drawn up by the Named Nurse in consultation with the patient and/or representative using Roper, Logan and Tierney Model, Braden Tool, MUST Tool, Falls Assessment, Infection Control Assessment, Manual Handling Assessment,	Compliant

Pain Assessment, Body Map and Wound Management. 5.2 On admission to Lisadian, a comprehensive, holistic assessment of the Patients Care needs is drawn up by the Named Nurse in consultation with the patient and/or representative using validated assessment tools such as Braden (pressure ulcers) Abbey (pain) MUST (nutrition) Fall Risk Assessment, Body Map and Wound Assessment, Bed Rail Assessment, Manual Handling Assessment, Continence Assessment, Infection Assessment and any other assessment required. 8.1 Each resident is assessed on admission using "MUST". This will be completed within the standard eleven days that are given for compilation of Care Plans. When carrying out a Pre-Admission Assessment the Nurse Manager or Charge Nurse will highlight those residents who have been scored as being at risk by the multidisciplinary team assessments from the Dietitian and Speech and Language will be available. The staff in the kitchen will receive information of each new resident's special requirements and food preferences. 11.1 A pressure ulcer risk assessment (Braden Score) MUST, pain and continence assessments are some of the assessmens included in the preadmission assessment carried out prior to admission, along with all information received from professionals involved with the patient. All this information is used to decide the patients needs e.g. pressure relieving mattress, prior to admission. Within 6 hours of admission - Braden Pain Assessment and Body Map are completed in case of any change in the patient. Other assessments are completed within 11 days of admission.	

<table>
<tr><th colspan="2">Section B</th></tr>
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<tr><td>Criterion 5.3
• A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.
Criterion 11.2
• There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.
Criterion 11.3
• Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.
Criterion 11.8
• There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.
Criterion 8.3
• There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.

Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.3
All patients are delegated and introduced to the Named Nurse as soon as possible after admission. Photos of their Named Nurse, Associate Nurse and Care Assistants involved in their care are on the Notice Board in their room. All</td><td>Compliant</td></tr>
</table>

information obtained from preadmission assessment, Care Manager and other professionals involved with the patient are correlated to assist the Named Nurse in consultation with the patient and/or representative to draw up a holistic plan of care which encourages maximum independence and rehabilitation of the patient. 11.2 In Lisadian House, there are policies and procedures in place to ensure patients are referred quickly and efficiently to any relevant professional perceived to promote better patient care for example Tissue Viability Nurse, Dietition, Chiropodist, Physio, SALT, OT, Respiratory Nurse. 11.3 When a patient has been assessed as being "At Risk" of developing pressure ulcers using the validated tools such as Braden, MUST, Pain Assessment, Continence Assessment and visual judgment of Registered Nurses and carers, immediately a pressure ulcer prevention and treatment plan of care will be drawn up taking into account the individual's needs and comfort with advise from professionals such as Tissue Viability Nurse. 11.8 Registered Nurses in the home have attended up to date wound and dressing care and if a patient has any lower limb or foot ulceration a referral is made by the nurse in charge for a visit from the Tissue Viability Nurse or in the case of the foot the podiatrist to diagnose and prescribe the most suitable care. Other relevant health professionals may include Dietition, Palliative Care Team, Diabetes Specialist Nurse, Dermatology and G.P. Northern Ireland Wound Care Formulary 2011 provides evidence-based guidance on all wound management programmes. NICE Guidelines give important recommendations abount wound care and are taken into account when the registered nurses are choosing wound dressings. All information is discussed with the patient and/or representatives, documented in the patient's care plan and an accurate wound care chart is essential. A wound evaluation is updated at each prescribed dressing change and the relevant health professiona notified of any further problems. 8.3 Referrals to the Community Dietitian and Speech and Language Therapist are made through the Resident's G.P. After the initial referral, the Registered Nurse may contact the Dietitian/SALT at any time for further advice e.g. by phone or by requesting a visit#The dietitian and SALT document their visit and advice given in the Resident's Case Records. They may also forward a formal account of advice.	

The Registered Nurse incorporates the information into the Resident's Care Plan. The information is then passed on to other members of staff including kitchen staff.	

<table>
<tr><th colspan="2">Section C</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 5.4
• Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.

Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.4
Reassessment and documentation is carried out at least twice daily and any changes made recorded in the care plans with agreed date of reassessment. Nursing Care Plans are audited monthly by the Registered Manager.</td><td>Compliant</td></tr>
</table>

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.5 Research evidence and guidelines by professional bodies and national standard setting organisations such as Gain Documents, Braden Assessment Tool, MUST tool are used in drawing up patient's care plans to ensure safe and effective nursing care. 11.4 In Lisadian House Braden Tool is used to assess resident's risk of a pressure ulcer and when necessary referred to the tissue viability nurse who will use her expertise and in consultation with the nurses, resident/representative draw up an appropriate treatment plan. Pressure relieving equipment is ordered if necessary and referrals made to other professionals for advice such as dietition. The Tissue Viability Nurse will liaise closely with the nurses to ensure treatment is appropriate. 8.4 Nutritional Guidelines are available e.g. GAIN Care for People with Diabetes in Care Homes, CREST Guidelines for	Compliant

The Management of Enteral Tube Feeding in Adults, Nutritional Guidelines and Menu Checklist produced by Community Dietitians, N.I. March 2006, Guidance on Residents suffering from Dyspagia are also available for staff. Date regarding supplements is also available.	

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<tr><th colspan="2">Section E</th></tr>
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<tr><td>Criterion 5.6
• Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.
Criterion 12.11
• A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.
Criterion 12.12
• Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.
Where a patient is eating excessively, a similar record is kept.
All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.6
Contemporaneous Nursing Records in accordance with NMC Guidelines are kept of all nursing interventions in each patient's care plan. All care plans provide holistic care, assessments, plan and evaluation and outcomes for patients. Record keeping is in accordance of legislative requirements, minimum standards, trust policies and procedures and professional guidance, all in agreement with the patient and/or representative.

12.11
Records of residents choices are held. Food charts are kept on file of residents where necessary to include how much they ate of their meal. Staff report to the R.N. if a resident has not eaten their usual amount. When there is a deviation in a resident's appetite, this is documented in their daily evaluation notes so it can be monitored. Food temperatures are recorded by kitchen staff for each meal.</td><td>Compliant</td></tr>
</table>

12.12 Any resident not eating a meal is recorded in the food chart and daily evaluation record with the reason if known. Fluid records are kept for residents assessed as being at risk of dehydration. If the resident continues to refuse to eat and/or drink the GP is contacted and where necessary a referral made to the Dietitian/SALT. A record is made in the case notes. The outcome of any diet change will be evaluated daily by the nurse in charge to ensure the patient is happy and receiving adequate nutrition.	

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.7 Care delivered is monitored and recorded twice daily and is reviewed monthly by the Named Nurse or at a time interval agreed necessary. The Registered Manager audits the Care Plans monthly and discusses any other action she deems necessary to assure a high quality of care is delivered and agreed a time interval with the named nurse to reassess any necessary action highlighted. All care and documentation is drawn up by using evidence based tools and guidance documents and with the involvement of other professionals deemed necessary and the patient and/or representative. All registered nurses adhere to NMC guidelines on record keeping.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.8 Patients are encouraged and facilitated to participate in all aspects of care review meetings arranged by local HSC Trusts. These take place 6-8 weeksafter admission to Lisadian and yearly thereafter unless an earlier meeting is deemed necessary. These formal multidisciplinary review meetings ensure the the patient, family and nursing staff are in agreement that the patient has been placed in an appropriate home and all their needs are being met. 5.9 The results of all care reviews and the minutes of the review meetings are recorded. Where required, and in agreement with the patient, representative and nursing staff changes are made to the nursing care plan and signed by the patient and/or representative that they understand any changes made. Patients and/or their representatives are kept informed of progress towards agreed goals.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
12.1 There is a 3 week menu planner in place that has been drawn up taking into account. "The Nutritional Guidelines and Menu Checklist" Document. Individual resident preferences are known to both kitchen and care staff as are their special requirements e.g. consistency of food, special diet, prescribed supplements. The guidance provided for specific residents by GP, Dietitian and SALT etc is also followed. 12.3 An alternative meal is always on offer. Menus are provided at all dining tables for the day and if there is something a resident would prefer staff will endeavout to provide a meal to their liking and records kept of these choices. Choices are also offered to residents on therapeutic or specific diets following guidelines provided by Dietitian and SALT.	Compliant

<table>
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<tr><td>Criterion 8.6
• Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.
Criterion 12.5
• Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.
Criterion 12.10
• Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:
o risks when patients are eating and drinking are managed
o required assistance is provided
o necessary aids and equipment are available for use.
Criterion 11.7
• Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>8.6
Nurses maintain their knowledge and skills in this area through training and ongoing practice. They implement techniques following the advice and instructions from the multidisciplinary team e.g Resident's posture, feeding utensils, consistency of food. Nurses cascade this information to care staff and to visitors who may be involved in</td><td>Compliant</td></tr>
</table>

feeding a resident for whom they have responsibility. 12.5 Meals are provided in the morning, lunch time and tea time. Morning tea, afternoon tea and supper are also served with choices of hot and cold drinks and a variety of snacks which meet individual dietry requirements. Chilled drinking water machines are available upstairs and downstairs for use by residents, staff and visitors at any time. Jugs of orange juice are available in lounges for residents throughout the day. 12.10 The staff to patient ratio is adhered to. On the daily work sheet, staff members are allocated to assist residents in the dining room and in their bedrooms. Two extra members of staff are employed to assist residents with meals for 2 hours each morning. Staff have had training on dyspagia, the use of food thickeners and in-house first aid training includes choking and burns and scalds. Plate guards, cups with lids and handles, clothes protectors etc are provided. Staff are updated on risks concerning specific residents. 11.7 If a patient requires wound care, all nurses have received training which is updated at least yearly to enable them to carry out a wound assessment and the expertise to apply would care products and dressings. Registered Nurses have attended up to date Leg Ulcer Training and Wound Care Training in the past year. Nurses receive latest research and information from the tissue viability nurse/clinical facilitator when she visits. All care given in Lisadian House takes into account the Human Rights Act 1998 which is highlighted to staff during induction, along with The Mental Capacity Act 2005, Nursing Home Minimum Standards, Northern Ireland Human Rights - The Human Rights of Older People in Nursing Homes 2012, NICE Dementia Guidelines 2006, Your Human Rights - a guide for oder people second edition 2010, Age UK Older People and Human Rights and Commisioner for Older People for Northern Ireland draft themes and priorities. This ensures our Statement of Purpose and care takes into account each patient as an individual.	

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Compliant

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic care: (BC) – basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.**
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are☐ tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	Examples include: Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) – communication which is disregarding of the residents' dignity and respect.**
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Unannounced Primary Care Inspection

Lisadian House

16 October 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the registered manager. Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	14 (2) (c)	It is a requirement that at the time of each patient's admission to the home, the following minimum information should be completed on the day of admission to the home. • a validated nursing assessment such as Roper, Logan and Tierney • a validated bedrail assessment • a validated pressure risk assessment such as Braden • a validated nutritional risk assessment such as MUST • a validated falls risk assessment • a validated safe moving and handling assessment • a validated continence assessment **Ref Criterion 5.1; Section 10.0 A of report; Follow on from previous inspection**	Two	These assessment are being completed at the time of each admission to the home. Risk assessment are being reviewed and evaluated on a monthly basis, and more often as the patient's condition determines.	From date of inspection

2.	16 (2) (b)	It is a requirement that care plans are kept up to date and reflect the patient's current assessment of need and the action taken to meet that need. • registered nurses must ensure there is evidence of risk assessment and individual assessment of need to show the decision making process when applying any form of restrictive practice . • Bedrail risk assessments must be reviewed monthly or more often as deemed appropriate as per the home's policy. **Ref Criterion 10.7; Section 9.0 and 10.0 D of report; Follow on from previous inspection**	Two	Individual careplan are kept up to date. These are reflective of the patien's current assessment of the needs and carried out monthly and more often necessary. Bed rail risk assessment are up to date and individual consent from the Next of Kin has been obtained when bed rails are in use.	From date of inspection
3.	15 (2) (a) (b)	The responsible person must ensure that a review of all risk assessments including but not limited to pressure ulcer, manual handling and nutritional assessment is undertaken at least monthly or more often as the patient's condition changes. **Ref Criterion 5.4; Section10.0 C of report**	One	A review of all risk assessment has been carried out and this parctise will continue monthly and more often as the patient's condition changes.	From date of inspection

4.	16 (1)	The responsible person must ensure that when a risk is identified in the risk assessments a corresponding care plan must be prepared as to how the patient's needs in respect of his health and welfare are to be met **Ref Criterion 11.3; Section 10.0 B of report**	One	Risk asessments are in place once the patient is considered to be 'at risk' of developing pressure ulcer. A corresponding care plan is made to address the patient's needs in respect to his health and welfare with advise from professionals such as the TVN.	From date of inspection
5.	30 (1) (a-g)	The responsible person shall give notice to the RQIA without any delay of the occurrence of any death, illness or other event adversely affecting a patient in the nursing home in compliance with regulation 30. **Ref Criterion 25.17; Section 11.8 of report**	One	RQIA has been informed of the occurrence of any death, illness and other event adversely affecting patient in the nursing home.	From date of inspection

6.	27 (2) (b & d)	The responsible person must ensure that the premises are kept in a good state of repair externally and internally at all times and the following issues are effectively addressed: • light pull cords must have full length wipeable covers • shelf edging in the laundry and upstairs sluice room require repair or replacement • cleaning of pipework and filters in the laundry room • a review of the extractor fans is required to ensure that malodour is sufficiently controlled • wall tiling in the hallway two sluice requires repair or replacement and a drip tray is required for the bed pan rack to prevent cross contamination • ground floor sluice wall and floor damage requires repair or replacement • the flooring in the upstairs sluice requires repair or replacement • rusted bin holders need to be replaced to enable effective cleaning • in the ground floor bathroom wall tiling must be repaired or replaced, the radiator cleaned and repainted and the rusted laundry hamper replaced • repair of chipped furniture in patient's bedrooms must be undertaken • that the stained carpet in one patient's bedroom is cleaned or replaced	One	These issues have been addressed and routine maintenance is ongoing. An environmental audit has been sent with this QIP, this will be carried out routinely and any shortfalls will be addressed. (I posted additional information to your office).I	From date of inspection

		• the correct procedure is to be followed in the decontamination of mop heads. The registered person must submit a full environmental audit and an action plan submitted to RQIA as to how these issues will be addressed with the return of the QIP **Ref Criterion 35.1; Section 11.9 of report**			
7.	20 (3)	The responsible person shall ensure that at all times the registered manager carries out a competency and a capability assessment with any nurse who is given the responsibility of being in charge of the home. **Ref Criterion 30.4; Section 11.7.1 of report**	One	Competency and capability assessment has been carried out to any of the nurses whose given the responsibility of being in charge of the home. These documents are in their respective file.	From date of inspection

Recommendations **These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.**					
No.	**Minimum Standard Reference**	**Recommendations**	**Number Of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1.	25.11	It is recommended that an audit of care records is undertaken prior to any transfer to electronic records. **Ref: Section 10.0 C of report**	One	Discussion with the general manager assured the inspector that the move to electronic records would enable outstanding care plans and risk assessments to be identified more easily. It was agreed that each chart should be reviewed by the named nurse prior to entry on to the system and that there would no longer be a requirement to submit an audit 4 weeks post inspection.	From date of inspection
2.	6.2	All entries in case records are to be contemporaneous; dated, timed and signed, with the signature accompanied by the name and designation of the signatory. **Ref: Section 10.0 E of report**	One	All entries in the case records are contemporaneously dated, timed and signed with the signature accompanied by the name and designation of the signatory.	From date of inspection
3.	6.4	It is recommended that the fluid intake and output of each patient, where this is being monitored, is reconciled in to the case records. **Ref: Section 10.0 E of report**	One	The fluid intake and output of each patient is being monitored and reconciled in to the case records.	From date of inspection

4.	5.7	It is recommended that falls audits are undertaken at least monthly in order to identify and reduce risk for patients. **Ref: Section 11.8 of report**	One	Falls audit has been carried out in order to identify and reduce risk for patients.	From date of inspection
5.	28.4	The training needs of individual staff for their roles and responsibilities must be identified and arrangements put in place to meet them. This could not be verified at the time of inspection. Training required includes but is not limited to: • Safeguarding of vulnerable persons • Record Keeping • Wound care training • Nutrition and Dysphagia training • Human rights training **Ref: Section 10.0 E of report**	One	mandatory trainings has been conducted to address the needs of individual staff, further training has been scheduled and this is ongoing.	From date of inspection
6.	27.2	The responsible person must ensure that a policy for the management of records detailing the arrangements for the creation, use, retention, storage, transfer, disposal of and access to these records is developed and this submitted to the RQIA within six weeks post inspection. **Ref: Section 10.0 E of report**	One	The general manager confirmed to the inspector post inspection that this policy was completed and this will be submitted and verified by the inspector.	From date of inspection

7.	26.6	The responsible person must ratify any revision of or introduction of new, policies and procedures. **Ref: Section 10.0 E of report**	One	All policies revised, or new will be signed by the registered manager and resposnible person.	From date of inspection
8.	28.1	The responsible person must ensure that staff who are newly appointed complete a structured orientation and induction. • On the day of inspection there was insufficient evidence to verify that 1 newly appointed staff nurse had received an appropriate induction. The general manager must send confirmation that this induction has been completed within two weeks post inspection **Ref: Section 11.7.1 of report**	One	Newly appointed staff have completed the structured orientation and induction.	From date of inspection
9.	35.1	The responsible person must review the storage provision within the home to ensure the health and safety of patients and staff. **Ref: Section 11.9 of report**	One	The storage provision within the home has been reviewed to ensure the health and safety of patients and staff, this will continue to be monitored.	From date of inspection

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	DANIEL J. CEREZO
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	ELAINE HILL PASTOR EDWIN MICHAEL

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Karen Scarlett	7/1/14
Further information requested from provider			