Announced Primary Care Inspection

Name of establishment:	**Lisburn Care Home**
RQIA number:	**1265**
Date of inspection:	**10 October 2014**
Inspector's name:	**Sharon McKnight**
Inspection number:	**IN017169**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of establishment:	Lisburn Care Nursing Home
Address:	119a Hillsborough Road Lisburn BT28 1JX
Telephone number:	(028) 9266 6763
Email address:	lisburn@fshc.co.uk
Registered organisation/ Registered provider / Responsible individual	Four Seasons Health Care Mr James McCall
Registered manager:	Mrs Karen Moriarty
Person in charge of the home at the time of inspection:	Mrs Karen Moriarty
Categories of care:	NH-I, NH-DE, NH-PH, NH-PH (E) NH-TI, RC-I
Number of registered places:	38
Number of patients:	34
Date and type of previous inspection:	Unannounced Primary inspection 12 November 2013
Date and time of inspection:	10 October 2014 09 50 – 17 00 hours
Name of inspector:	Sharon McKnight

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/residents 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:

- Analysis of pre-inspection information
- discussion with the nurse in charge

- observation of care delivery and care practices
- discussion with staff
- examination of records
- consultation with patients individually and with others in groups
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation process

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

Patients/Residents	**9 individually and with the majority generally.**
Staff	**5**
Relatives	**2**
Visiting professionals	**2**

Questionnaires were provided by the inspector, during the inspection, to patients their representatives and staff to seek their views regarding the quality of the service
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Issued to	**Number issued**	**Number returned**
Patients / residents	**2**	**2**
Relatives / representatives	**2**	**2**
Staff	**6**	**4**

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.

An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

The inspector will also undertake an overarching view of the management of patient's human rights to ensure that patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.

The registered persons and the inspectors have rated the home's compliance level against each criterion of the standard and also against each standard.

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

Lisburn Care Home is a 38 bedded purpose built facility on the outskirts of Lisburn, close to the Lagan Valley Hospital and in close proximity to Sprucefield Shopping Centre.

The gardens and associated grounds are well maintained and car parking is provided to the rear of the home.

The home is a split level facility with patient accommodation on the upper floor and ancillary services below. There are 34 single bedrooms. There is a range of toilet and bathing facilities appropriately located within the home along with three communal sitting rooms and a dining room. A quiet lounge is also provided.

The home is registered to provide care under the following categories of care:

I Old age not falling into any other category
PH Physical disablement under 65 years of age
PH(E) Physical disablement over 65 years of age
TI Terminal illness

The home is owned by Four Seasons Health Care Ltd and the registered manager is Mrs Karen Moriarty.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) was reviewed and was appropriately displayed in the foyer of the home.

8.0 Summary of inspection

This summary provides an overview of the services examined during an unannounced primary care inspection to Lisburn Care Home. The inspection was undertaken by Sharon McKnight on 10 October 2014 from 09 50 to 17 00 hours.

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards.

The inspector was welcomed into the home by the registered manager Mrs Karen Moriarty. Verbal feedback of the issues identified during the inspection was given to Mrs Moriarty at the conclusion of the inspection.

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. This self-assessment was received on 9 April 2014. The comments provided by the responsible individual/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.

The inspector also spent one extended period observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool was designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 12 November 2013 two requirements and three recommendations were issued. These were reviewed during this inspection and the inspector evidenced that the requirements and recommendations have been fully complied with. Details can be viewed in the section immediately following this summary.

Conclusion

The inspector can confirm that at the time of this inspection, the delivery of care to patients was evidenced to be of a good standard and patients were observed to be treated by staff with dignity and respect. Good relationships were evident between staff and patients. Patients were well groomed, appropriately dressed and appeared comfortable in their surroundings. Those patients who were unable to verbally express their views were generally observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings. Review of bed side charts evidenced that those patients who were being nursed in bed, and unable to summon help, were attended by staff on a regular basis.

There were systems and processes in place to ensure the effective management of the standards inspected. One area for improvement was identified in relation to separate care plans for each individual wound. A recommendation has been made.

The inspector observed the serving of the lunch and concluded that the dining experience in the home was a positive one for patients with meals served in a calm, well

organised manner. All patients spoken were very satisfied with the selection and quality of food served to them daily. The approach to mealtimes in the home was commended by the inspector.

Since the previous inspection the home has undergone refurbishment and the standard of décor and soft furnishings was finished to a high standard and has improved the quality of the environment. The home was fresh smelling throughout, clean and appropriately heated.

The inspector would like to thank the patients, relatives, the visiting professionals, registered manager, registered nurses and staff for their assistance, co-operation and hospitality throughout the inspection process.

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

9.0 Follow-up on the requirements and recommendations issued as a result of the previous primary announced care inspection conducted on 12 November 2013.

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's validation of compliance
1	Regulation 19(1)(a), schedule 3, 2(k)	The registered person shall maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts must be accurately maintained to evidence care delivered.	Review of three repositioning charts evidenced that patients were being repositioned on a regular basis. This requirement is assessed as compliant.	Compliant
2	Regulation 12(1)(b)	The registered person must ensure that pressure ulcers graded 2 or above are reported to RQIA in keeping with best practice.	The inspector can confirm that RQIA are receiving notifications of pressure ulcers graded 2 or above.	Compliant

No	Minimum Standard Ref.	Recommendations	Action taken – as confirmed during this inspection	Inspector's validation of compliance
1	16.2	It is recommended that all induction programmes are reviewed, and where required developed, to ensure that an awareness of the procedures for protecti vulnerable adults are included in the induction programme for all staff.	Review of completed induction programmes evidenced that the registered manager provides an awareness safe guarding procedures and reporting arrangements. This recommendation is assessed as compliant.	Compliant
2	10.7	It is recommended that the use of alarm mats is discussed with the patient, where appropriate, and if the patient is unable to give their consent then consultation with relatives and healthcare professionals, if required, in regard to best interest decisions for the patient, should be undertaken and records maintained of the outcome of these discussions.	Three patients care records reviewed contained evidence of consultation with patients and/or relatives with regard to the use of alarm mats. This recommendation is assessed as compliant.	Compliant
3	5.1	It is recommended that all patients have a baseline pain assessment completed and an on-going pain assessment where indicated.	Six care records, selected at random by the inspector, all contained a pain assessment. This recommendation is assessed as compliant.	Compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not the remit of RQIA to investigate complaints made by or on 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.

Since the previous inspection on 12 November 2013, RQIA have been notified by the home of an ongoing investigation in relation to an alleged safeguarding of vulnerable adults (SOVA) issues. The SEHSCT safeguarding team are managing the SOVA issues under the regional adult protection policy/procedures. 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.

10.0 Inspection findings

10.1 Management of nursing care – Standard 5

There was evidence of comprehensive and detailed assessment of patient needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool. The assessment of patient need was evidenced to inform the care planning process.

Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis and as and when required. There was also evidence that the referring health and social care trust (HSCT) maintained appropriate reviews of the patient's satisfaction with the placement in the home, the quality of care delivered and the services provided.

Patients spoken with commented positively in regard to staff and the care they receive and that they were happy in the home. Those patients who were unable to verbally express their views were generally observed to be well groomed, appropriately dressed in clean matching attire and were relaxed and comfortable in their surroundings.

There were no requirements or recommendations made in relation to this standard.

Compliance Level: Compliant

10.2 Management of wounds and pressure ulcers – Standard 11 (selected criteria)

The inspector evidenced that prevention of pressure ulcers and wound care were generally well managed.

There was evidence of appropriate assessment to identify the risk of the development of pressure ulcers which demonstrated timely referral to tissue viability specialist nurses (TVN) for guidance and referral to the HSCT regarding the supply of pressure relieving equipment if appropriate. Care plans for the management of risks of developing pressure ulcers and wound care were maintained. Staff spoken with were knowledgeable regarding the referral process. Discussion with two registered nurses evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

Following review of two patients' care records the inspector evidenced that wound management in the home was generally well managed. Details of the wounds and frequency with which they required to be dressed were recorded in patients' care plans. One care record reviewed contained one care plan which referenced two wounds. To support the planning and evaluation of care it is recommended that a separate care plan is written for each wound. The care records contained an initial wound assessment and an assessment of the wound following each dressing renewal. Review

of completed wound assessment records evidenced that prescribed dressing regimes were adhered to.

A daily repositioning chart was in place for patients with the wound and also for patients who were assessed as being at risk of developing pressure ulcers. Review of a sample of these charts evidenced that patients' skin condition was inspected for evidence of change at each positional change and that patients were repositioned in bed in accordance with the instructions detailed in their care plans on pressure area care and prevention.

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above, were reported to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005**.**

One recommendation is made in this regards to this standard.

Compliance Level: Compliant

10.3 Management of nutritional needs and weight loss – Standard 8 and 12 (selected criteria)

The inspector reviewed the management of nutrition and weight loss within the home.

Review of care records evidenced that a Malnutrition Universal Screening Tool (MUST) to identify those patients at risk of malnutrition was completed on admission and reviewed monthly. Patients' weights were generally monitored on a monthly basis. Those patients identified as actively losing weight were weighed weekly. Records evidenced that staff were actively managing those patients at risk of weight loss.

The registered nurses confirmed that there were procedures in place for referral to the dietician in the local healthcare Trust. Staff spoken with were knowledgeable regarding the referral process. Discussion with staff evidenced that they were knowledgeable of the action to take to meet the patients' needs in the interim period while waiting for the relevant healthcare professional to assess the patient.

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 their likes and dislikes.

The inspector also observed the serving of the lunch time meal and can confirm that patients were offered a choice of meals. The dining experience is further discussed in section 11.4 of this report.

There were no requirements or recommendations made in regards to this standard.

Compliance Level: Compliant

10.4 Management of dehydration – Standard 12 (selected criteria)

The inspector examined the management of hydration during the inspection which evidenced that the fluid requirements and fluid intake details for patients were recorded and maintained for those patients assessed at risk of dehydration.

Patients were observed to be able to access fluids with ease throughout the inspection. Staff were observed offering patients regular drinks throughout the inspection. Fresh drinking water/various cordials were available to patients in lounges, dining rooms and bedrooms.

The inspector examined the management of hydration during the inspection which evidenced that individual food and fluid records were maintained for those patients' nurses in bed and/or assessed as at risk of inadequate food and fluid intake. There was a daily fluid target identified for these patients. The fluid intake chart was totalled at the end of each 24 hour period. Following review of care records and observation of care delivery the inspector was satisfied that hydration was being appropriately managed in the home.

There were no requirements or recommendations made in regards to this standard.

Compliance Level: 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 confirmed that the required records were maintained in the home and were available for inspection.

11.2 Patients under guardianship

There were no patients currently under guardianship resident at the time of inspection in the home.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)

The inspector discussed deprivation of liberty with the registered manager who was aware of the Human Rights Act 1998 and deprivation of liberty issues. . The inspector discussed the management of the key padded locking mechanism on the main entrance door to the home and was informed that it was only key padded from the outside and was operated by a push button when leaving the home. Therefore patients could leave the home when and if they wished.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a period of observation in the home which lasted for approximately 25 minutes.

The inspector observed the interactions between patient and staff during the serving of lunch in the dining room.

The observation tool used to record this observation uses a simple coding system to record interactions between staff, patients and visitors to the area being observed.

Positive interactions	7
Basic care interactions	0
Neutral interactions	0
Negative interactions	0

A description of the coding categories of the Quality of Interaction Tool is appended to the report.

The lunchtime meal was homemade cream of celery soup followed by a choice of meatloaf or baked salmon with peas, sweetcorn and creamed potatoes.

The dining room was well organised; the tables were nicely set with tablecloths, cutlery and condiments and the menu was displayed. A selection of napkins and dress protectors were available if patients wished to use them. Twenty eight of the thirty four

patients resident in the home came to the dining room for their lunch and this lead to a lively atmosphere creating a feeling of a real social event. The inspector discussed with staff how seating arrangements were managed and was informed that patients of similar needs and ability were encouraged to sit together allowing patients who require more assistance to be seated together. Staff explained that this helped promote the social aspect of dining and promoted dignity for those patients who required full assistance with their meals.

Meals were transported in a heated trolley to the dining room. The chef and catering assistant serve the meals directly to the patients. While patients in the dining room were having their soup, meals were served to those patients who prefer to have their meals in the lounge or in their bedroom. The trays were set with cutlery and condiments and the meals were covered prior to leaving the dining room.

Patients decided on which choice of meal they wanted at the time of the meal. As the catering assistant cleared the soup dishes in the dining room patients were asked which choice they would like from the menu. The Chef explained that this approach allowed him to adjust portion size on an individual basis. With the chef and catering assistant focusing on the serving of the meals care staff were free to fully focus on the needs of the patients. Staff were observed providing an explanation of the meal served, offering regular, gentle encouragement to patients and talking informally. Patients were observed to be assisted with dignity and respect throughout the meal. Patients were observed chatting to each other and commenting positively with regard to their meal.

The inspector concluded that the dining experience in the home was a positive one for patients with meals served in a calm, well organised manner. All patients spoken were very satisfied with the selection and quality of food served to them daily. The approach to mealtimes in the home was commended by the inspector.

11.6 Complaints

Prior to the inspection 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 inspector reviewed the complaints records. This review evidenced that complaints were investigated in a timely manner and the complainant's satisfaction with the outcome of the investigation was sought.

11.7 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, at the time of inspection, patients' monies were being managed in accordance with legislation and best practice guidance.

11.8 NMC declaration

Prior to the inspection the registered person 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.

11.9 Stake holder participation

11.9.1 Patient comments

During the inspection the inspector spoke with 9 patients individually and with a number in groups. In addition, on the day of inspection, two patients completed a questionnaire.

The following are examples of patients' comments made to the inspector and recorded in the returned questionnaires.

"This is a great home"
"…everything is very good…"
"…staff are hard working and always do their best….."
"...I find everything is ok…"
"..great food and plenty of variety."
"…I like everything about the home"
"…its like home to me…"

11.9.2 Patient representative/relatives' comments

During the inspection the inspector spoke with two relatives. In addition, two relatives competed and returned questionnaires.
All of the comments and responses received were positive.

11.9.2 Visiting healthcare professionals

The inspector spoke with two healthcare professional during the inspection who reported that staff knew their patients and that appropriate, timely referrals were made to the Trust. Confirmation was also provided that recommendations made following assessment were communicated to the staff team and implemented as prescribed.

11.1 Staffing comments

During the inspection the inspector spoke to five staff and received four completed questionnaires from staff following the inspection. Staff responses in discussion and in the returned questionnaires indicated that staff received an induction, completed mandatory training, completed additional training in relation to the inspection focus and were very satisfied or satisfied that patients were afforded privacy, treated with dignity and respect and were provided with care based on need and wishes. In one questionnaire received after the inspection the respondent indicated that they were very

dissatisfied with the time they had to listen and talk to patients, citing the high dependency of patients and increase in paperwork as a factor.

11.10 General environment

The inspector undertook a general inspection of the home and examined a number of patients' bedrooms, lounges, bathrooms and toilets at random. The home has undergone refurbishment since the previous inspection which has included repainting and replacement of the furniture in the reception area, replacement flooring in the corridor areas and a rolling programme of re-painting throughout the home. The standard of décor and soft furnishings was finished to a high standard and has significantly improved the quality of the environment.

The home was fresh smelling throughout, clean and appropriately heated.

12.0 Quality Improvement Plan

The details of the quality improvement plan appended to this report were discussed with Karen Moriarty, registered manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager 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:

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

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Sharon McKnight **Date**
Inspector / Quality Reviewer

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**
Prior to admission to the home, the Home Manager or a designated representative from the home carries out a pre admission assessment. Information gleaned from the resident/representative (where possible), the care records and information from the Care Management Team informs this assessment. Risk assessments such as the Braden Tool are carried out, if possible, at this stage. Following a review of all information a decision is made in regard to the home's ability to meet the needs of the resident. If the admission is an emergency admission and a pre admission is not possible in the resident's current location then - a pre admission assessment is completed over the telephone with written comprehensive, multidisciplinary information regarding the resident being emailed, faxed or left into the home. Only when the Manager is satisfied that the home can meet the residents needs will the admission take place.	Substantially compliant

On admission to the home an identified nurse completes initial assessments using a patient centred approach. The nurse communicates with the resident and/or representative, refers to the pre admission assessment and to information received from the care management team to assist her/him in this process. There are two documents completed within twelve hours of admission - an Admission Assessment which includes photography consent, record of personal effects and a record of 'My Preferences' and a Needs Assessment which includes 16 areas of need - the additional comments section within each of the 16 sections includes additional necessary information that is required to formulate a person centred plan of care for the Resident. In addidtion to these two documents, the nurse completes risk assessments immedidiately on admission. These include a skin assessment using the Braden Tool, a body map, an initial wound assessment (if required), a moving and handling assessment, a falls risk assessment,a pain assessment and nutritional assessments including the MUST tool, FSHC nutritional and oral assessment. Other risk assessments that are completed within seven days of admission are a continence assessment and a bowel assessment, Following discussion with the resident/representative, and using the nurse's clinical judgement, a plan of care is then developed to meet the resident's needs in relation to any identified risks, wishes and expectations. This can be evidenced in the care plan and consent forms. The Home Manager ,Deputy Manager and Regional Manager will complete audits on a regular basis to quality assure this process	

Section B	
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 5.3 • **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**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A named nurse completes a comprehensive and holistic assessment of the resident's care needs using the assessment tools as cited in section A, within 7 days of admission. The named nurse devises care plans to meet identified needs and in consultation with the resident/representative. The care plans demonstrate the promotion of maximum independence and focuses on what the resident can do for themselves as well as what assistance is required. Any recommendations made by other members of the	Substantially compliant

mutidisciplinary team are included in the care plan. The care plans have goals that are realistic and achievable. Registered nurses in the home are fully aware of the process of referral to a TVN when necessary. There are referral forms held in a designated file in the nurse's office, the Tissue Viability Nurse's details are also held in this file - name, address and telephone no. Once the form has been sent it, is then followed up by a telephone call to the TVN where advice can be given prior to their visit. Referrals are also made via this process in relation to residents who have lower limb or foot ulceration to either the TVN or a podiatrist. If necessary, a further referral is made to a vascular surgeon by the G.P, TVN or podiatrist. Where a resident is assessed as being 'at risk' of developing pressure ulcers, a Pressure Ulcer Management and Treatment plan is commenced. A care plan will be devised to include skin care, frequency of repositioning, mattress type and setting. The care plan will give due consideration to advice received from other multidisciplinary members. The treatment plan is agreed with the resident/representative, Care Management and relevant members of the MDT. The Regional Manager is informed via a monthly report and during the Reg 29 visit. The Registered Nurse makes a decision to refer a resident to a dietician based on the score of the MUST tool and their clinical judgement. Dietician referral forms are held within the home. These forms can be completed by staff in the home and faxed directly to the dietician for referral. The dietician is also available over the telephone for advice until she is able to visit the resident. All advice, treatment or recommendations are recorded on the MDT form with a subsequent care plan being compiled or current care plan being updated to reflect the advice and recommendations. The care plan is reviewed and evaluated on a monthly basis or more often if necessary. Residents, representatives, staff in the home and other members of the MDT are kept informed of any changes.	

Section C	
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 5.4 • **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**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
The Needs Assessment, risk assessments and care plans are reviewed and evaluated at a minimum of once a month or more often if there is a change in the resident's condition. The plan of care dictates the frequency of review and re assessment, with the agreed time interval recorded on the plan of care. The resident is assessed on an ongoing daily basis with any changes noted in the daily progress notes and care plan evaluation forms. Any changes are reported on a 24 hour shift report for the Home Manager's attention. The Sister, Manager and Regional Manager will complete audits to quality assure the above process and compile action plans if any deficit is noted.	Substantially compliant

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**
The home refers to up to date guidelines as defined by professional bodies and national standard setting organisations when planning care. Guidelines from NICE, GAIN, RCN, NIPEC, HSSPS, PHA and RQIA are available for staff to refer to. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading sysytem. If a pressure ulcer is present on admission or a resident develops a pressure ulcer during admission then an initial wound assessment is completed with a plan of care which includes the grade of pressure ulcer, dressing regime, how to clean the wound, frequency of repositioning, mattress type and time interval for review. Thereafter, an ongoing wound assessment and care plan evaluation form is completed at each dressing change, if there is any change to the dressing regime or if the condition of the pressure ulcer changes. All pressure ulcers graded 2 or above are reported to the RQIA and recorded on the FSHC Datix system. There are up to date Nutritional Guidelines such as 'Promoting Good Nutrition', RCN- 'Nutrition Now', ' PHA - 'Nutritional Guidelines and Menu Checklist for Residential and Care homes' and NICE guidelines - Nutrition Support in Adults, available for staff to refer to on an ongoing basis. Staff also refer to FSHC policies and procedures in relation to nutritional care, diabetic care, care of subcuteanous fluids and care of percutaneous endoscopic gastrostomy (PEG)..	Substantially compliant

Section E

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 5.6

- **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

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are kept of all nursing interventions, activities and procedures that are carried out in relation to each resident. These records are comtemporaneous and are in accordance with NMC guidelines. All care delivered includes an evaluation and outcome plan. Nurses have access to policies and procedures in relation to record keeping and have their own copies of the NMC guidelines - Record keeping:Guidance for nurses and midwives. There is a 4 week menu and any deviation from the meal planned to be served is recorded by the Catering Manager and the reason for the deviation. The Catering Manager also keeps a record of the meals provided on the 'Cooked temperature Record sheet' which is part of the Food Safety Management System. Each resident has an individual 'Daily Food and Fluid Intake Booklet' which nursing/care staff complete for each meal and document the meal choice and portion size the resident consumed .	Substantially compliant

In addition Residents who are assessed as being 'at risk' of dehyration or on Fluid restriction have fluids recorded in detail on a daily basis using a FSHC fluid record booklet. These charts are recorded over a 24 hour period with the fluid intake totalled at the end of the 24 hour period. The nurse utilises the information contained in these charts in their daily evaluation. Any deficits are identified with appropriate action being taken and with referrals made to the relevant MDT member as necessary. Any changes to the resident's plan of care is discussed with them and/or their representative. Care records are audited on a regular basis by the Sister and Manager with an action plan compiled to address any deficits or areas for improvement - this is discussed during staff meetings or on an individual basis with each nurse as necessary.	

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**
The outcome of care delivered is monitored and recorded on a daily basis on the daily progress notes with at least a minimum of one entry during the day and one entry at night. The outcome of care is reviewed as indicated on the plan of care or more frequent if there is a change in the resident's condition or if there are recommendations made by any member of the MDT. Residents and/or their represenatatives are involved in the evaluation process.	Substantially 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**
Care Management Reviews are generally held six-eight weeks post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The Trust are responsible for organising these reviews and inviting the resident or their representative. A member of nursing staff attends these reviews. Copies of the minutes of the review are sent to the resident/representative with a copy held in the resident's file. Any recommendations made are actioned by the home, with care plans reviewed to reflect the changes. The resident or representative is kept informed of progress toward the agreed goals.	Substantially 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**
The home follows FSHC policy and procedures in relation to nutrition and follows best practice guidelines as cited in section D. Registered nurses fully assess each resident's dietary needs on admission and review on an ongoing basis. The care plan reflects type of diet, any special dietary needs, personal preferences in regard to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations made by the Dietician or the Speech and Language Therapist. The plan of care is evaluated on a monthly basis or more often if necessary. The home has a 4 week menu which is reviewed on a 6 monthly basis taking into account seasonal foods. The menu is compiled following consultation with residents and their representatives , residents meetings, one to one meetings ,staff meetings and food questionnaires. The PHA document - 'Nutritional and Menu Checklist for Residential and Nursing homes' is used to ensure that the menu is nutritious and varied. The Catering Manager is currently reviewing the 4 weeks menu for Lisburn Care Home. Copies of instructions and recommendations from the dietician and speech and language therapist are made available to staff and a diet notification form is completed and informs the kitchen of each resident's specific dietary needs. Residents are offered a choice of two meals and desserts at each meal time, if the resident does not want anything from the daily menu the staff will offer an alternative meal of their choice .The menu offers the same choice, as far as possible to those who are on therapeutic or specific diets.	Substantially compliant

The Chef and Catering assistant serve the meals in the dining room daily and each resident is offered a visual choice of the meal at this time . A variety of condiments, sauces and fluids are available at each meal. The black board at the entrance to the Dining Room is updated daily with menu choices and the 4 week menu is displayed in a menu display folder in the foyer and also available in the Dining room and Kitchen.	

Section I	
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 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**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Registered nurses have received training on dysphagia and enteral feeding techiques (PEG) and attend update sessions as advertised by the South Eastern Trust. Swallow Awareness Training is also offered by the SALT at Lagan Valley Hospital for all nurses, care and catering staff and the next session is planned for 10/6/14. The Speech and Language therapist and dietician also give informal advice and guidance when visiting the home. Nurses refer to up to date guidance such as NICE guidelines - 'Nutrition Support in Adults' and NPSA document - 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by	Substantially compliant

the speech and language therapist are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to use and assistance required. The kitchen receive a copy of the Diet Notification Form which incorportaes any SALT recommendations and this is kept on file for reference by the kitchen. A summary sheet of all residents diets including any special diets is displayed on a white board in the kitchen. Meals are served at the following times:- Breakfast - 830am-10.00am Morning tea - 11am Lunch - 12.30pm Afternoon tea - 2.15pm Evening tea - 4.30pm Supper - 7pm-8pm There are variations to the above if a resident requests to have their meals outside of these times. Hot and cold drinks and a variety of snacks are available throughout the day and night and on request by informing a staff member and also those resident's who require modified or fortified diets. Cold drinks including fresh water are available at all times in the lounges and bedrooms, these are replenished on a regular basis. Any matters concerning a resident's eating and drinking are detailed on each individual care plan - including for eg. likes and dislikes, type of diet, consistency of fluid, any special equipment required and if assistance is required. A diet notification form is completed for each resident with a copy given to the kitchen and one held in the care file. Meals are not served unless a staff member is present in the dining room. Residents who require supervision, full or part assistance are given individual attention and are assisted at a pace suitable to them. Appropriate aids such as plate guards and specialised cutlery are available as necessary and as indicated in the plan of care. Each nurse has completed an education e-learning module on pressure area care. The home has 2 link nurses who has received enhanced training, to provide support and education to other nurses within the home . Central training on wound care related topics are arranged for nurses requiring additional support and nurses can also access training through the Trust at Lagan Valley Hopsital.. All nurses within the home have a competency assessment completed. Competency assessments have a quality assurance element built into the process.	

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Unannounced Care Inspection

Lisburn Care Home

10 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 Karen Moriarty either during or after the inspection visit.

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.

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	5.3	To support the planning and evaluation of care it is recommended that a separate care plan is written for each wound. **Ref section 10, 10.2**	One	The care plan identified has been amended to reflect the recommendation. The Nursing Team are also aware that this practice should be applied going forward with care plans for wound care.	From the 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	Karen Moriarty
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall Alan Cousins DIRECTOR of OPERATIONS

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			