Unannounced Care Inspection

Name of establishment:	**Lecale Lodge Care Home**
RQIA number:	**1285**
Date of inspection:	**19 December 2014**
Inspector's name:	**Donna Rogan**
Inspection number:	**17181**

The Regulation And Quality Improvement Authority
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1.0 General Information

Name of Establishment:	Lecale Lodge Care Home
Address:	26 Strangford Road Downpatrick BT30 6SL
Telephone Number:	028 44616487
Email Address:	Lecale.lodge@fshc.co.uk
Registered Organisation/ Registered Provider:	Four Seasons Healthcare Mr James McCall
Registered Manager:	Mrs Linda Graham
Person in Charge of the Home at the Time of Inspection:	Mrs Linda Graham
Categories of Care:	NH-I, NH-PH, NH-PH(E), NH-DE,NH-TI, RC-I
Number of Registered Places:	56
Number of Patients Accommodated on Day of Inspection:	50
Scale of Charges (per week):	£450 - £609
Date and Type of Previous Inspection:	12 August 2014 Primary Unannounced
Date and Time of Inspection:	19 December 2014 10.15 – 16.00
Name of Inspector:	Donna Rogan

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 are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being 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.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

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 Residential 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

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

- Discussion with the registered manager
- Discussion with staff
- Discussion with patients/residents individually and to others in groups
- Discussion with two relatives visiting at the time of inspection
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Review of the accidents and incidents records
- Review of the daily routine
- Observation during a tour of the premises
- Evaluation and feedback

5.0 Consultation Process

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

Patients/Residents	33
Staff	10
Relatives	2
Visiting Professionals	1

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

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	5	2
Relatives/Representatives	2	0
Staff	10	5

6.0 Inspection Focus

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

STANDARD 19 - CONTINENCE MANAGEMENT

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion 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		
Compliance Statement	**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

Lecale Lodge is a purpose built care home. It is one of two homes on a pleasant site on the outskirts of Downpatrick.

Lecale Lodge Care Home provides general nursing care for sixteen patients, residential care for fifteen residents and the Quoile Suite is registered for ten dementia nursing patients. The new Slieve Patrick suite is now registered for fifteen patients with nursing mental health needs.

Lecale Lodge Care Home is a two-storey building with bright and spacious patient accommodation and with good parking facilities adjacent to the Home.

The home is registered to provide care for a maximum of 56 persons under the following categories of care:

Nursing care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH (E)	physical disability other than sensory impairment over 65 years
DE	dementia care, accommodated within the dementia unit on the ground floor.
MP (E)	mental disorder excluding learning disability or dementia over 65 years
TI	terminally ill

Residential care

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH (E)	physical disability other than sensory impairment over 65 years

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

8.0 Executive Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection to Lecale Lodge Care Home. The inspection was undertaken by Donna Rogan on 19 December 2014 from 10.15 to 16.00 hours.

The inspectors were welcomed into the home by Linda Graham registered nurse manager of the home. Mrs Graham had to leave prior to the completion of the inspection. However the Clinical Lead Nurse, Daniel Oliveria, was provided with feedback at the conclusion of the inspection. Verbal feedback was also provided to Linda Graham by telephone.

During the course of the inspection, the inspector met with patients and staff and relatives. The inspector observed care practices, examined a selection of records, and carried out a general inspection of the nursing home environment as part of the inspection process.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. This self-assessment was received by RQIA on 17 April 2014. The inspector reviewed the responses provided, however, due to a change in inspection focus has been unable to validate all of the statements provided. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one.

As a result of the previous inspection conducted on 12 August 2014, five requirements and one recommendation was made. They were reviewed during this inspection. The inspector evidenced that all requirements and the one recommendation were fully complied with. Details of the previous requirements and recommendations 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. There were processes in place to ensure the management of continence care. One recommendation was made in regard to this theme.

In addition to the theme inspected the inspector also reviewed the following;

- Care practices
- Patients' views
- Staffing/staff views
- Relatives views
- NMC checks
- Complaints
- Patients' finances
- Environment

Requirements are made in relation to the environment and care practices. A total of, four requirements and one recommendation is made following this inspection. The requirements and recommendation are detailed throughout the report and in the quality improvement plan (QIP).

The inspector would like to thank the patients, the registered manager, clinical lead nurse, visiting professional, and staff for their assistance and co-operation throughout the inspection process.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	17 (1)	Ensure that following completion of care audits, and where action is required, that the records evidence that any actions are returned to the named nurse and should be completed within a timely manner and when completed should be signed off by the auditor.	A review of care plan audits evidenced that where action was required that the identified care records were returned to the named nurse and the necessary actions were observed to be completed in a timely manner. The completed audits were then signed by the person conducting the audit when completed. A review of five care records evidenced an overall improvement regarding the management of care records in keeping with best practice.	Compliant
2	13 (7)	Ensure infection control audits are further enhanced and they include audits on the environment and care practices.	A review of the infection control audits evidenced that they were completed monthly and the audits included a review of the environment and care practices.	Compliant

3	27	Forward to the RQIA an updated refurbishment plan detailing the planned improvements to the furniture and decoration alongside timescales particularly in the frail elderly nursing unit.	Following the inspection, the inspector can confirm that an updated refurbishment plan was forwarded to RQIA. The plan details the planned improvements for furniture and the decoration of the home. The plan included timescales. Confirmation has also been received that refurbishment has also commenced in the frail elderly nursing unit. Following a review of the environment there was evidence that the refurbishment plan is being adhered to. The plan to refurbish the frail elderly nursing unit is in keeping with the set timescales.	Compliant
4	14 (2) (c)	Ensure bedrails are maintained within best practice guidelines as identified in the safety device bulletin issued by the Health and Safety Executive. Further checks are required to ensure they are meeting the required standard. Staff should be aware of the guidelines and report any issues observed to the person in charge.	During a review of the environment there were no third party bed rails in use. All bed rails observed were in keeping with the guidelines issued by the Health and Safety Executive. Weekly checks are carried out on bed rails and staff have completed formal training in their management both formally and through the home's e-learning programme.	Compliant

5	27	Ensure the following issues are addressed; • Ensure the two bedrooms identified bedrooms are refurbished • Replace the torn chairs in the identified lounge • Ensure all chairs are maintained clean • Ensure the smoking room is regularly checked to ensure cigarettes/cigars are properly extinguished, records should be maintained of checks carried out • Replace the identified mattress to ensure it fits the bed • Ensure an audit is carried out of existing furnishings and ensure all are fit for purpose as discussed	During a review of the environment the inspector observed that the identified two bedrooms have been refurbished. The torn chairs have been replaced in the identified lounge. All chairs were observed to be clean. A review of the smoking room observed it to be maintained appropriately cigarettes/cigars were observed to be properly extinguished. Regular checks were being maintained and records were maintained of the checks completed. All mattresses observed were an appropriate fit on the beds. An audit of the existing furnishings has been completed and any furnishings which were not fit for purpose have been removed. As previously stated the refurbishment programme is on-going.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	29 (5) and (6)	Ensure information is placed on the patient/relatives' notice board informing patients and their representatives that copies of the Regulation 29 unannounced visit reports and the annual quality report are available on request.	A review of the information placed on patient/relatives information board included information that copies of the Regulation 29 unannounced visits and the annual report are available upon request.	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 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 there is considered to be a breach of regulation as stated in the Nursing Homes Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

Since the previous care inspection, RQIA have received notifications of incidents occurring in the home, all have been managed appropriately. There are currently no safeguarding of vulnerable adult (SOVA) incidents on-going in respect of Lecale Lodge Care Home.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Review of five patients' care records evidenced that bladder and bowel continence assessments were undertaken for all patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care. There was evidence in all patients care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken and patients were referred to their GPs as appropriate. Review of five 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. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Discussion with staff and observation during the inspection evidenced that there were adequate stocks of continence products available in the nursing home.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
The inspector can confirm that the following policies and procedures were in place; • continence management / incontinence management • colostomy and ileostomy care • catheter care The policy and procedure in relation to colostomy and ileostomy care is required to be updated. A recommendation is made in this regard. The inspector can also confirm that the following guideline documents were in place: • RCN improving continence care for nurses • RCN guidance for nurses on catheter care • NICE guidelines for faecal and urinary continence Discussion with staff revealed that they had an awareness of these policies, procedures and guidelines.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
There was guidance documentation available in leaflet form regarding the promotion of continence care for patients/residents and their representatives. These leaflets were available throughout various areas of the home and on patients/residents/relatives notice boards.	Compliant
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with the registered manager and review of training records confirmed that staff were trained and assessed as competent in continence care. Discussion with the clinical lead nurse revealed that all the majority of registered nurses in the home were deemed competent in female and male catheterisation and the management of stoma appliances. There is a continence link nurse working in the home who is involved in the review of continence management and education programmes for staff. This is good practice and is commended.	Compliant

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

11.0 Additional Areas Examined

11.1 Care Practices

During the inspection staff were noted to treat the patients/residents with dignity and respect throughout the home. Good relationships were evident between patients/residents and staff.

Patients/residents were well presented with their clothing suitable for the season. Staff were observed to respond to patients'/residents' requests promptly. The demeanour of patients/residents indicated that they were relaxed in their surroundings.

The afternoon routine was observed to be well organised in all suites of the home. Patients/residents spoken with stated that they could choose where to have their lunch. Patients/residents also informed the inspector that their continence needs were tended to in a timely way, they stated that when they sounded the nurse call system that their request was usually answered promptly.

There was a good atmosphere in the home. There is an organised activity programme ongoing. Patients/residents spoken with stated they enjoyed the activities organised and were looking forward to the social activities organised for Christmas.

The registered manager should ensure that equipment designed for single use regarding oral care is maintained in keeping with good infection control practices. This issue should be addressed with staff.

11.2 Patients'/relatives' views

During the inspection the inspector spoke to approximately 33 patients/residents individually and with others in groups. Patients/residents spoken with expressed high levels of satisfaction with the standard of care, facilities and services provided in the home. A number of patients/residents were unable to express their views verbally. These patients indicated by positive gestures that they were happy living in the home. Examples of patients' comments were as follows:

"Staff treat me and my belongings with respect"
"Staff are always polite to me"
"I am happy and content here"
"The food is good we always get a choice"
"The buzzer is always answered promptly"
"My visitors can see me in the privacy of my own room"
"Staff are great; they are a great bunch of people"
"I couldn't be happier"
"I have recently moved upstairs, I am getting used to it"

The inspector spoke with two relatives during the inspection. Both relatives were commendable regarding the care in the home and the care their relative was receiving.

There were no issues raised to the inspector during the inspection by patients/residents or relatives.

11.3 Staffing/Staff views

During the inspection the inspector spoke with approximately ten staff. Staff spoken with expressed satisfaction with the level of care in the home. All stated that the staffing arrangements were sufficient in numbers to meet the needs of the patients. However a review of the staffing skill mix in the residential and frail elderly unit is required to be reviewed to ensure nursing staff maintain their roles in the frail elderly unit. Medicines should be completed by a senior care assistant who is appropriately trained in medicines management in the residential unit as discussed.

Staff spoken with informed the inspector that they had regular staff meetings and were confident if they required to raise issues that they could approach management and have them resolved.

Comments returned in the staff questionnaires included the following;

- "residents receive the best care all the time"
- "care provided is based on individual needs and wishes"
- "the new unit is brilliant place and the patients live an independent a life as possible, staff work well as a team"
- "work satisfaction is definitely a plus here"
- "love the home, love the staff, love the patients"

There were no issues raised by staff to the inspector during the inspection.

One visiting professional spoken with commended the staff in the home. They stated that they were always professional and carried out instructions and advice in a timely and positive manner.

11.4 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.

The acting manager informed the inspector that lessons learnt from investigations were acted upon.

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.

11.7 Environment

The inspector undertook an inspection of the premises and viewed the majority of the patients' bedrooms, bathroom, shower and toilet facilities and communal areas. The home was comfortable and all areas were maintained to a good standard of hygiene.

There is an on-going refurbishment programme in place and the majority of the home has been refurbished and redecorated to compliment the changes to the units within the home. The first floor refurbishment plan has commenced and is due to be completed early in the New Year. This is welcomed by patients and residents on the first floor.

The following issues are required to be addressed;

- Provide a new heated trolley in the Slieve Patrick Unit
- Address the issue of the identified patient smoking in their bedroom

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Linda Graham, 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:

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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 any admission to the home, the home manager or a designated representative from the specific unit in the home carries out a pre- admission assessment of needs. information is received from care management team, resident or resident's representative.This information then is used for the pre admission assessment so that the home can make a decision that needs can be met. Following admission to the home risk assessment tools such as Braden Scale, Must Tool, Manual Handling Risk Assessment, Continence assessment ,oral assessment, falls risk assessment, bedrail assessment (if applicable) initial wound assessments(if applicable) and pain assessments(if applicable) are completed within 11 days of admission. The Must Tool is used for all residents for nutritional screening along with Four Seasons Health Care Nutritional assessment form. Following all information assessed and received from resident or representative a plan of care is then developed to meet the resident's needs in relation to any identified risks or wishes. The outcome of these care plans are reviewed monthly or following any change in a resident's condition. The nursing staff are being trained in the use of electronic records and are now inputing records onto the EPIC system. The home manager and regional manager will complete audits to quality assure this process.	Substantially compliant

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 Four Seasons Healthcare documentation. This is recorded on the epic system. The named nurse then devises care plans to meet the identified needs in consultation with the resident and/or representative. The care plan will demonstrtae the promotion of maximum independence and rehabilitation and will take into account advice from the relevant heathcare professionals. The care plan will focus on what the resident can do for themselves and what care they require. The nursing staff will place a referral for advice and support from the trust clinical nurse practitioner who has expertise in tissue viability. Referrals are also made to podiatry for any circulatory issues with residents foot care. When a resident is assessed as being at risk of developing pressure ulcers a pressure ulcer management plan is commenced. A care plan is written to include skin care, frequency of repositioning, type of mattress or seating. The care plan will take into account any advice from the multidisciplinary team. The treatment plan is agreed with the resident or representative. The regional manager is informed during the regulation 29 visit and also via a monthly wound analysis report. There are referral arrangements to the dietician for residents who have a must score indicating at risk and /or, recent weight loss. This process is used for guidance and support on nutritional management plan for the resident. A care plan is formulated following any recommendations from the dietician. This care plan is reviewed on a monthly basis or sooner if there is any change in condition. The kitchen staff are informed of any recommendations made from the dietician. Residents, representatives, members of the multi disciplinary team are kept informed of any changes.	Substantially compliant

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**
Resident's notes are wrtten daily and resident's needs are reassessed daily by a registered nurse. Any change to assessed needs are reflected on the resident's daily progress report, care planning or risk assessments. All residents have risk assessments and care plans evaluated monthly or sooner if any change noted in condition. Outcomes of care needs are reviewed also by the care management team . The manager and regional manager will complete audits to quality assure the above process and address with the nursing staff any deficits. Any changes in resident's conditions are reported on the 24 hour shift report for the Home Manager's attention.	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
All records are written in accordance with NMC guidelines and details are recorded of all nursing interventions, activities and procedures that are carried out in relation to each resident. The nursing staff refer to up to date guidelines when planning care. These guidelines include NICE,GAIN,RCN, NIPEC,HSSPS,PHA AND RQIA. The validated pressure ulcer grading tool used by the home to screen residents who have skin damage is the EPUAP grading system. If a pressure ulcer is present on admission or a resident develops a pressure ulcer following admission than 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. An ongoing wound assessment is then completed following each dressing change. A body map is also completed and braden scale. The up to date Nutritonal guidelines used in the home is Promoting Good Nutrition, RCN- Nutrition Now, PHA-Nutritional Guidelines and menu checklist for Residential and Care Homes and NICE Guidelines- Nutrition support in Adults is also available for staff to refer to. Staff also have FSHC Policies and procedures in relation to nutritional care, diabetic care, care of subcutaneous 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 contemporaneous and are in accordance with NMC guidelines. All care delivered include an evaluation and outcome plan. Nursing staff have access to policies and procedures in relation to record keeping and are fully aware of NMC guidelines on record keeping. Records of meals provided for each resident at each mealtime are recorded on a daily menu choice form. Residents who are assessed as being at risk of malnutrition, dehyration or eating excessively have all their food and fluids recorded in detail on a daily basis using a Four Seasons Healthcare food record chart booklet or 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 members of the multi disciplianry team as necessary such as Gp or Dietician.	Substantially compliant

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 for each resident with a minimum of one entry during the day and one entry during the 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 multidisciplinary team. Resident and representatives are kept informed of any changes in care being delivered.	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 normally held 6 weeks after admission and then annually. Reviews can also be arranged as a result of changing needs, expressions of dissatisfaction with care or at the request of the resident or representative. The care management team will organise these reviews by writing and inviting the resident and representatives to attend the review. A member of the nursing team also will attend the review to explain the care being delivered. Copies of minutes of the reviews are sent to the home and a copy retained in the residents file. If the home does not receive a copy then the home will request a copy from the care manager. Any recommendations made are then actioned by the home, with review of care plans to reflect changes. The resident and representative is kept informed of progress towards the agreed goals.	Moving towards compliance

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 Four Seasons Healthcare policies and procedures in relation to nutrition and follows best practice guidelines such as GAIN. NICE,PHA and RQIA. Registered nurses fully assess each resident's dietary needs on admission and review this on an ongoing basis. The care plan reflects the type of diet, any special dietary needs, personal preferences in regards to likes and dislikes, any specialised equipment required, if the resident is independent or requires some level of assistance and recommendations from 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 3 week menu which is reviewed on a six monthly basis taking into account seasonal foods. The menu is complied following consultation with residents and their representatives- residents meetings, one to one 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. Copies of instructions and recommenations from the dietcian and Salt and Language therapist are made available in the kitchen along with a diet notification form which informs the kitchen of each resident's dietary needs. Residents are offered a choice of two meals at each mealtime, if the resident does not want anything from the daily menu an alternative meal of choice is provided. The menu offers the same choice as far as possible to those who are on therapeutic or specific diets. Each resident is offered a choice of meal which is then recorded on a daily menu sheet. A variety of condiments, sauces and fluids are available at each meal. Daily menus are on display in each dining room.	Substantially compliant

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
Nursing staff and care staff have been on training on dysphagia and swallow awareness. Further training is arranged. Speech and Language theraist and dietician also give informal advice and guidance when visisting the home. Nurses refer to up to date guidance such as NICE Guidelines-'Nutritional Support in Adults' and NPSA document 'Dysphagia Diet Food Texture Descriptors'. All recommendations made by Speech and Language Therapists are incorporated into the care plan to include type of diet, consistency of fluids, position for feeding, equipment to be used and assistance required. The kitchen receives a copy of the recommendations from the Speech and Language Therapist and this is kept in a file for reference by the kitchen.Meals are provided at the following times. Breakfast- 9.00am - 10.30am Morning Tea- 11am Lunch- 12.30pm- 1.30pm Afternoon Tea- 3pm Evening Tea- 4.45- 6pm Supper- 8.15pm 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 on request. Any matters concerning a resident's eating and drinking are detailed on each individual care plan including their likes and dislikes, type of diet, consistency of fluids, any special equipment required and if assstance required. A diet notification form is completed and a copy given to the kitchen and one held on the care file. Meals are not served unless a member of staff is present in the dining room. Residents who require assistance are given individual attention and are assisted at a pace suitable to them. Plate guards are available and used as indicated in the plan of care. At present a pilot study is being carried out in the home to heighten awareness of staff on residents who are at risk due to swallowing difficulties. Each nurse has completed an education on pressure area care. The home has a wound care link nurse who has received enhanced training to provide support and education to other nurses within the home. Staff also receive verbal advice and education during visists from the trust tissue viability nurse.Nurses within the home also have a competency assessment completed.	Substantially compliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Moving towards compliance

The **Regulation** and **Quality Improvement Authority**

Quality Improvement Plan

Secondary Unannounced Care Inspection

Lecale Lodge

19 December 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 Linda Graham, registered manager, 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.

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	13 (7)	Ensure staff adheres to best practice in regards to infection control management. **Ref 11.1**	One	Staff have been instructed regarding best practice in infection control management and the Registered Manager continues to monitor the use of oral hygiene packs for single use only.	From the date of inspection
2	20 (1) (a)	Ensure staffing in the residential and frail elderly unit are kept under review. Nursing staff should maintain their roles in the frail elderly unit in keeping with RQIA minimum staffing levels and skill mix. Medicines should be completed by a senior care assistant who is appropriately trained in medicines management in the residential unit. **Ref 11.3**	One	A Senior Care Assistant has been recruited for the Residential Unit and will commence in post on completion of the recruitment process. Medicines are administered by staff who have completed their Administration of medicines competency.	From the date of inspection
3	12 (4) (b)	Ensure meals a heated trolley is provided in the Slieve Patrick Suite. **Ref 11.7**	One	As confirmed during the inspection a heated trolley was ordered and has now been delivered and is in use in the Slieve Patrick Unit.	From the date of inspection
4	14 (2)	Review the issue of the identified patient smoking in their bedroom. **Ref 11.7**	One	A care management review with this resident has taken place with the psychiatrist and family present. Smoking policy issued to resident and staff	From the date of inspection

				continue to educate the resident on the policies of the home and monitor smoking activity.	

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	19.2	The registered person should ensure that the policy on colostomy and ileostomy care is updated. **Ref 19.2**	One	Policy is currently under review by Four Seasons Health Care Quality Team.	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	Linda Graham
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Jim McCall Alex Cousins.

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes		23/2/15
Further information requested from provider			