Unannounced Care Inspection Report
17 January 2017

Leabank

Type of Service: Nursing Home
Address: 1 Beechwood Avenue, Ballycastle, BT54 6BL
Tel No: 028 2076 3392
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Leabank took place on 17 January 2017 from 09:45 to 15:50 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The term 'patients' is used to describe those living in Leabank, which provides both nursing and residential care.

Is care safe?

It was evident that patients' safety, health and well-being were protected and of paramount importance to management and staff.

A review of the home's environment was undertaken and included observations of a number of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts.

There were no requirements or recommendations made.

Is care effective?

It was evident that systems and processes were in place to ensure the delivery of effective care.

Staff were commended for the detailed knowledge they had of their patients which enabled them to deliver effective care. In addition, staff stated that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection. Each staff member clearly knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their relatives was evident on a one to one basis as recorded in the care records and through observations of interactions between staff and patients. Communication with other healthcare professionals was also demonstrated within the care records reviewed. Patients confirmed that the registered manager was available to them on a daily basis.

Two recommendations were made in relation to record keeping.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Patients and relatives' were very positive in the comments regarding the staffs' ability to deliver care and respond to needs and or requests for assistance.

As stated previously staff clearly demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. This ensured the safe, effective and compassionate delivery of care.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients unable to attend to their own personal hygiene and dress were well presented and it was evident that staff paid attention these details.

There were no requirements or recommendations made.

Is the service well led?

Based on the inspection findings detailed in each domain, review of records, systems and processes; and comments from patients, relatives and staff it was evident that Leabank was well led. The registered manager clearly demonstrated how she and the senior management team ensured the delivery of safe, effective and compassionate care, and that this was an integral part of the day-to-day operational control of the home. This was commended.

There were no requirements or recommendations made.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Herlindina Roble, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent medicines management inspection

The most recent inspection of the home was an unannounced premises inspection undertaken on 21 September 2016. This inspection resulted in no requirements or recommendations being made. Enforcement action did result from the findings of this inspection which evidenced that building work had been undertaken to add a bedroom to the home without prior approval from RQIA.

Following discussion with RQIA senior managers the registered persons were required to attend an intention to issue a failure to comply notice meeting. This meeting took place on 29 September 2016. Following the meeting the decision was made not to issue a failure to comply notice; however the registered persons were required to submit a new application to vary the home's registration. This application was duly received and processed.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Leabank/ Mr Brian Macklin and Mrs Mary Macklin	**Registered manager:** Mrs Herlindina Roble
Person in charge of the home at the time of inspection: Mrs Herlindina Roble	**Date manager registered:** 26 January 2016
Categories of care: NH-DE, NH-I, NH-PH, RC-DE, RC-I, RC-PH. A maximum of 10 residents within categories RC-I and RC_PH. A maximum of 2 residents in category RC-DE and a maximum of 2 patients within category NH-DE. All new admissions to categories RC-DE and NH-DE must receive prior approval from RQIA.	**Number of registered places:** 52

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection we spoke with 10 patients individually and greeted others in small groups; three care staff, two registered nurses, two staff from housekeeping, one relative, the activity therapist and Mr and Mrs Macklin, registered persons, who were also visiting the home.

In addition questionnaires were provided for distribution by the registered manager; 10 for relatives, eight for patients and 10 for staff not on duty during the inspection. Four relatives, seven patients and six staff questionnaires were returned. Refer to section 4.5 for details.

The following information was examined during the inspection:

- four patient care records
- four patients' charts regarding repositioning
- staff roster 9- 22January 2017
- staff training and planner/matrix
- one staff recruitment record
- complaints record
- a sample of incident and accident records
- a sample of quality monitoring visits carried out in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 - Regulation 29
- records of audit/governance
- registration checks for nursing and care staff
- records pertaining to consultation with staff, patients and relatives

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 September 2016

The most recent inspection of the home was an unannounced premises inspection. There was no QIP issued. Refer to section 1.2.

4.2 Review of requirements and recommendations from the last care inspection dated 25 January 2016

Last care inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 14(4) **Stated:** Second time	The registered provider must ensure that chemicals for use in the home are stored in accordance with COSHH guidance.	**Met**
	Action taken as confirmed during the inspection: Observations evidenced that this requirement had been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 5.8 **Stated:** First time	All patient information should be held in a confidential manner to safeguard the privacy and dignity of patients.	**Met**
	Action taken as confirmed during the inspection: Observations evidenced that this recommendation had been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 9 to 22 January 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with the registered manager and review of documents evidenced that the organisation had a robust recruitment process. If a candidate was successful and progressed to employment they were provided with a comprehensive induction programme supported by a mentor.

Discussion with the registered manager and review of records evidenced that a robust system was in place to ensure staff attended mandatory training. Training was kept under review by the registered manager and the senior management team. Staff confirmed that they were required to complete mandatory training. Records confirmed that 100% of staff had completed their mandatory training requirements for 2016; this was commended by the inspector. Observation of the delivery of care and patient records evidenced clearly that training had been embedded into practice.

The registered manager and staff spoken with clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities, in general, and specifically in relation to adult safeguarding. Staff described their role and responsibilities with and said that they were enabled to 'make a difference'. Patients and one relative spoken with confirmed that they were assured and confident of the staffs' ability to care for them or their loved ones and that they 'trusted' staff to always do the right thing.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC) requirements. Safety and medical alerts were reviewed on a regular basis and relevant notices were 'actioned' and/or disseminated to staff as required.

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since April 2016 confirmed that these were managed appropriately. Audits of falls and incidents were maintained and clearly evidenced analysis of the data to identify any emerging patterns or trends and action plans were in place as required. Audit outcomes regarding falls and incidents also informed the responsible individual's monthly monitoring visit in accordance with The Nursing Homes Regulations (Northern Ireland) 2005, regulation 29.

A review of the premises was undertaken and included observations of a number of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts. Infection prevention and control measures were adhered to.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

4.4 Is care effective?

Patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer a care plan was in place to direct staff on the management of this risk and evaluations of the wound were recorded appropriately. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds.

Three of the four care records reviewed accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. One record had not be updated following significant changes t the patients assessed needs. Discussion with registered nurses ad care staff demonstrated that the patient was receiving the necessary care but a recommendation was made regarding the records keeping. Registered nurses assessed planned, evaluated and reviewed care in accordance with NMC guidelines.

There was evidence that the care planning process included input from patients and/or their relatives, if appropriate. There was evidence of regular communication with representatives within the care records. One relative and patients stated they had confidence in the staff to deliver the right care at the right time.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Supplementary records such as reposition, food intake and fluid intake records were maintained for identified patients. However, review of four patients' reposition records evidenced that staff did not record contemporaneously nor did the records demonstrate clearly the position or reposition of the patient following staff interventions. Details were discussed with the registered manager during feedback and a recommendation was made.

Observations evidenced that call bells were answered promptly and patients requesting assistance in one of the lounge areas or their bedrooms were responded to in a calm, quiet and caring manner. Patients were confident of the ability of staff to meet their need effectively and in a timely manner. Patient said that they were well cared for by caring and kind staff. Patients were confident that if they had any concerns the manager or the deputy manager "would sort it all out."

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the handover reports at the beginning of their shift. Staff also confirmed that regular staff meetings were held, that they contributed to the agenda and that minutes were made available.

Staff stated with enthusiasm that there was "good teamwork"; this was evidenced through discussion and observation of interactions throughout the inspection. Staff stated they were 'proud' to be a part of their team and to 'make a difference'. Each staff member clearly knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge, the registered manager or the deputy manager. Staff said that the registered manager knew them and the patients well and was "on the floor" every day. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their relatives was evident on a one to one basis as recorded in the care records and through observations of interactions between staff and patients. Patients confirmed that the registered manager was available to them on a daily basis. They referred to her as "Jan" and they said they knew her well.

Areas for improvement

A recommendation was made that risk assessments and care plans are updated when there is a change to the patient's condition.

A recommendation was made that record keeping should be contemporaneous and reflect the care delivered accurately.

Number of requirements:	0	Number of recommendations:	2

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. As stated in section 4.4 patients and the relative spoken with was very positive regarding the staffs' ability to deliver care and respond to needs and or requests for assistance.

As stated previously in section 4.4 staff clearly demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs. This ensured the safe, effective and compassionate delivery of care.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients unable to attend to their own personal hygiene and dress were well presented and it was evident that staff paid attention these details.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their relatives and staff on the running of the home. For example, patients, relatives, visitors to the home and staff were invited to provide feedback on an ongoing basis. For example, both Mr and Mrs Macklin, Registered Persons, were visiting the home during the inspection. Mrs Macklin was observed greeting each patient and/or their relatives and asked how they were and f they had any worries or concerns. It was evident that patients were familiar with this from the interactions observed and greetings overheard. Discussion with the registered manager confirmed that the registered persons maintained a record of their visits and issues/concerns raised with them and any subsequent actions undertaken to address these. For example, one patient requested, of Mrs Macklin, that the home get 'Wi-Fi' and the home now had access to Wi-Fi.

All patients and relative spoken with commented positively regarding the care they received and the staffs' caring and kind 'nothing is any trouble' attitude. It was evident good relationships had been developed and that there was a high level of confidence in the staffs' ability to deliver care and to address concerns effectively. The attitude and actions of staff were commended.

RQIA provided questionnaires for distribution by the registered manager to patients, staff and relatives. At the time of writing this report, four relatives, seven patients and six staff had returned their questionnaires.

Comments and outcomes were as follows:

Patients: respondents indicated that they were very satisfied or satisfied that care was safe, effective, compassionate and well led. Comments recorded included:

- "…with a manager so caring it is lovely to see her daily and be asked if one is all right."
- "The staff from kitchen, domestic, carers, nurses and administration have made me feel safe and secure at all times."
- "It is a great team who all work extremely well to make sure that myself and other residents are content."

Relatives: indicated that they were all very satisfied that care was safe, effective, compassionate and well led. There were no additional comments recorded.

Staff: One respondent submitted an incomplete form. Four respondents indicated that they were very satisfied across all areas questioned. One respondent indicating they were very satisfied did record comments about the staffing levels for night duty. Staffing levels are discussed in section 4.3.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	**0**	**Number of recommendations:**	**0**

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff confidently described their role and responsibility in the home. In discussion patients were aware of the roles of the staff in the home and to whom they should speak to if they had a concern. Patients and the relative consulted spoke in very positive terms in relation to the registered manager and their confidence in her leadership skills. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 - regulation 24 and the DHSSPS Care Standards for Nursing Homes 2015. Patients and staff spoken with confirmed that they were aware of the home's complaints procedure. Patients/relative confirmed that they were confident that staff and management would address any concern raised by them appropriately.

Staff were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function. A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents/accidents. Records also evidenced that the results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Review of reports and discussion with the registered manager evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

There was an effective system in place to ensure nursing staff were registered with the nursing and Midwifery Council (NMC); and that care staff were registered with the Northern Ireland Social Care Council (NISCC). New care staff not registered with NISCC were required and supported to register.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed.

Discussion with the registered manager and observations evidenced that the home was operating within its registered categories of care.

Based on the inspection findings detailed in the preceding domains, review of records, systems and processes; and comments from patients, one relative and staff it was evident that

Leabank was well led. The registered manager clearly demonstrated how she and the senior management team ensured the delivery of safe, effective and compassionate care, and that this was an integral part of the day to day operational control of the home. This was commended.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Herlindina Roble, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to the RQIA **web portal** for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 31 March 2017	The registered provider should ensure that risk assessments and care plans are updated when there is a change to the patient's condition. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Registered Manager has informed key workers to update the care plan, files were checked and same were amended on 20.01.17. Nurses are advised to continue with the plan of care and review on monthly basis or when patient's condition change.
Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 31 March 2017	The registered provider should ensure that record keeping is contemporaneous and reflective of the care delivered. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: The home has a daily patient care form, during inspection same was not fully completed or it was not consistent and does not always reflect the care delivered . The home manager spoke to the staff, suggestions and inputs were encouraged, then we have an amended Patient Daily Chart in each patient, same was put in placed on 30.01.2017.

Please ensure this document is completed in full and returned to the RQIA web portal

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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