Unannounced Care Inspection Report
27 April 2018

Lisnisky Care Home

Type of Service: Nursing Home
Address: 16 Lisnisky Lane, Portadown, Craigavon
BT63 5RB
Tel no: 028 38 339153
Inspector: Sharon McKnight

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 63 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Maureen Claire Royston	**Registered Manager:** Jolly Joseph
Person in charge at the time of inspection: Jolly Joseph	**Date manager registered:** 17 April 2018
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. TI – Terminally ill. Residential Care (RC) I – Old age not falling within any other category. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment. LD(E) – Learning disability – over 65 years. PH – Physical disability other than sensory	**Number of registered places:** 47 Nursing : 16 Residential Of the 47 residents accommodated in the nursing category there shall be a maximum of 14 assessed as DE. The home is approved to provide care on a day basis only to 9 persons

4.0 Inspection summary

An unannounced inspection took place on 27 April 2018 from 09.30 to 16.10 hours.

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.

The term ‘patient’ is used to describe those living in Lisnisky which provides both nursing and residential care.

Evidence of good practice was found in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home’s environment. There were examples of good practice found throughout the inspection in relation to assessment of patient need and care planning, the management of nutrition, falls and wound care and the communication of patient needs between staff. Good practice was observed in relation to the culture and ethos of the home, provision of activities and valuing patients and their representative views. There were robust systems in place for governance, the management of complaints and incidents and maintaining good working relationships.

An area for improvement was identified in relation to reviewing the recording of wound care to ensure that records consistently evidence care delivery.

Patients said they were happy living in the home. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. A number of comments received are included in this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Jolly Joseph, 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.

4.2 Action/enforcement taken following the most recent inspection dated 13 December 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 13 December 2017. There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with 11 patients, eight staff and two patients' relatives. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was provided which directed staff to an online survey.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- duty rota for all staff from 16 – 29 April 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- three patient care records
- two patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 13 December 2017

The most recent inspection of the home was an unannounced medicines management inspection. There were no areas for improvement identified as a result of this inspection.

6.2 Review of areas for improvement from the last care inspection dated 21 June 2017

There were no areas for improvement identified as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 16 to 29 April 2018 evidenced that the planned staffing levels were

adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Lisnisky.

We spoke with relatives of two patients during the inspection both of whom were complimentary regarding staff. A total of two completed questionnaires were received from relatives following the inspection. Both of the respondents indicated that they were very satisfied that there were enough staff and that they could talk to staff if they had a concern.

Review of two staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work. A review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC. There were systems and processes in place to ensure that alerts issued by Chief Nursing Officer (CNO) were managed appropriately and shared with key staff.

We discussed the provision of mandatory training with staff and reviewed staff training records. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training was delivered through face to face interactive sessions and via an e learning programme. Training records included the date the training was attended/completed, the names and signatures of those who attended face to face training and provided compliance rates of staff who have completed training in each topic. Records evidenced good compliance with mandatory training. The registered manager confirmed that systems were in place to ensure staff received annual appraisal and regular supervision.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

We reviewed accidents/incidents records from January – March 2018 in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Review of three patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

Discussion with the registered manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. From a review of records, observation of practices and discussion with the registered manager and staff there was evidence of proactive management of falls.

Records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example; bed rails and alarm mats. The registered manager completed a monthly audit to monitor the type of restrictive practice in use, the completion of documentation and appropriate consultation with relevant persons.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges and dining rooms. The home was found to be warm, well decorated, fresh smelling and clean throughout. Fire exits and corridors were observed to be clear of clutter and obstruction. We discussed the storage of a large volume of medical equipment in one identified patient's bedroom and the potential impact on patient dignity if they received visitors in their bedroom. The registered manager agreed to address the storage issue without delay.

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control measures were consistently adhered to. We observed that personal protective equipment, for example gloves and aprons, were available throughout the home. Equipment for the management of laundry and waste was in place for patients with a known HCAI.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of nutrition, patients' weight and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care. Interventions prescribed were individualised and care records were reviewed regularly.

We discussed the monitoring of patients' weights and were informed that all patients were weighed a minimum of monthly. We reviewed the management of nutrition and weights for two patients. The patients had been referred to the dietician. A nutritional risk assessment was completed monthly; a care plan for nutritional management was in place. Food and fluid intake charts were maintained for both patients.

We reviewed the management of falls for two patients. Falls risk assessments were completed and reviewed regularly. A post falls review, to examine a range of factors, was completed for each patient following a fall. Care plans for falls management were in place.

We reviewed the management of wound care for two patients. Care plans contained a description of the wound, location and the prescribed dressing regime. Wound care records reviewed for the period February – April 2018 did not consistently evidence that prescribed dressing regimes were always adhered to. This was identified as an area for improvement.

Supplementary care charts, for example; food and fluid intake records and repositioning charts were completed daily. Records evidenced that patients were assisted to change their position for pressure relief in accordance with their care plans. Staff demonstrated an awareness of the importance of contemporaneous record keeping.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), SALT and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), the speech and language therapist (SALT) or the dietician changed.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the registered manager or the nurse in charge. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to assessment of patient need and care planning, the management of nutrition, falls and wound care and the communication of patient needs between staff.

Areas for improvement

An area for improvement was identified in relation to reviewing the recording of wound care to ensure that records consistently evidence care delivery.

	Regulations	Standards
Total number of areas for improvement	**0**	**1**

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 9.30 hours and were greeted by staff who were helpful and attentive. Patients were enjoying breakfast in the dining rooms or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect.

Discussion with patients and staff and review of the activity programme evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. A group of patients were engaged in a craft activity mid-morning. The patients spoken with were enjoying both the craft and the opportunity for socialising. The personal activity leader (PAL) explained that they planned to repeat the activity with another group of patients in the afternoon.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A variety of methods were used to promote orientation, for example appropriate signage, photographs, the provision of clocks and prompts for the date.

We observed the serving of the lunchtime meal in the dementia unit. Patients were assisted to the dining room tables or had trays delivered to them as required. Staff were observed assisting patients with their meal appropriately and a registered nurse was overseeing the mealtime. Patients able to communicate indicated that they enjoyed their meal.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

"…all the staff are very caring and attentive and nothing is too much trouble for them."

"…you made them feel at home and I felt reassured that they were safe and well care for."

"…as a family we were delighted to witness the dignity, humanity and compassion that was demonstrated to her especially in her last weeks."

There were systems in place to obtain the views of patients and their representatives on the running of the home. The systems provided the registered manager with an oversight of views obtained.

Patients said that they were generally happy living in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. The following comments were received:

“Everyone is so good, I’m very comfortable.”
“I am well looked after.”
“Everything is ok, no complaints.”

We spoke with the relatives of two patients. Both commented positively regarding the care their loved ones were receiving. Issues raised by one relative were shared with the registered manager who readily agreed to meet with the relative and discuss the issues further.

Relative questionnaires were also provided. As previously discussed two were returned within the timescale. Both relatives indicated that they were very satisfied or satisfied with the care provided across the four domains.

Staff were asked to complete an on line survey; we received no responses within the timescale specified.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, provision of activities and valuing patients and their representative views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection a permanent manager has been appointed. Registration with RQIA was completed on 17 April 2018. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff, patients and relatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the registered manager.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The registered manager explained that diversity and equality of patients was supported by staff and training would be provided to staff to support patients, as required.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the registered manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, the use of restrictive practice and care records.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jolly Joseph, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 25 May 2018	The registered person shall review the recording of wound care to ensure that records consistently evidence care delivery. Ref: Section 6.5
	Response by registered person detailing the actions taken: Registered manager has completed a full review of wound management. Supervision has been completed with Registered Nurses relating to wound management. Registered manager will monitor compliance in documentation ensuring care plan and assosciated risk assessments are fully updated following each dressing change.

Please ensure this document is completed in full and returned via Web Portal

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