Unannounced Care Inspection Report
26 January 2017

Lisburn Intermediate Care Centre

Type of Service: Nursing Home
Address: 119b Hillsborough Road, Lisburn, BT28 1JX
Tel No: 028 9266 9523
Inspector: Sharon McKnight and James Laverty

1.0 Summary

An unannounced inspection of Lisburn Intermediate Care Centre took place on 26 January 2017 from 09:30 hours to 16:30 hours.

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

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 that the assessed needs of the patients were met. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels. Through discussion with staff we were assured that they were knowledgeable in relation to their specific roles and responsibilities. The registered manager confirmed that there is an ongoing programme of mandatory training for staff which is kept under review. A general inspection of the home confirmed that the premises were generally well maintained. The home was noted to be clean, clutter free and appropriately warm.

Weaknesses have been identified in the delivery of safe care specifically in relation to the management of those patients assessed as being at risk of choking. Two requirements were made.

Is care effective?

A review of two patient care records (one in the interim care unit and one in the intermediate care unit) evidenced that a range of validated risk assessments and care plans were completed as part of the admission process within the recommended timeframe for completion. These patients' risk assessments informed the care planning process and were reviewed as required.

We examined the management of enteral feeding. The registered nurses spoken with were knowledgeable regarding the prescribed nutritional regime. A review of the dietician's report and the completed fluid intake charts evidenced that the prescribed regimes were adhered to on a daily basis. Care plans were in place for the management of enteral feeding,

A review of mouth care identified weaknesses in the delivery of care and the maintenance of care records. One requirement and one recommendation were made.

We reviewed the recording of repositioning charts for two patients for the period 7 - 11 January 2017. The records of repositioning were not consistently recorded and did not evidence that care was being delivered as prescribed. Through observations and discussion with staff we were assured that repositioning was being undertaken, however improvement was required in the records to evidence the care delivery. A recommendation was made.

Is care compassionate?

The interpersonal contact between staff and patients was observed to be compassionate and caring. Patients were afforded choice, privacy, dignity and respect.

Patients, representatives and members of staff spoken with confirmed that patients were listened to, valued and communicated with in an appropriate manner. 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.

The Registered manager confirmed that there are systems in place to ensure that the views and opinions of patients, and or their representatives, are sought and taken into account in all matters affecting them.

There were no requirements or recommendations made for this domain.

Is the service well led?

The current manager has been registered with RQIA since 06 September 2013. Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. There were systems were in place to monitor and report on the quality of nursing and other services provided.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff members and trust representatives. .

There were no requirements or recommendations made for this domain.

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	3	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Judith Derby, 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 care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 8 September 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

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. An SAI investigation was undertaken by the

South Eastern Health and Social Care Trust (SEHSCT) in February 2016 and recommendations were made. It is the responsibility of the relevant health and social care trust to ensure recommendations they make are adhered to. However, where issues have the potential to be breaches of regulations or associated standards RQIA will review the issues through our inspection process. Following a review of care we concluded that the recommendations had not been fully complied with. Please refer to section 4.3 of this report.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Maureen Claire Royston	**Registered manager:** Judith Derby
Person in charge of the home at the time of inspection: Judith Derby	**Date manager registered:** 06 September 2013.
Categories of care: NH-TI, NH-PH(E), NH-PH, NH-I, NH-DE There shall be a maximum of 12 patients accommodated within category of care NH-DE and located within the designated dementia unit (lower ground floor	**Number of registered places:** 63

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report
- pre inspection assessment audit
- South Eastern Health and Social Care Trust (SEHSCT) Serious Adverse Incident (SAI) findings and recommendations

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with 21 patients, three care staff, three registered nurses, one domestic staff and six patients' representatives.

The following information was examined:

- staffing arrangements in the home
- nine patient care records
- complaints records
- accident and incident records
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 08 September 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and was validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 08 September 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 44.2 **Stated:** First time	It is recommended that the moss on the paths in the garden/patio area of the dementia unit is removed and the garden furniture cleaned to ensure the area is safe and clean for the patients to use.	**Met**
	Action taken as confirmed during the inspection: The garden furniture and patio area of the dementia unit were observed to be generally clean and tidy. No moss was evident on the paths.	
Recommendation 2 **Ref**: Standard 16.11 **Stated:** First time	It is recommended that the recording of complaints should be further developed to include how the complainants' level of satisfaction was determined.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and examination of the complaints records confirmed that that complainants' level of satisfaction was clearly recorded	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subjected to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for all three floors for week commencing 23 January 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives/relatives 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.

Review of the training matrix for 2015 and 2016 indicated that training was planned to ensure that mandatory training requirements were met. The registered manager confirmed that at the time of the inspection 92 per cent of staff had attended safeguarding training; 95 per cent of staff had attended infection control training and 83 per cent of staff had attended first aid training; this was commended by the inspectors.

The registered manager informed us that there was an ongoing programme of training within the home in relation to dementia care and that staff who typically work in the home's dementia unit will receive enhanced dementia training.

The registered manager and staff spoken with demonstrated the knowledge, skills and experience necessary to fulfil their role. Staff described their responsibilities with enthusiasm with one staff member commenting "I love it here." Patients and relatives spoken with confirmed that they were assured and confident of the staffs' ability to care for their loved ones. One patient stated "staff are really super" while one relative commented "staff are wonderful."

A review of the home's environment was undertaken and included observations of a sample 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.

Fire exits and corridors were observed to be generally clear of clutter and obstruction. However, in the early afternoon we observed six black bags containing general waste and two small cardboard boxes at the bottom of one stairwell adjacent to an emergency exit on the ground floor. This was brought to the immediate attention of the registered manager who instructed staff to dispose of these items immediately thereby ensuring that the emergency exit was kept clear. Following discussion with the registered manager and a staff member we were assured that this was not normal practice and that the staff member had been called away while taking the bags outside. The importance of ensuring that fire exits are kept clear at all times was discussed.

Review of two patient care records in the intermediate / interim care unit 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.

As previously discussed an SAI investigation was undertaken by the SEHSCT in February 2016 and recommendations were made relating to the management of patients at risk of choking. These recommendations were reviewed during this inspection.

In the dementia unit we observed one patient who was served their breakfast in their bedroom. This patient was then left unattended; no supervision was provided throughout the meal. This

patient's records indicated that the Speech and Language Therapist (SALT) had recommended that supervision was required for all meals. The swallowing assessment competed by the home indicated a medium risk of choking. Two staff spoken with were aware of the recommendations regarding the type and consistency of food the patient could eat but they were unaware of the recommendation that the patient must be supervised. The patient's relevant care plan had not been updated to reflect the SALT assessments in October 2016 and January 2017.

Another patient in the dementia unit was served breakfast in their bedroom. This patient was also left unattended and not provided with any supervision during their meal. Staff reported that the patient did not require to be supervised. A review of the patient's swallowing assessment indicated that they were at low risk of choking. However, their care plan stated that they were at a medium risk of choking and therefore required supervision with meals.

A third patient in the dementia unit was observed to have been served their breakfast in the dining room. This patient was left unattended and not provided with any supervision. A review of their swallowing assessment indicated that they were at a medium risk of choking while the care plan stated that they were at a low risk of choking.

All patients who are identified as being at risk of choking must be appropriately supervised when eating and drinking. The registered manager must ensure that staff are aware of identified risks and introduce monitoring arrangements to ensure that there is proper provision for the nursing and where appropriate, treatment and supervision of patients. A requirement was made.

The information contained in the assessments and care plans did not accurately or consistently identify the needs of the patients and failed to provide clear direction for staff with regard to risk. Care records must be reviewed and updated to ensure that unnecessary risks to health and safety of patients are identified and so far as possible eliminated. A requirement was made.

As a result of the findings of this inspection we concluded that the recommendations made by the SEHSCT had not been complied with. The findings of this inspection, with regard to the management of patients at risk of choking, were shared with the SEHSCT on 27 January 2017.

Areas for improvement

All patients who are identified as being at risk of choking must be appropriately supervised when eating and drinking. The registered manager must ensure that staff are aware of identified risks and introduce monitoring arrangements to ensure that there is there is proper provision for the nursing and where appropriate, treatment and supervision of patients.

The information contained in the assessment and the care plan did not accurately or consistently identify the needs of the patients and failed to provide clear direction for staff. Care records must be reviewed and updated to ensure that unnecessary risks to health and safety of patients are identified and so far as possible eliminated.

Number of requirements	2	Number of recommendations	0

4.4 Is care effective?

We examined the management of enteral feeding. The registered nurses spoken with were knowledgeable regarding the prescribed nutritional regime. The dietetic reports which detailed

the prescribed nutritional regime were readily available in the patient's care records. Fluid intake charts were maintained for patients who were prescribed enteral feeds. A review of the dietician's report and the completed fluid intake charts evidenced that the prescribed regimes were adhered to on a daily basis. Care plans were in place for the management of enteral feeding,

We observed one patient whose lips were visibly dry and cracked and their tongue was coated. The patient had an oral assessment in place but it was not reflective of the condition of the patient's mouth. A care plan prescribing mouth care was in place. Staff were knowledgeable regarding the required care. There were no records to evidence that regular mouth care was being provided throughout the day. Medication administration records (MARS) evidenced that mouthwash was being administered twice daily as prescribed; registered nurses had not evaluated the effectiveness of the daily care or identified that it was not meeting the patient's needs. The patient's condition was brought to the immediate attention of the staff who attended to the patient straight away. Nursing staff agreed to seek further advice from the patient's G.P. in relation to mouth care and this was actioned prior to the conclusion of the inspection. The registered person must ensure that proper provision is made for the nursing, health and welfare of patients. A requirement was made.

Reassessment of patient need should be an ongoing process that is carried out daily with records updated to reflect changes in patient conditions. Records should be maintained to evidence care delivery. Two recommendations were made.

We reviewed the recording of repositioning charts for two patients for the period 7 - 11 January 2017. The patients' care plans stated that repositioning should be completed 2 – 3 hourly. The records of repositioning were not consistently recorded; for example on one date there were only three entries; on other day there were gaps of up to 5 hours between records of repositioning. The registered nurses spoken with reported that neither patient currently had pressure ulcers. Staff spoken with were knowledgeable of the patients' needs and the necessity to ensure they were repositioned regularly. One patient confirmed that staff assisted them to change position throughout the day and night. Through observations and discussion with staff we were assured that repositioning was being undertaken, however improvement was required in the records to evidence the care delivery. The inspectors highlighted the importance of maintaining accurate records which reflect the pressure area care being given to patients. A recommendation has been made to ensure that records are maintained to evidence care delivery. This recommendation includes repositioning charts.

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. Relatives confirmed that they were kept informed of any changes in their loved ones' care. We spoke with one visiting professional from the SEHSCT who confirmed that arrangements were in place for the referral and re referral to multi professional specialist teams such as physiotherapy.

Staff confirmed that regular staff meetings were held, that they contributed to the agenda and that minutes were made available. Staff stated that there was a holistic approach to the planning and delivery of nursing care and this was evidenced through discussion and observation of interactions throughout the inspection process. Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Areas for improvement

Proper provision must be made for the nursing, health and welfare of patients

Reassessment of patient need should be an ongoing process that is carried out daily with records updated to reflect changes in patient conditions.

Records should be maintained to evidence care delivery.

Number of requirements	1	Number of recommendations	2

4.5 Is care compassionate?

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

Staff generally demonstrated a good knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

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.

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

In addition to speaking with patients, relatives and staff, RQIA provided questionnaires. At the time of writing this report five relatives and seven staff had retuned their questionnaires. All questionnaires evidenced a high level of satisfaction with the quality of care provided within the Home.

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 were able to describe their role and responsibility within the home. Conversations with patients confirmed that they were aware of the roles of the staff in the home and to whom they should speak if they had a concern. 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 Regulation 24 of the Nursing Homes

Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would address any concern raised by them appropriately.

Staff were knowledgeable of 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. Audits were noted to be in place 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.

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 Judith Derby, 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/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to 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

Statutory requirements

Requirement 1 **Ref**: Regulation 13 (1)(b) **Stated:** First time **To be completed by** 23 February 2017	The registered person must ensure that there is proper provision for the nursing and where appropriate, treatment and supervision of patients. All patients who are identified as at risk of choking must be appropriately supervised when eating and drinking. The registered manager must ensure that staff are aware of identified risks and introduce monitoring arrangements to ensure that risks are appropriately and safely managed. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Speech and Language Therapist has been contacted and has agreed to review all residents who have previously been assessed by SALT to ascertain level of supervision required when eating and drinking using new Trust supervision documentation. Monitoring arrangements will be implemented accordingly.
Requirement 2 **Ref:** Regulation (14(2)(c) **Stated:** First time **To be completed by:**23 February 2017	The registered person must ensure that care records are reviewed and updated to ensure that unnecessary risks to health and safety of patients are identified and so far as possible eliminated. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: A review of residents records has taken place to ensure the care plans reflect assessments by Speech and Language Therapist and choking risk assessments.
Requirement 3 **Ref:** Regulation 13(1)(a) **Stated:** First time **To be completed by:** 23 February 2017	The registered person must ensure that proper provision is made for the nursing, health and welfare of patients. The registered person must ensure that all patients receive effective and timely mouth care as required. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Oral care documentation has been implemented to ensure oral hygiene needs are provided and documented for identified resident

Recommendations	
Recommendation 1 **Ref**: Standard 4.7 **Stated:** First time **To be completed by:** 23 February 2017	It is recommended that reassessment of patients need should be an ongoing process that is carried out daily with records updated to reflect changes in patient conditions. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Updating assessments has been discussed with trained staff to ensure they accurately reflect changes in residents needs
Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 23 February 2017	It is recommended that contemporaneous records are maintained for all nursing interventions. The registered person must ensure that repositioning charts are completed in full and contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning or when continence needs are attended too. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Completion of repositioning charts has been discussed with trained staff and care staff to ensure repositioning charts are completed in a timely manner, records are being monitored to ensure compliance with care plan

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