Unannounced Care Inspection Report
6 February 2018

Lisburn Intermediate Care Centre

Type of Service: Nursing Home (NH)
Address: 119b Hillsborough Road, Lisburn, BT28 1JX
Tel no: 028 9266 9523
Inspector: Sharon McKnight
Lay assessor: Frances McCluskey

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 for up to 63 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual:** Dr Claire Royston	**Registered Acting manager:** See box below
Person in charge at the time of inspection: Alfie Corvera – acting acting manager	**Date acting manager registered:** Temporary management arrangements were in place at the time of the inspection.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 63 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).

4.0 Inspection summary

An unannounced inspection took place on 6 February 2018 from 09.00 to 15:55 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 inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to the provision and development of staff, risk management and the home's environment. There were examples of good practice found in relation to the assessment of patient need and care planning; we observed good communication between patients, staff and visitors. The culture and ethos of the home promoted dignity and privacy. Good practice was also identified in relation to governance arrangements, management of complaints and incidents and maintaining good working relationships.

Areas requiring improvement were identified in relation to the delivery of catheter care and the development of the initial care plans, following admission, to include individual preferences.

Patients said they were 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 comments and opinions of patients and relatives may be found in section 6.6.

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	**1**	**1**

Details of the Quality Improvement Plan (QIP) were discussed with Alfie Corvera, acting 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 September 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 13 September 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 17 patients, 6 staff and 2 patients' relatives. Questionnaires were also left in the home to obtain feedback from patients' representatives. A poster informing staff of how to submit their comments electronically, if so wished, was given to the acting manager to display in the staff room.

A lay assessor, Frances McCluskey, was present during the inspection and their comments are included within this report.

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

The following records were examined during the inspection:

- staff duty rota for week commencing 5 February 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
- seven patient care records including fluid intake charts and repositioning charts
- a selection of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

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 September 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 13 June 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 12.7 **Stated:** First time	The registered person shall ensure that supervision arrangements at mealtimes for the identified patient are reflected in the care plan.	**Met**
	Action taken as confirmed during the inspection: A review of the identified patients care records evidenced that this area for improvement has been met.	

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 acting manager confirmed the planned daily staffing levels for the home and that these were subject to regular review to ensure the assessed needs of the patients were met.

A review of the staffing rota for week commencing 5 February 2018 evidenced that the planned staffing levels were generally adhered to. Rotas also confirmed that catering and housekeeping staff were on duty daily. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. There were no concerns raised by staff in respect of the staffing arrangements.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We spoke with 17 patients and two relatives during the inspection; all commented positively regarding the staff.

The acting manager confirmed that a nurse was identified to take charge of the home when the acting manager was off duty. A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the acting manager. The assessments were signed by the manager to confirm that the assessment process has been completed and that they were satisfied that the registered nurse was capable and competent to be left in charge of the home.

A review of two staff recruitment records evidenced that they were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records confirmed that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the acting manager. A review of the records of NMC and NISCC registration evidenced that all of the staff on the duty rota for the week of the inspection were included in these checks. There were robust systems in place to confirm registration at the time of renewal.

The acting manager confirmed that newly appointed staff commenced a structured orientation and induction programme at the beginning of their employment. A review of two induction programmes evidenced that these were commenced/completed within a meaningful timeframe.

We discussed the provision of mandatory training with the acting manager who explained that training continued to be delivered via e learning and face to face. A review of the training records for 2017 evidenced good compliance with safeguarding, infection prevention and control and moving and handling. Mandatory training compliance was monitored by the acting manager. Training opportunities were also provided by the local health and social care trust;

for example records reflected that staff had attended training in recognising the deteriorating patient, the management of delirium and modified diets.

Review of seven 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 between September 2017 – January 2018 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. With the exception of one identified bedroom the home was found to be warm, fresh smelling and clean throughout. The management of odours in one bedroom was discussed with the acting manager; it was agreed that they would review the issue further.

Infection prevention and control measures were adhered to and equipment was appropriately stored. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the provision and development of staff, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified with the delivery of safe care 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.

A review of seven patients' care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process.

Initial plans of care, based on the information available at the time of admission to the home, were put in place. The need to review the initial plans of care for patients in the dementia unit and develop them further as staff get to know the patients and their individual preferences was discussed; this was identified as an area for improvement under the standards.

We reviewed the recording of wound care for one patient. The care records contained a care plan which included the frequency with which the wound required to be redressed. An assessment was recorded at each dressing change and a review of these assessments evidenced that care was being provided as prescribed.

A care plan to manage the patient's risk of developing pressure ulcers included the frequency with which the patient was required to be repositioned for pressure relief. Pressure relieving equipment, for example mattresses and cushions, were in place. Repositioning charts were well maintained and generally evidenced that patients were assisted to reposition in accordance with the prescribed frequency. There was evidence that skin checks to identify redness or early detection of pressure ulcers were completed when the patient was repositioned.

We reviewed the management of catheter care for two patients. Care plans were in place which detailed the frequency with which catheters were due to be changed. Care records for one patient evidence that catheter care was managed appropriately; the catheter was changed regularly and no less than 12 weekly as detailed in the care plan. The second care record reviewed evidenced that the catheter had not been changed in accordance with the prescribed care. There was no system in place to alert staff to when the catheter was due to be change; the date the catheter was due for renewal had not been calculated and there were no entries in the unit diary, to act as an aid memoir, to alert the registered nurses at the time the change was due. This was identified as area for improvement under regulation. Records evidenced that patients' intake and urinary output were recorded daily and totalled at the end of every 24 hour period.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Discussion with the acting manager and 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.

The acting manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meetings were held on 18 December 2017.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the assessment of patient need and care planning; we observed good communication between patients, staff and visitors.

Areas for improvement

The following areas were identified for improvement in relation to the delivery of catheter care and the development of the initial care plans to include individual preferences

	Regulations	Standards
Total number of areas for improvement	1	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.

When we arrived in the home we were greeted by staff who were helpful and attentive. Patients were enjoying their breakfast in the dining rooms or in their bedrooms as was their personal preference; some patients remained in bed, again in keeping with their personal preference. There was a calm atmosphere throughout the home.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with six patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

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 are examples of comments provided by patients:

"5 star care home, staff are excellent both day and night."
"Everyone knows what to do and gets on with it…great teamwork."
"Food good."
"This is home for me…girls look after me very well."

We issued questionnaires for eight relatives; two were returned within the timescale for inclusion in this report. Both relatives were either very satisfied or satisfied that care was safe, effective and compassionate and that the service was well led. The following are examples of comments provided:

"I am confident that my loved one is treated with dignity and respect." (Dementia unit)
"…I can discuss any and all aspects of my … care with staff who are kind and committed." (Dementia unit)
"Everything is great; cleanliness, visiting and staff team." (Intermediate care scheme)

Discussion with the acting manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. The home continues to use the "Quality of Life" system which patients, relatives/visitors and staff can access through the portable iPad available in the home. The acting manager confirmed that when a questionnaire is submitted they receive an alert by e mail and are required to review the completed questionnaire and respond to any areas for improvement.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy and listening to and valuing patients.

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.

Discussion with the acting manager and observation of patients evidenced that the home was operating within its registered categories of care. The most recent certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with the acting manager and staff evidenced that there was a clear organisational structure within the home. In discussion patients and relatives were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The acting manager's hours were clearly recorded in the home. Discussion with patients and staff evidenced that the acting manager's working patterns provided good opportunity to allow them contact as required.

Discussion with the acting manager and 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. The complaints record was well maintained with information of the action taken in response to complaints and a detailed response to the complainant.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. The following are examples of comments received on thank you cards:

"I would like to thank you all for the care you provide for my …. Knowing you are here for him makes his condition easier to deal with." (December 2017)

"Thank you so much to all the staff. The care and attention our … received was brilliant." (November 2017)

"Thanks for all the care you gave me. All the staff are brilliant, friendly and very helpful."

Discussion with the acting 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 care records, infection prevention and control, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been addressed.

Discussion with the acting manager and review of records from September 2017 to January 2018 evidenced that Regulation 29 monthly quality monitoring visits were completed in accordance with the regulations. 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.

Discussions with staff confirmed that there were good working relationships and that management were 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 Alfie Corvera, acting manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/acting 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(1) (a) **Stated:** First time **To be completed by:** 6 March 2018	The registered person shall ensure that proper provision is made for the nursing, health and welfare of patients. Catheters must be changed in accordance with the prescribed frequency. Ref: Section 6.4
	Response by registered person detailing the actions taken: Clinical Supervision has been conducted for all nurses on record keeping relating to catheters particularly on how to complete the catheter history in EPIC to alert nurses when the catheter is due for changing
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 4.7 **Stated:** First time **To be completed by:** 6 March 2018	The registered person shall ensure that the initial plans of care for patients in the dementia unit are develop further as staff get to know the patients and their individual preferences. Ref: Section 6.4
	Response by registered person detailing the actions taken: A Clinical supervision has been done for Nurses highlighting the timescale for completing a personalized care plan for new admissions, as well as updating care plans to reflect changes when needed.

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