Unannounced Care Inspection Report
7 & 8 September 2016

Lisburn Intermediate Care Centre

Type of Service: Nursing Home
Address: 119b Hillsborough Road, Lisburn, BT28 1JX
Tel No: 02892669523
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Lisburn Intermediate Care Centre took place on 7 September 2016 from 10:15 to 17:05 hours and 8 September 2016 from 09:00 to 16:00 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 systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises were generally well maintained. An area for improvement was identified to ensure that the garden/patio area in the dementia unit was kept safe and clean for use by the patients.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that the outcome of care delivery was positive for patients. Records evidenced that care was planned and delivered with support from a range of healthcare professionals, for examples physiotherapists and occupational therapists. Discussion with patients and observations made confirmed that there was a programme of active rehabilitation for patients receiving intermediate care. There were arrangements in place to monitor and review the effectiveness of care delivery.

We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. Patients and staff were of the opinion that the care delivered provided positive outcomes.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding day to day issues affecting them. Patients spoken with commented positively in regard to the care they received.

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure and staff were aware of their roles and responsibilities. A review of care confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.
There was evidence of good leadership in the home and effective governance arrangements. An area for improvement was identified with the recording of complaints. A recommendation was 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 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 medicines management inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 25 April 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 currently being concluded by the South Eastern Health and Social Care Trust in 2016. The registered manager confirmed that they had received a draft report of the investigation in June 2016. The final version had not been received at the time of this inspection. The registered manager was knowledgeable of the importance of ensuring that any recommendations made are fully addressed.

2.0 Service details

Registered organisation/registered person: Maureen Claire Royston	**Registered manager:** Judith Derby
Person in charge of the home at the time of inspection: Judith Derby	**Date manager registered:** 6 September 2013
Categories of care: NH-TI, NH-PH(E), NH-PH, NH-I, NH-DE	**Number of registered places:** 63

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events 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

During the inspection we met with eighteen patients individually and with the others in small groups, the deputy manager, two nursing sisters and a charge nurse, five care staff, a personal activity leader (PAL) and three patients' relatives. We also met with a GP and social worker who visited the home regularly.

Eight questionnaires were issued to patients. Ten questionnaires were also issued to relatives and staff with a request that they were returned within one week from the date of this inspection.

The following information was examined during the inspection:

- six patient care records
- staff duty roster for the week commencing 5 September 2016
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- reports of monthly quality monitoring visits

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 25 April 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 15 June 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref: Regulation 27** **Stated: First time** **To be Completed by: 03 August 2015**	The registered person shall ensure that the issues in relation to the environment in section 5.4.2.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that 55 bedrooms have been redecorated since the previous inspection and that a plan was in place for the remaining bedrooms. It was agreed that one identified bedroom would be prioritised. The practice of wedging open doors was not observed during this inspection. The registered manager confirmed that the flooring had been replaced as part of the odour management plan in the identified bedroom. Oxygen masks were observed to be stored appropriately. Information regarding patient's personal care was managed appropriately. This requirement has been met.	

Requirement 2 **Ref: Regulation 15** **Stated: First time** **To be Completed by:** **13 July 2015**	The registered person shall ensure that the identified care record is updated to meet the needs of the patient. **Ref: 5.4.3**	**Met**
	Action taken as confirmed during the inspection: The registered manager explained that the care records of the identified patient had been updated at the time; they was no longer resident in the home. A review of care records evidenced that systems were in place to ensure they were regularly reviewed and updated to meet the needs of the patients. This requirement has been met.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref: Standard 19** **Stated: First time** **To be Completed by:** **3 August 2015**	The registered person shall ensure that following the receipt of the new policy documentation in respect of on communicating effectively and palliative and end of life care, a system is implemented to ensure and verify that staff are knowledgeable of the policy documentation and regional guidelines.	**Met**
	Action taken as confirmed during the inspection: The registered manager explained that the home now had access to the “care blox” system; a multi-functional electronic communication system. Staff were required to log into this system at the beginning of each shift. A message, for example of a new updated policy or training, would then appear to alert staff. Staff are asked to confirm that they have actioned the alert. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the current occupancy of the home and the planned daily staffing levels. They advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 5 September 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic, laundry and maintenance staff were on duty daily. There were also three personal activity leaders (PAL) employed part time. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients commented positively regarding the staff and care delivery.

We also sought staff opinion on staffing via questionnaires; four were returned following the inspection. All of the respondents indicated that there was sufficient staff to meet the needs of the patients.

Staff spoken with were aware that a nurse was identified to be in charge of the home when the registered manager was off duty. The nurse in charge of the home was clearly displayed in the foyer of the home and on the staffing roster. 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 registered manager. The assessments were signed by the registered 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 one personnel file evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 21, schedule 2. The record maintained of Access NI checks included the unique identification number of the certificate. The records evidenced that the certificate had been received and checked prior to the candidate commencing employment.

Discussion with the registered manager and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed. The registered manager was knowledgeable regarding the management of the Northern Ireland Social Care Council (NISCC) registration process for newly employed care staff.

Discussion with staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The programme included a written record of the areas completed and the signature of the staff member and the person supporting the new employee. On completion of the induction programme the registered manager signed the record to confirm that the induction process had been satisfactorily completed.

Training was available via an e learning system and internal face to face training arranged by FSHC. Training opportunities were also provided by the local health and social care trust. Systems were in place to monitor staff attendance and compliance with training.

These systems included a print out of which staff had completed an e learning training and signing in sheets to evidence which staff had attended face to face training in the home. An individual training record was also maintained for all staff.

A review of the print out of mandatory training evidenced good compliance; for example in 2016 88% of staff have completed fire safety, 85% moving and handling and 91% adult safeguarding training. Training was ongoing in 2016.

The registered manager confirmed that systems were in place for staff supervision to ensure that all staff received supervision a minimum of four times per year. Supervision was conducted in individual and group sessions depending on the nature of the focus of supervision. Records of supervision were not reviewed. Appraisals were completed annually by the registered manager, deputy manager and sisters/ charge nurse.

Review of six patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. The registered nurses and care staff were aware of whom to report concerns to within the home. Annual refresher training was considered mandatory by the home.

Discussion with the registered manager and a review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A monthly analysis of accidents to identify any trends or patterns was included in the monthly programme of audits undertaken.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. All of the responses we received in the returned questionnaires confirmed that this was normal for the home. The paths of the patio area for the dementia unit had a heavy presence of moss which made the surface slippery; the garden furniture required cleaning. The Personal Activity Leader (PAL) explained that they used the patio area to provide the patients with some time outdoors. A recommendation was made to ensure that the garden/patio area was kept safe and clean for the use by the patients.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for improvement

The moss on the paths in the garden/patio area of the dementia unit should be removed and the garden furniture cleaned to ensure the area is safe and clean for the patients to use.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

A review of six care records evidenced that initial plans of care were based on the pre admission assessment and referral information. A comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home. A range of assessments were completed for patients admitted for intermediary care with input from the referring health care trust. As previously discussed validated risk assessments were completed as part of the admission process for all patients.

There was a programme of active rehabilitation, involving the appropriate healthcare professionals, for example physiotherapist and occupational therapist, to support and enable patients in the intermediary care scheme to return home. Discharge planning was included in the care plans for these patients.

Care records detailed correspondence with patients' General Practitioners (GP) and evidenced ongoing contact by staff when further treatment or review was required. 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.

A review of wound care records for three patients evidenced that details of the wounds and frequency with which they required to be dressed were recorded in the patient's care records. The care record contained an initial wound assessment and an assessment of the wound following each dressing renewal. Review of completed wound assessment records evidenced that prescribed dressing regimes were adhered to. Repositioning charts were maintained for patients who required assistance with postural changes; charts for one patient evidenced that positional changes were carried out regularly.

There was evidence within the care records of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home. Weekly meetings took place with staff from the local health and social care trust to review the care and progress of patients receiving intermediate care.

Discussion with the registered 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. Staff spoken with confirmed that they were provided with the necessary information regarding patients' condition.

The registered manager confirmed that staff meetings were held regularly with all staff teams. Due to the differing nature of the services delivered over the three floors of the home the registered manager explained that they meet with each staff team individually to discuss the issues relevant to their service. In addition the registered manager also meets with the registered nurses as a team to discuss professional nursing and operational issues. Records of attendees, the issues discussed and agreed outcomes were maintained for all meetings. The most recent meeting was held in August 2018 with the registered nurses; team meetings were held on a number of dates throughout June 2016. Records evidenced that the registered manager and house keeper also met with the domestic and laundry staff in June 2016.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff confirmed that if they had any concerns, they would raise these with the registered manager.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. They explained that they had regular, daily contact with the patients and visitors and were available, throughout the day, to meet with both on a one to one basis if needed. Patients and relatives spoken with confirmed that they knew who the registered manager was, that she was regularly available in the home to speak with and that they were confident in raising any concerns they may have with the staff and/or management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference.

Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients' likes, dislikes and individual preferences. We were assured by the observed interactions that patients were treated with dignity and respect.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. Observation of care delivery evidenced that patients were assisted appropriately and in a timely manner. Patients spoken with were satisfied that staff responded to nurse call bells promptly.

The provision of activities in the dementia unit was reviewed and we spoke with the personal activity leader (PAL) based in this unit. They explained that activities were planned on both a group and one to one basis. The PAL had taken up post a few months prior to the inspection. We discussed their induction and training opportunities related to the PAL post. The PAL expressed an interest in further training specific to activities and dementia. This was discussed with the registered manager who explained that a series of training on dementia related topics was planned for October 2016; this training included a session on communication, engagement and activities specific to patients with dementia. Assurances were provided that the PAL would be attending this training in keeping with the new dementia framework; an internal initiative by Four Seasons Heath Care (FSHC).

We spoke with the relatives of three patients who commented positively with regard to the standard of care, the attentiveness of staff and communication in the home. Relatives confirmed that they were made to feel welcome into the home by all staff.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. Patient and relatives' meetings were held approximately every six months. A record of who attended and the issues discussed was maintained and available in the home. The most recent meeting was held on 23 June 2016; the records reflected that seven relatives attended.

There were systems in place to regularly obtain the views of patients, their representatives, and staff on the running of the home. A 'Quality of Life' feedback system was available at the reception area. This was an iPad which allowed relatives/ representatives, visiting professionals and/or staff to provide feedback on their experience in the home. A portable iPad was also available to record feedback from patients. The registered manager explained that, on a daily basis, staff take the iPad to different units in the home to ensure all patient or relative who wishes to provide feedback are afforded the chance to do so. Anyone completing the feedback has the option to remain anonymous or leave their name. Management have the option to contact people who leave their contact details to gain further clarification on the feedback received. Any complaints received via the "Quality of Life" system would also be recorded in the record of complaints and addressed through the complaints process.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are examples of comments received:

"Without exception all of your colleagues who were involved in his care exercised total professionalism and compassion making what was a difficult period for the family less stressful…"

"…they worker really well as a team bouncing off one another. That is all staff, from the kitchen staff, carers and nursing staff."

Eight patient questions were issued to patients. All were returned following the inspection. All of the respondents indicated that they were very satisfied or satisfied with their patient care.

Ten relative questionnaires were issued; nine were returned prior to the issue of this report. Responses were received from each of the units within the home. All of the respondents indicated that, overall, they were satisfied or very satisfied with the care. In response to the question "Is the home generally clean and fresh smelling" the following comments were received from two relatives:

"Mostly but not always…"
"…there was a smell that certainly wasn't fresh."

These comments were shared with the registered manager who agreed to address the issues generally with staff.

Ten questionnaires were issued to nursing, care and ancillary staff; four were returned prior to the issue of this report. All of the respondents indicated that they were very satisfied with patient care.

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?

The 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 staff, a review of care records and observations confirmed that the home was operating within the categories of care registered.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff spoken with were knowledgeable regarding the line management arrangements within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships; staff stated that management were responsive to any suggestions or concerns raised.

Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients and their representatives confirmed that they were confident that staff and/or management would address any concern raised by them appropriately.

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint and the action taken by the registered manager. The records evidenced if the complaints recorded were closed. However there was no information to indicate how the registered manager had concluded that the complaint was closed. The recording of complaints should be further developed to include how the complainant's level of satisfaction was determined. A recommendation was made.

There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

As previously discussed there were systems in place to ensure that notifiable events were investigated as appropriate and reported to the relevant bodies. The registered manager completed a monthly analysis of falls to identify any trends or patterns.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included care records, accidents and incidents and the management of restraint, for example bedrails and alarm mats.

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. A copy of the report was maintained and available in the home; the report included an action plan to address any identified areas for improvement. There was evidence in the reports that the action plans were reviewed during the next visit.

Areas for improvement

The recording of complaints should be further developed to include how the complainants' level of satisfaction was determined.

Number of requirements	0	Number of recommendations	1

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 nursing.team@rqia.org.uk 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: No Requirements are stated as a consequence of this inspection.

Recommendations	
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. **Ref section 4.3**
To be completed by: 10 October 2016	**Response by registered provider detailing the actions taken:** Garden furniture has been cleaned and will be monitored by Maintenance staff. Moss removal has been costed and approved for removal, date to be confirmed.
Recommendation 2 **Ref**: Standard 16.11 **Stated:** First time	It is recommended that the recording of complaints should be further develop to include how the complainants' level of satisfaction was determined. **Ref section 4.6**
To be completed by: 10 October 2016	**Response by registered provider detailing the actions taken:** Manager will record complainants level of satisfaction on the record of complaints where possible

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

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