Unannounced Care Inspection Report
13 June 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

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

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: 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.. TI – Terminally ill.	**Number of registered places:** 63 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).

4.0 Inspection summary

An unannounced inspection took place on 13 June 2017 from 09:00 to 15:00.

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 staffing, risk management and the home's environment. Staff were knowledgeable regarding patient need and the management of swallowing difficulties and the recommended plans prescribed by speech and language therapists. We observed good working relations between staff in the home.

One area requiring improvement was identified with care plans and a recommendation was made.

Patients spoken with were complimentary regarding the care they received. Seven patients receiving intermediate care completed questionnaires during the inspection; all of the respondents were either very satisfied or satisfied that the care they were receiving was safe, effective, compassionate and well led. No additional comments were received.

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 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.

4.2 Action/enforcement taken following the most recent inspection dated 26 January 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 13 June 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this 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 the inspector met with 13 patients individually and with others in small groups, one nursing sister, one charge nurse, two registered nurses and five care staff. Eight patients receiving intermediate care completed questionnaires during the inspection. Questionnaires were also left in the home to obtain feedback from patients' relatives and staff not on duty during the inspection.

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 nursing and care staff for week commencing 12 May 2017
- five patient care records
- two patient care charts including food and fluid intake charts and reposition charts

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 26 January 2017

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.

6.2 Review of areas for improvement from the last care inspection dated 26 January 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (1)(b) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Staff spoken with were knowledgeable regarding which patients required supervision at mealtimes. We observed the serving of breakfast in the dementia unit and the serving of lunch on the first floor. Staff were observed to supervise patients appropriately. A review of staff allocation sheets evidenced that staff were allocated to oversee the dining room or deliver meals to patients in their rooms and provide the required assistance . This requirement has been met. Mealtimes are further discussed in section 6.4.	

Area for improvement 2 **Ref:** Regulation (14(2)(c) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of five patients care records evidenced that risk assessments and care plans consistently identified the risk of patients choking. Staff were knowledgeable of patients at risk of choking and who required supervision. This requirement has been met.	
Area for improvement 3 **Ref:** Regulation 13(1)(a) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Observations of care evidenced that this recommendation has been met.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4.7 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Care records reviewed contained details of the patients' needs and daily care delivered. Records were updated to reflect any change to patients' condition. This recommendation has been met.	

Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of two patients repositioning charts evidenced that this recommendation 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 registered manager confirmed the planned daily staffing levels for the home. A review of the staffing rota for week commencing 12 June 2017 evidenced that the planned staffing levels were adhered to. Observation of the delivery of care confirmed that patients' needs were met by the levels and skill mix of staff on duty. No concerns were identified with staffing levels during discussion with patients. Patients were satisfied that when they required assistance staff attended to them in timely manner. Seven patients receiving intermediate care completed questionnaires during the inspection; all of the respondents replied "yes" to the question "Are there enough staff to care for you?" Six respondents indicated they were very satisfied and one was satisfied with staffing and the delivery of safe care.

In one unit staff expressed concern regarding the high dependency of patients and the impact on staffing. Staff confirmed that they had discussed their concerns with the registered manager and were confident that she would address them. We sought staff opinion on staffing via questionnaires. Five of the eight staff who returned questionnaires were satisfied that there were sufficient staff to meet the needs of the patients. Three staff did not feel there were sufficient staff; they commented on the dependency of patients in one identified unit.

We sought relatives' opinion on staffing via questionnaires. Six were returned within in time for inclusion in the report. All of the respondents were satisfied that staff had sufficient time to care for their relative. One relative commented:

"I have total confidence in the staff and know they have their residents care and protection at the forefront of their care and handling procedures."

One member of staff on duty was supplied by an employment agency. They confirmed that when they arrived on duty they had received an induction to the home which included fire safety and the systems in place to communicate patient need, for example which patients required modified diets.

We observed that systems were in place to ensure accidents and incidents were recorded appropriately. Discussion with the registered manager evidenced that following a recent incident advice had been sought from Four Seasons Health and Safety Officer. Following this advice discussions were held with the patient, their relatives and the local health and social care trust to agree a protection plan to minimise the risk of a reoccurrence. Notification of the incident was also forwarded to RQIA.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Fire exits and corridors were observed to be generally clear of clutter and obstruction.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, induction of agency staff, 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.

We reviewed five patient care records, four in the dementia nursing unit and one in the general nursing unit, and two patients' repositioning charts.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as speech and language therapist (SALT) or 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.

Care records evidenced that when changes were noted to patients' conditions referrals were made to the relevant healthcare professionals. Entries in one care record reflected that following a referral to SALT staff had liaised with the patient's GP and family and agreed actions to be taken to maintain the patient's safety until they were assessed. This is good practice.

Supplementary care charts, for example repositioning charts evidenced that records were maintained in accordance with best practice guidance, care standards and legislation. Staff demonstrated an awareness of the importance of contemporaneous record keeping.

We observed the serving of breakfast in the dementia unit and lunch for the patients on the first floor. Staff were present in the dining rooms and lounge throughout the meal times and assistance was offered in a timely manner. Patients were provided with modified diets in accordance with SALT recommendations. As previously discussed staff spoken with were knowledgeable of individual patient need and those patients who required a modified texture meal. Care plans in place were reflective of the recommendations made by the SALT. One care record reflected a patient's non-compliance with the level of supervision recommended by the SALT; care records evidenced that the patient had capacity to make informed decisions. Following discussion with staff we observed how they unobtrusively observed the patient in an attempt to provide as much supervision as possible. The actions of the staff to provide a level of supervision was not reflected in the care plan. This was identified as an area for improvement in accordance with standards.

The dining tables were nicely set with cutlery and napkins. Patients who remained in their bedrooms had their meals served on a tray; we observed that the meals were covered prior to leaving the dining room. Patients confirmed that they were offered a number of choices at mealtimes; they were complimentary regarding the quality and variety of food provided. Salt and pepper was available in sachets on each table. Patients reported that they found the small sachets hard to open and often had to ask staff for assistance. This was shared with the registered manager who agreed to review how condiments were provided and consider re-introducing traditional salt and pepper pots.

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 their line manager and /or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records, management of swallowing difficulties, staff knowledge of patient need and the serving of meals.

Areas for improvement

There was one area for improvement identified under the standards in relation to the further development of a care plan.

	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 09:00. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were observed either in their bedrooms as was their personal preference, walking around the home or seated in the dining room or lounge areas again in keeping with their personal preference. Staff interaction with patients was observed to be compassionate, caring and timely. Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients spoken with were complimentary regarding the care they received.

There was evidence that patients were involved in decision making about their care. Patients were consulted with regarding meal choices and were offered a choice of meals, snacks and drinks throughout the day. Staff encouraged those patients who could express their preference to do so and demonstrated a detailed knowledge of patients' likes and dislikes for those patients who were unable to express their opinion.

As previously discussed, seven patients receiving intermediate care completed questionnaires during the inspection; all of the respondents were either very satisfied or satisfied that the care they were receiving was safe, effective, compassionate and well led. No additional comments were received.

Questionnaires were also issued to ten relatives; six were returned within the timescale for inclusion in this report. The relatives were either very satisfied or satisfied with care provided across the four domains. The following comments were provided by a relative from the dementia unit:

"The nursing staff and care staff are friendly and approachable. They know the residents wasy and needs and treat them with care and compassion."
"I have witnessed many compassionate interactions between staff and residents…ther eis genuine warmth to their care."

We issued ten questionnaires to nursing, care and ancillary staff; eight were returned within the timescale for inclusion in this report. Staff were either very satisfied or satisfied with the care provided across the four domains. As previously discussed in section 4.3 and 4.4 individual comments were discussed with the registered manager following the inspection.

Any comments from relatives and staff in returned questionnaires received after the return date will be 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 mealtimes, patient choice and dignity and privacy.

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 registered manager and staff evidenced that there was a clear organisational structure within the home. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

A nurse was identified on the staffing rota to take charge of the home when the registered manager was off duty; this information was also clearly displayed in the foyer of the home to inform visitors who was in charge when they arrived in the home.

Discussion with the registered manager, 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 review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

The registered manager confirmed that the regional manager was in the home regularly to provide support and assistance as required. An unannounced quality monitoring visits were also completed on a monthly basis by the regional manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements 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 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 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.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref**: Standard 12.7 **Stated:** First time **To be completed by:** 11 July 2017	The registered person shall ensure that supervision arrangements at mealtimes for the identified patient are reflected in the care plan. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: The identified patients care plan has been updated to reflect the supervsion arrangements in place for meal times. This will be monitored for all residents during the audit processs.

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

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