Unannounced Care Inspection Report
6 and 7 October 2016

Bradley Manor

Type of Service: Nursing Home
Address: 420 Crumlin Road, Belfast, BT14 7GE
Tel no: 028 9074 5164
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Bradley Manor took place on 6 October 2016 from 10.00 to 17.00 hours and 7 October 2016 from 09.30 to 15.45 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?

There were safe systems in place for the recruitment and selection of staff. Registration checks were conducted on a regular basis to ensure that all staff were registered with the relevant professional bodies. New staff completed an induction programme and there were systems in place to monitor staff performance and compliance with mandatory training. The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adults safeguarding and any potential safeguarding concern had been managed appropriately and in accordance with the regional safeguarding protocols. The home was clean, well decorated and warm throughout. Infection prevention and control measures were adhered to and fire exits and corridors were maintained clear from clutter and obstruction.

Is care effective?

A range of risk assessments were completed and the outcomes were reflected in the care plans. With the exception of two issues identified in the management of the elimination needs of patients, there was evidence that outcomes of the assessments had informed the care planning process. Communication was well maintained in the home and all those consulted with expressed their confidence in raising concerns with the home's staff/ management. Two recommendations have been made.

Is care compassionate?

Staff interactions were observed to be compassionate, caring and timely and all patients and relatives consulted with provided positive comments in relation to the care. Patients, relatives and staff were very positive in their comments regarding the quality of nursing and other services provided by the home. Communication systems were well established and innovative. There was an active and varied activities programme both internally and external to the home with many links with the local community having been established.

Is the service well led?

There was a clear organisational structure within the home. All comments received in relation to the responsiveness of the registered manager were positive. The home was observed to be operating within the categories of care for which the home is registered. RQIA had been informed appropriately of any notifiable incidents and there were systems in place to review urgent communications, safety alerts and notices where appropriate. There were systems in place to monitor and report on the quality of nursing and other services provided

The term 'patients' is used to describe those living in Bradley Manor which provides both nursing and residential care.

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 Mandy Mitchell, 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 2 February 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.

2.0 Service details

Registered organisation/registered person: Healthcare Ireland (Belfast) Limited Gilbert Yates	**Registered manager:** Amanda Mitchell
Person in charge of the home at the time of inspection: Amanda Mitchell	**Date manager registered:** 16 July 2015
Categories of care: NH-DE, NH-I, RC-DE	**Number of registered places:** 82

3.0 Methods/processes

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 plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with 15 patients individually, six care staff, the activities coordinator, three registered nurses, four patient's representatives and a professional from a health and social care trust.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- staff training records
- accident and incident records
- notifiable incidents
- quality audits
- records relating to adult safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- staff, patients' and patients' representative questionnaires
- monthly 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 2 February 2016

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

The completed QIP was returned and approved by the care inspector and was validated during this inspection. Refer to section below for details.

4.2 Review of requirements and recommendations from the last care inspection dated 2 February 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 44 **Stated:** First time	Temperatures on the first floor should be monitored and recorded daily to ensure that these meet the standard expected. Any deficits identified should be appropriately addressed and records maintained.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed temperatures throughout the home are monitored and recorded by maintenance personnel. There have been no further issues regarding room temperatures.	

Recommendation 2 **Ref:** Standard 12, criterion 6 **Stated:** First time	The menu in the dining rooms should be displayed in an accessible format for patients.	**Met**
	Action taken as confirmed during the inspection: A written and pictorial menu was displayed in the four dining rooms in the home.	
Recommendation 3 **Ref:** Standard 35, criterion 7 **Stated:** First time	The starting and finishing times of the monthly quality monitoring visits should be documented on the report.	**Met**
	Action taken as confirmed during the inspection: A review of three monthly monitoring reports completed in accordance with Regulation 29 The Nursing Homes regulations (Northern Ireland) 2005, confirmed the time of commencing and finishing the monthly visits were stated on the reports.	

4.3 Is care safe?

There were safe systems in place for the recruitment and selection of staff. A review of three personnel files evidenced that these were reviewed by the home's human resources officer and the registered manager and checked for possible issues. Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidence that enhanced criminal records checks were completed with AccessNI and the reference number and date received had been recorded.

There was evidence that new staff completed an induction programme to ensure they developed their required knowledge to meet the patients' needs. Staff consulted confirmed that they received induction and shadowed experienced staff until they felt confident to care for the patients unsupervised.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on a range of topics including; medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, moving and handling and adult prevention and protection from harm. Individual staff members have either completed, or are in the process of completing, dementia specific training for example; Dementia Champion training, 'My Home Life' facilitator training and Best Practice in Dementia Care for Healthcare Assistants, a staff member had completed this training course and was validated to be the facilitator for the training of other staff.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

The staff consulted with were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The complaints and safeguarding records provided evidence of incidents. A review of the records identified that concerns had been logged appropriately. A review of documentation confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. The review of the duty rota from 3 October to 16 October 2016 confirmed the planned staffing levels were adhered to. There were no issues raised by patients, staff or patient representatives regarding the staffing arrangements of the home.

A range of risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails, if appropriate; regular repositioning due to a risk of developing pressure damage and wound assessment, if appropriate, and assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. The risk assessments generally informed the care planning process.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident. Care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken and included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, tidy, well decorated and warm throughout. The home was very spacious with various areas for patients to choose to sit. A dementia café and family room were available. These facilities afforded relatives and visitors the opportunity to have a cup of tea or coffee in a comfortable and more domestic style environment. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

The home used an electronic system to record the assessing and planning of patients' care needs. A review of six patient care records evidenced that risks to patients were reassessed on a regular basis. These assessments included assessments in moving and handling, falls, wounds/pressure ulcers, nutrition, bed rails and choking. The review of care records evidenced that risk assessments were completed as part of the admission process and were reviewed as required. There was also evidence that risk assessments informed the care planning process. For example, where a patient had a wound, there was evidence of regular wound assessments and review of the care plan regarding the progress of the wound. A review of the daily progress notes evidenced that the dressing had been changed according to the care plan.

Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. However, the review of the care records did not evidence that nursing and care staff were consistently monitoring the bowel function of patients. Two issues arose and were discussed with the registered manager and staff. Firstly, care staff should be directed to record bowel function in a particular section of the care record. Currently there were a number of areas where staff were recording this and therefore an accurate assessment of individuals' bowel function was not possible. Secondly, registered nurses should monitor and report on patients' bowel function on a daily basis and record any action taken. The review of care records evidenced that on occasions patients' bowel function was not regulated for up to nine days. A recommendation has been made.

The unit manager of each of the four suites completes an audit of care records. The issues identified at inspection should have been identified during the audits of care records. The care record proforma in use was reviewed and as discussed with the registered manager, should be revised to audit more than if a care plan is in place. A more robust audit is recommended.

The care records reflected the assessed needs of patients were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

There was evidence of regular communication with patient representatives within the care records, regarding changes in the patients' condition. Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and it provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective. Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff, patients and patients' representatives consulted with expressed their confidence in raising concerns with the home's staff/ management.

Discussion with the registered manager and review of records evidenced that relatives meetings were held on a regular basis and records were maintained. The activities coordinator convenes patients meeting on a three monthly basis and minutes of the meetings detailing actions taken as a result of the meeting were available.

Observation of the mid-day meal confirmed that dining tables were attractively set, a range of condiments were available and patients, including patients who required a modified diet, were afforded a choice of meals at mealtimes. Meals were delivered on trays to patients who choose to not come to the dining room, the meal was appropriately covered and condiments and the patients preferred choice of drink , for example; juice or milk were on the tray. The meal time was not rushed in any manner and there were sufficient staff on duty to assist patients with their meal. A registered nurse was present in the dining room to assist and monitor patients' nutritional intake. The home has the facility of a 'snack' kitchen on the ground and first floors which is frequently used on a daily basis by relatives/visitors and patients.

The mid-morning tea trolley was also observed. Patients were offered a choice of snack including fresh fruit, yoghurts and biscuits.

Areas for improvement

Care records should accurately and consistently evidence that patients' bowel function is being monitored on a daily basis. Care staff should be informed of where to report/record on bowel function and evidence should be present that registered nurses are monitoring individuals' bowel function on a daily basis and that they record any action to this regard that may be required.

A robust system of quality auditing of care records should be established. The current audit proforma should be revised and enhanced, so as a more comprehensive audit is in use.

Number of requirements	0	**Number of recommendations**	2

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed 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.

We were impressed by the level of engagement in meaningful activities by staff throughout the home. The activities coordinator was very enthusiastic and was keen to provide a varied range of activities both internally and outside of the home. Links with the local community have been established and children and young people from local schools are actively involved in the life of the patients in the home. The home has established a volunteer network and currently a volunteer, who was previously a visiting relative, comes to the home five days per week.

Patients have attended tea dances organised by local community groups and the home recently hosted a 50th Wedding Anniversary wedding renewal vows celebration with lunch and entertainment provided. The home also keeps relatives and visitors informed of events and occasions in the home via their social media website. The activities coordinator produces a newsletter which is available for patients and relatives, on a regular basis.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Views and comments recorded were analysed and an action plan was developed and shared with staff, patients and representatives. Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Consultation with patients individually, and with others in smaller groups, confirmed that living in Bradley Manor was a positive experience.

Patient comments to the inspector included:
'So far no complaints whatsoever.'
'Nice lot of people, very attentive.'
'If I had any problems I would say.'
'Very good here, staff are always around''

Comments received from relatives included:
'It's like a 5* star hotel'
'Staff are second to none'

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. However, one relative commented that they felt the home was understaffed. The registered manager should consider and action, if appropriate, the comment received from the relative

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 roles and responsibilities. In discussion patients knew the staff in the home and whom they should speak to if they had a concern.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed. Discussion with the registered manager and observations evidenced that the home was operating within its registered categories of care.

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. Representatives spoken with, and those who responded by questionnaire, confirmed that they were aware of the home's complaints procedure. Staff and representatives confirmed that they were confident that staff and management would manage any concern raised by them appropriately. Numerous 'thank you' cards were viewed from the relatives and patients who had been in the home. The cards were displayed in the entrance foyer

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. A review of notifications of incidents to RQIA since the last care inspection in February 2016 confirmed that these were managed appropriately.

Discussion with the registered manager and staff, and a review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. Audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints and incidents/accidents. The results of these 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. However, as stated in section 4.4 a recommendation has been stated regarding the establishment of a more robust audit of patient care records.

Discussion with the registered manager and review of records for July, August and September 2016 evidenced that unannounced monthly quality monitoring visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations and/or care standards. 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. There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised, as discussed in the previous sections.

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 Amanda Mitchell, 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

Recommendations	
Recommendation 1 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that care records accurately and consistently evidence that patients' bowel function is being monitored on a daily basis. Care staff should be informed of where to report/record on bowel function in care records and evidence should be present that registered nurses are monitoring individuals' bowel function on a daily basis and record any action to this regard that may be required. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: This has been addressed through supervision and training and will be monitored through internal audit by unit managers and manager
Recommendation 2 **Ref:** Standard 35.3 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that a robust system of quality auditing of care records should be established. The current audit proforma should be revised and enhanced so as a more comprehensive audit is in use. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: A new audit has been implemented and will be monitored through internal audits by unit managers and manager

Please ensure this document is completed in full and return via web portal

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