Unannounced Care Inspection Report
25 October 2016

Bloomfields

Type of Service: Nursing Home
Address: 115-117 North Road, Belfast, BT5NF
Tel no: 0289065 7799
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Bloomfields took place on 25 October 2016 from 09 30 hours to 16 30 hours.

The inspection sought to assess progress with any issues raised during and since the previous 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 and grounds were well maintained.

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

Is care effective?

Evidenced gathered confirmed that there were systems and processes in place to ensure that the outcome of care delivery was positive for patients. We examined the systems in place to promote good communication between staff, patients and relatives and were assured that these systems were effective. Patients, relatives and staff were of the opinion that the care delivered provided positive outcomes.

A review of care records confirmed that patients were assessed and care plans were created to manage and direct the care required. One area for improvement was identified regarding the recording of wound care and a recommendation was made. There were arrangements in place to monitor and review the effectiveness of care delivery.

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. Numerous compliments had been received by the home from relatives and friends of former patients. Systems were in place to ensure that relatives were involved and communicated with regarding issues affecting them. Those patients who were able to offer their opinion spoke positively in regard to living in the home; those who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable.

One area for improvement was identified with the annual quality report and a recommendation was made.

Is the service well led?

There was a clear organisational structure evidenced within Bloomfields and staff were aware of their roles and responsibilities. A review of care observations 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 leadership in the home and effective governance arrangements. Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. There were systems in place to monitor the quality of the services delivered.

There were no areas of improvement identified in the domain of well led.

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 Mr Desmond McLaughlin, registered person and Ms Jincy Mathew, 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 7 June 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: Desmond McLaughlin Jean McLaughlin	**Registered manager:** Jincy Mathew
Person in charge of the home at the time of inspection: Jincy Mathew	**Date manager registered:** 14 March 2016
Categories of care: NH-DE	**Number of registered places:** 36

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 all of the patients informally, one registered nurse, four care staff, a member of housekeeping staff, the administrator, one visiting healthcare professional and the relatives of three patients.

The following information was examined during the inspection:

- staff duty roster for the week commencing 24 October 2016
- three patient care records
- staff training records
- staff induction records
- staff recruitment records
- records of staff NMC/NISCC registration
- 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 7 June 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 25 May 2016.

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. They 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 24 October 2016 evidenced that the planned staffing levels were adhered to. Nursing and care staff spoken with were generally satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff and relatives opinion on staffing via questionnaires; four staff and two relatives questionnaires were returned following the inspection. All of the respondents were very satisfied or satisfied that care was safe; two staff answered no to the question “Are there sufficient staff to meet the needs of the patients?” One respondent commented on the affect the dependency of patients had on staffing. This comment was shared with the registered manager.

The registered manager and registered nurses spoken with were aware of who was in charge of the home when the manager was off duty. The nurse in charge on day and night duty was clearly identified 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 was reviewed and evidenced that the certificate had been 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 and administrator were 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 employee 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 management. An annual training plan was in place with a number of trainings identified to be completed each month. Practical training, for example manual handling and fire, were contracted by the home from external training agencies. 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. The registered manager explained that they check compliance with the training plan on a monthly basis. Signing in sheets were also available to evidence which staff had attended face to face training in the home. Staff were of the opinion that the training provided was relevant to their role and responsibilities within the home.

A review of the print out of mandatory training evidenced good compliance with training in 2016; for example to date 100% had attended adult safeguarding training and 98% dementia training. Training was ongoing for 2016.

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

Review of patients' care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk.

The registered manager and staff 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.

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 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. Both of the relatives' responses in the returned

questionnaires confirmed their satisfaction with the environment of the home. One staff member in their returned questionnaire commented that the carpets and furniture were in need of replacing; the registered manager informed us during the inspection that a refurbishment plan was ongoing throughout the home.

Fire exits and corridors were observed to be clear of clutter and obstruction. Fire safety training took place in the afternoon of the inspection.

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

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?

A review of three patient 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. As previously discussed a range of validated risk assessments were completed as part of the admission process. Care records were regularly reviewed and updated, as required, in response to patient need.

One of the three records we reviewed was with regard to wound care. A review of the wound charts for the period 17 September to 22 October 2016 evidenced that generally wounds were redressed in accordance with the recommended frequency. There were variances in the information recorded at each dressing changes. Some registered nurses commented on the condition of the wound and any improvement/deterioration noted others only recorded that the dressing had been renewed. An assessment of the wound should be recorded at each dressing change in keeping with best practice, a recommendation was made.

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.

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.

Additional records such as repositioning charts and food and fluid intake charts were maintained in accordance with care standards and legislative requirements. Each patient had a daily fluid target identified. We discussed the importance of ensuring targets set were achievable. The registered manager explained that an initial target was identified on admission using a recognised calculation; the patient's actual fluid intake would be monitored for a period and then reviewed with the GP to identify an achievable target, this was recognised as good practice and patient centred. Staff demonstrated an awareness of the importance of contemporaneous record keeping.

We observed the serving of lunch to patients on the first floor. There was a dining area in the lounge and recently a separate dining room had been added to the home. This was a bright spacious room, tastefully decorated in a style which reinforced to the patients the purpose of the room. The dining room was not used during the inspection. Instead patients were assisted to the tables provided in the dining space of the lounge or were provided with individual tables at their lounge chairs. The use of the new dining room was discussed with the registered manager who confirmed that it was generally used; they agreed to monitor the use of the dining room which provides an environment more conducive to a positive dining experience.

There was a choice of two meals on the menu and this choice was also available for patients who required a modified diet. Staff explained that patents were supported to choose which meal they would like; for those patients who were unable to indicate a preference staff would choose, taking into account the patients' likes and dislikes. The serving of the meal was unhurried and patients spoken with reported that they enjoyed the food.

The registered manager confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff spoken with confirmed that a verbal handover took place and a written handover report completed every 24 hours for the registered manager. In the questionnaires issued to staff we asked if they received an effective handover at the start of each shift. Three of the respondents confirmed that they did. Comments in the fourth questionnaire were shared with the registered manager.

The registered manager confirmed that staff meetings were held regularly with staff. Records of the issues discussed and agreed outcomes were maintained. A review of the minutes of meeting evidenced that in 2016 the registered manager had met with each staff team. Minutes of these meetings, detailing who had attended and the areas discussed, were available. The most recently recorded meeting was with the night staff on 2 September 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.

Areas for improvement

An assessment of wounds should be recorded at each dressing change in keeping with best practice.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Throughout the inspection there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. 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.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took

time to find out what the patients wanted. Patients spoken with were content in their surroundings; one patient commented that the tea and cake were “some of the best in Belfast.” Another patient spoken with was anxious regarding her bedroom and who could access it, they also were dissatisfied with the meals. The issues raised were discussed with the patient’s relatives who was visiting. With agreement we shared the issues with the registered manager who agreed to speak with the patient and their family to try and alleviate some of the patient’s concerns.

Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

Relatives confirmed that they were made to feel welcome into the home by all staff. They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

“A belated thank you for making ….birthday so memorable and a special thank you to the chef for the lovely cake.”

“I wanted to express my heartfelt thanks to all of you for your patience, expertise and care for … whilst he was at Bloomfields.”

“Thank you to all the team at Bloomfields for your care, dedication and kindness to …. We can’t put into words how much we appreciate all you have done.”

We spoke with the relatives of three patients who all commented positively with regard to the standard of care, the attentiveness of staff and communication in the home.

We discussed what systems were in place to obtain the views of relatives and inform them of issues and initiatives affecting the home. The registered manager explained that quality assurance questionnaires were sent out annually to relatives. These were last completed in January 2016 with a return rate of 57%. The results were analysed and included in the annual quality report completed in March 2016. There were some areas for improvement suggested in the returned questionnaires; for example a request for an additional armchair in bedroom for visiting and suggestion to the menu. There was no evidence of the action taken in response to the comments made. We were assured through discussion with the registered manager that action had been taken. The benefits of making reference to the action taken in the report were discussed and a recommendation made.

Ten relative questionnaires were issued; two were returned within the timescale for inclusion in this report. The respondents indicated that they were very satisfied or satisfied that the care was safe, effective and compassionate and that the service was well led. There were no additional comments provided.

Ten questionnaires were issued to nursing, care and ancillary staff; four were returned prior to the issue of this report. All of the staff were either very satisfied or satisfied the care was safe, effective and compassionate.

Comments provided regarding staffing and the environment were discussed within the domain of safe care in section 4.3. Comments regarding leadership in the home are discussed in section 4.6. All of the comments were shared with the registered manager.

We spoke with one healthcare professional who visited the home regularly. They commented positively on the outcome of care for patients and the good communication between the registered manager, staff and the healthcare trust.

Areas for improvement

Any areas for improvement suggested in returned annual quality assurance questionnaires and the action taken to address the issues should be included in the annual quality report.

Number of requirements	0	Number of recommendations	1

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 home.

Discussion with the registered manager, staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were displayed and available in the reception area of the home.

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 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.

The registered manager 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. Relatives spoken with confirmed that she was approachable and regularly available in the home to speak with. We also sought relative and staff opinion on leadership in the home via questionnaires. As previously discussed in section 4.5; both of the relatives indicated in the returned questionnaires that they were either satisfied or very satisfied with the domain of well led. Four staff completed questionnaires and indicated that they were satisfied or very satisfied with the domain of well led.

The relatives spoke with were aware of how to raise a complaint and 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, details of the investigation and action taken, if any. The record also indicated how the registered manager had concluded that the complaint was closed. There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

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, infection prevention and control compliance, complaints, and the occurrence of accidents and incidents. Discussion with the registered manager confirmed that where an area for improvement was identified there was evidence of re-audited to check that the required improvement had been completed.

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any identified areas for improvement. The importance of ensuring that each area of the action plan is commented on at subsequent visits was discussed during feedback at the conclusion of the inspection.

Areas for improvement

No areas for improvement were identified within the domain of well led.

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 Mr McLaughlin, responsible person and Ms Jincy Mathews, 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 statutory requirements were made as a result of this inspection.

Recommendations	
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 22 November 2016	It is recommended that an assessment of wounds should be recorded at each dressing change in keeping with best practice. **Ref section 4.3**
	Response by registered provider detailing the actions taken: All staff have been reminded again to complete the necessary documents after each dressing change and more regular audits of wound charts / documents have been commenced.
Recommendation 2 **Ref**: Standard 35.16 **Stated:** First time **To be completed by:** 31 March 2016	It is recommended that any areas for improvement suggested in the returned annual quality assurance questionnaires and the action taken to address the issues are included in the annual quality report. **Ref section 4.5**
	Response by registered provider detailing the actions taken: From now on actions taken will be documented in the annual quality report.

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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