Unannounced Care Inspection Report
31 May 2017

Bloomfield

Type of Service: Nursing Home
Address: 115-117 North Road, Belfast, BT5 5NF
Tel no: 0289065 7799
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Bloomfield took place on 31 May 2017 from 10:25 hours to 16:30 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, staff training and development and the environment. Observation of the delivery of care and discussion with patents and staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. We discussed the new DHSSPS regional safeguarding policy and operating procedures. It was agreed that arrangements would be put in place to embed the policy into practice within the home. A recommendation was made.

Areas for improvement were identified in relation to registered nurses ensuring that in the event of a suspected head injury neurological observations are recorded and that items of equipment are not stored adjacent to stairwells; these must remain clear of any flammable items or materials. Two requirements were made.

Compliance with these requirements and recommendation will further drive improvements in this domain.

Is care effective?

A review of three patients care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process. Assessments and care records were reviewed as required and at least on a monthly basis. Care plan evaluations included an overview of the patients' condition. Care records contained good details of patients' individual needs and preferences.

We reviewed the management of wound care, catheter care and the care of patients identified as being at risk of losing weight. Care records evidenced that the care delivered was effective in meeting the needs of the patients. 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.

Staff confirmed that communication was good within the home and that they were provided with the relevant information in response to patients daily needs and any changes to their care.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that they enjoyed working in the home and with colleagues and if they had any concerns they could raise these with the registered manager or the responsible person who was in the home daily. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

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

Is care compassionate?

We arrived in the home at 10:25 hours. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

There was evidence that patients were involved in decision making about their care. 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.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. Examples of comments received are included in the report.

Discussion with the responsible person confirmed that there were systems in place to obtain the views of patients' representatives/relatives on the quality of the service provided. Results from the most recent satisfaction survey were displayed in the reception area of the home and evidenced high levels of satisfaction from relatives.

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

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. The Statement of Purpose and Patient Guide were available in the home.

Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required. The registered manager was on a period of planned leave at the time of the inspection. It was good to note that the systems and processes they had in place supported the day to day to running of the home in their absence. The administrator was knowledgeable regarding the management of the home and provided good support throughout the inspection.

We reviewed the record of complaints which included detail of the nature of the complaint and the action taken by the registered manager. One area for improvement was identified with recording and a recommendation was made.

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.

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	**2**	**2**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Desmond McLaughlin, responsible person, 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 inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 25 October 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: Bloomfield Care Homes Limited Desmond McLaughlin Jean McLaughlin	**Registered manager:** Jincy Mathew
Person in charge of the home at the time of inspection: Registered nurse Kriz Molina	**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 information:

- notifiable events since the previous care inspection
- 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 the inspector met with all of the patients, one registered nurse, three care staff, two housekeeping staff and one patient's relative.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from relatives and staff not on duty. Ten staff and relative questionnaires were left for completion.

The following information was examined during the inspection:

- duty rota for all staff for the week of the inspection
- records confirming registration of staff with the Nursing and Midwifery Council (NMC)and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment files
- competency and capability assessments of nurses
- staff register
- three patient care records
- record of staff meetings
- patient register
- complaints and compliments records
- record of audits
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports

4.0 The inspection

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

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.

4.2 Review of requirements and recommendations from the last care inspection dated 25 October 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time	It is recommended that an assessment of wounds should be recorded at each dressing change in keeping with best practice.	**Met**
	Action taken as confirmed during the inspection: A review of wound management for one patient evidenced that an assessment of the wound had been recorded at each dressing change. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 35.16 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of the summary of the quality assurance questionnaires evidenced that this recommendation has been met.	

4.3 Is care safe?

The nurse in charge confirmed the planned daily staffing levels for the home and that staffing was subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for week commencing 29 May 2017 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. Staff were employed to deliver activities for patients. Observation of the delivery of care and discussion with patients evidenced that their needs were met by the levels and skill mix of staff on duty.

Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; eight were returned following the inspection. Two of the respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?" The other staff replied "no" to this question. The individual comments were discussed with the registered manager on 26 June 2017 who confirmed that there were systems in place to manage staff shortages as a result of sickness. The registered manager also confirmed that staffing and the impact of patient dependency was reviewed regularly.

We observed that, although patients could not always verbalise their feelings in respect of care, they were attended to regularly and staff were present in the lounges and around the home to attend to their needs. No issues were identified with staffing during the inspection.

We spoke with one relative during the inspection; they commented positively regarding the staff and care delivery. We also sought relatives' opinion on staffing via questionnaires; seven were returned in time for inclusion in this report. All of the relatives were either very satisfied or satisfied with staffing.

The nurse in charge confirmed that when the registered manager was off duty a nurse was identified to be in charge of the home. A review of records evidenced that a competency and capability assessment had been completed with nurses 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 had been completed and that they were satisfied that the nurse was capable and competent to be left in charge of the home.

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

A record of staff including their name, address, contact number, position held, contracted hours, date of receipt of Access NI certificate, date commenced and date position was terminated (where applicable) was maintained electronically and provided an overview of all staff employed in the home. This additional detail supplemented the information contained in the staff recruitment files as required in accordance with regulation 19(2), schedule 4(6) of The Nursing Homes Regulations (Northern Ireland) 2005.

We discussed the arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC. A review of the records of NMC registrations evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The record of the checks of care staff registration included the expiry date of their registration with NISCC.

Records reviewed confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. A review of two completed induction programmes evidenced that these were completed within a meaningful timeframe.

We discussed the provision of mandatory training with staff and reviewed the training records for 2017. Training records evidenced good compliance; for example from January 2017 79% have completed training in safeguarding, 84% dementia, 43% fire safety e learning and 84% practical fire safety training. Systems were in place to facilitate compliance monitoring.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. We discussed the new regional safeguarding policy and operational procedures. The responsible person was not aware of this but agreed to obtain a copy of the policy and procedures and to put arrangements in place to embed the policy into practice within the home. A recommendation was made.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

A review of accidents and incident records since April 2017 confirmed that RQIA were appropriately notified of events occurring in the home. The review of completed accident reports and patients' care records evidenced that neurological observations were not always recorded when a patient sustained an injury to their head. To ensure that there is proper provision for the health and welfare of patients the nurse must ensure that in the event of a suspected head injury CNS observation are recorded. A requirement was made.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, sluice rooms, lounges, the dining room and storage areas. The home was found to be tidy, warm, well decorated, fresh smelling and clean throughout. Urgent action was required in relation to the storage equipment under one stairwell which was in close proximity to an external fire exit. These actions were discussed with the responsible person and it was agreed they would be addressed without delay. Confirmation was received via electronic mail on 1 June 2017 that the equipment had been removed and action taken to prevent the situation reoccurring. The registered persons must ensure that at all times stairwells remain clear of any flammable items or materials. A requirement has been made.

Areas for improvement

The responsible person will obtain a copy of the new regional safeguarding policy and operational procedures and put arrangements in place to embed these into practice within the home.

Nurses must ensure that in the event of a suspected head injury neurological observations are recorded.

The registered persons must ensure that at all times stairwells remain clear of any flammable items or materials.

Number of requirements	2	Number of recommendations	1

4.4 Is care effective?

A review of three patients care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process. Assessments and care records were reviewed as required and on at least a monthly basis. Care plan evaluations included an overview of the patients' condition. Care records contained good details of patients' individual needs and preferences.

We reviewed the management of wound care for one patient. An assessment of the wound was recorded after each dressing change. A review of wound care records for the period 15 April to 16 May 2017 evidenced that the wound dressing was regularly changed, consistent with the regimens recorded in the wound assessment chart and with good practice.

We reviewed the management of catheter care. Records evidenced that the patients' intake and urinary output were recorded daily and totalled at the end of every 24 hour period. Care plans were in place which detailed the frequency with which catheters were due to be changed; care records evidenced that they were changed in accordance with the prescribed frequency. Systems were in place to alert staff to when the next change was due. This is good practice.

Patients who had been identified as being at risk of losing weight had their weight regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner.

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

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that communication was good within the home and that they provided with the relevant information in response to patients daily needs and changing needs. Six of the seven staff who completed questionnaires confirmed that they received an effective handover. The comments of the other staff member were shared with the registered manager who confirmed that all staff are involved in a handover at the start of each shift.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that they enjoyed working in the home and with colleagues and if they had any concerns, they could raise these with the registered manager or the responsible person who was in the home daily. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

A record of patients including their name, address, date of birth, marital status, religion, date of admission and discharge (where applicable) to the home, next of kin and contact details and the name of the health and social care trust personnel responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas for improvement

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

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

We arrived in the home at 10.25 hours. 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.

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.

We observed the lunch time meal in both dining rooms. The meal served smelt appetising and patients were complimentary regarding the food. Staff were present in the dining rooms and lounge throughout the meal time and assistance was offered in timely manner. Tables were nicely set with cutlery and napkins; specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. 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. We discussed the provision of meals with one relative who confirmed that patients were offered a number of choices at mealtimes; they were complimentary regarding the quality and variety of food provided.

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

"Words cannot express the amount of gratitude we as a family would like to show to everyone who was involved in caring for …" (March 2017)
"We knew we had confidence that … was treated with care and compassion in the times that we as a family could not be there." (March 2017)
"…its gives us great comfort to know that she was loved and cared for in such a good humoured friendly and compassionate way." (February 2017)

Discussion with the responsible person confirmed that there were systems in place to obtain the views of patients' representatives/relatives on the quality of the service provided. Relatives were provided with the opportunity to complete a satisfaction survey annually. The most recent was completed in February 2017; thirty four questionnaires were issued, 17 were returned providing a 50% return rate. High levels of satisfaction were indicated with 100% of respondents saying that staff were friendly and approachable. When asked how they would rate the home five replied excellent and 12 responded good. The analysis of the results were displayed in the reception area of the home.

As previously discussed, ten relative questionnaires were issued; seven 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.

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 for improvement

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

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. The Statement of Purpose and Patient Guide were available in the home.

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with patients and staff evidenced that the registered manager's working patterns provided good opportunity to allow them to have contact as required. The registered manager was on a period of planned leave at the time of the inspection. It was good to note that the systems and processes they had in place supported the day to day to running of the home in their absence. The administrator was knowledgeable regarding the management of the home and provided good support throughout the inspection.

A record of complaints was maintained. The record included details of the nature of the complaint and the action taken by the registered manager. 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.

A review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in relation to falls, care records, complaints and incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

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

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. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

The unannounced quality 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.

Areas for improvement

The recording of complaints should be further developed to include how the complainant's 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 Mr Desmond McLaughlin, responsible person, 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	
Requirement 1 **Ref**: Regulation 13(1)(a) **Stated:** First time **To be completed by:** Immediate from the day of inspection	The registered persons must ensure that there is proper provision for the health and welfare of patients. In the event of a suspected head injury neurological observations must be recorded. **Ref section 4.3**
	Response by registered provider detailing the actions taken: All nursing staff reminded of policy for head injuries or suspected head injuries and it has been adhered to since date of inspection. Nurse Manager will continue to closely monitor all accident reports and treatment records.
Requirement 2 **Ref:** Regulation 27(4)(c) **Stated:** First time **To be completed by:** Immediate from the day of inspection	The registered persons must ensure that at all times stairwells remain clear of any flammable items or materials. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Stairwells have been cleared of all wheelchairs, mattresses, furniture, etc., and this continues to be daily monitored by Nurse Manager and Maintenance Person. All staff have been informed of same.
Recommendations	
Recommendation 1 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 28 June 2017	The registered provider should obtain a copy of the new regional safeguarding policy and operational procedures and put arrangements in place to embed the policy into practice within the home. **Ref section 4.3**
	Response by registered provider detailing the actions taken: Nurse Manager has obtained a copy of the new regional operational procedures and arrangements are now in place for Nurse Manager/Adult Safeguarding Champion to monitor any incidents and ensure that procedure has been followed. Monthly safeguarding report followed by an annual safeguarding position report will be set up for 2017 onwards.

Recommendation 2 **Ref**: Standard 16.11 **Stated:** First time	The registered provider should ensure that the recording of complaints is further developed to include how the complainant's level of satisfaction was determined. **Ref section 4.6**
To be completed by: 28 June 2017	**Response by registered provider detailing the actions taken:** Complaints records will be further developed to ensure that sufficient explanations given as to how complaint was resolved and the level of satisfaction.

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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