Unannounced Care Inspection Report
29 September 2016

Bryansburn

Type of Service: Nursing Home
Address: 96 – 100 Bryansburn Road, Bangor, BT20 3RG
Tel no: 028 9127 5182
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Bryansburn took place on 29 September 2016 from 09.30 to 16.00 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

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, attractively furnished, 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. A recommendation has been made that all staff undertake and complete training regarding adult protection and prevention and dementia awareness.

Is care effective?

A range of risk assessments were completed and the outcomes were reflected in the care plans and there was evidence that outcomes of the assessments had informed the care planning process. Personal care records evidenced that patients who were at risk of developing pressure damage, were repositioned in line with their care plans. The records also evidenced that patients' total fluid intake had been monitored and appropriate action taken in response to any identified deficits. Communication was well maintained in the home and all those consulted with expressed their confidence in raising concerns with the home's staff/ management. There were no requirements or recommendations 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. The staff consulted were satisfied with the staffing levels within the home and felt there was adequate time available for individualised personal care to be afforded to patients. There was an active and varied activities programme ongoing in the home. There were no requirements or recommendations made.

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 all 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 by the home. There were no requirements or recommendations made.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Agnes Jainar, 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 inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 13 April 2016. Other than those actions detailed in the QIP, there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Mrs. Briege Agnes Kelly	**Registered manager:** Ms. Luz Agnes Jainar
Person in charge of the home at the time of inspection: Agnes Jainar	**Date manager registered:** 18 March 2016
Categories of care: NH-DE	**Number of registered places:** 35

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, four staff and two registered nurses.

Questionnaires for patients (8), relatives (10) and staff (10) to complete and return were left for the home manager to distribute. Please refer to section 4.5 for further comment.

The following were examined during the inspection:

- validation evidence linked to the previous QIP
- staff roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- staff supervision and appraisal planner
- complaints and compliments records
- incident and accident records
- records of quality audits and
- records of staff, patient and relatives meetings
- patient care records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 April 2016 - Pharmacy

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 7 March 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 that these levels were subject to regular review to ensure the assessed needs of the patients were met. Review of the staffing rota from 26 September 2016 to 9 October 2016, evidenced that the planned staffing levels were adhered to. In the absence of the registered manager, a registered nurse is designated as the person in charge of the home. Competency and capability assessments for the nurse in charge of the home were current and reflected the responsibilities of the position. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Staff were mentored by an experienced member of staff during their induction. Records of three staff members were reviewed and found to be completed in full and dated and signed appropriately. Discussion with staff and a review of records confirmed that an annual appraisal and individual supervision was on-going.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Training outcomes for 2016, so far, indicated that the registered manager was monitoring staff compliance with mandatory training requirements and that mandatory training had been completed by staff. The exception was in relation to Adult Protection and Prevention training. Nursing and care staff had completed the training but ancillary staff had not. This was discussed with the registered manager who stated she was not aware that all staff in the home were to undertake adult protection and prevention training. Discussion also took place regarding dementia awareness training. Similarly, only nursing and care staff complete dementia awareness training. Given that ancillary staff are an integral part of the patients' lives in Bryansburn it was agreed that ancillary staff would also complete this training in future. A recommendation has been made. When staff complete training, their attendance is inputted onto a computerised system.

Staff consulted with and observation of care delivery and interactions with patients clearly, demonstrated that knowledge and skills gained through training and experience were embedded into practice. The registered manager also confirmed that staff had also completed a range of other training areas provided by the local trust including; wound care management, diabetes management and training in respect of palliative and end of life care including the use of a syringe pump driver.

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).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult protection and prevention and the review of staff training information, as discussed previously, confirmed training in respect of adult safeguarding procedures is considered mandatory and the attendance at training is monitored by the registered manager. A review of documentation confirmed that any potential adult protection concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were also notified appropriately.

Review of 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.

Review of management audits for falls confirmed that a quarterly thematic review of the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of the Nursing Home Regulations (Northern Ireland) 2005. Review of accidents/incidents records confirmed that notifications were forwarded to RQIA appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients' bedrooms were spacious and attractively furnished. Patients and staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

All staff employed in the home should complete training in respect of adult protection and prevention procedures and dementia awareness.

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

4.4 Is care effective?

Review of four 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 registered nurses, assessed, planned, evaluated and reviewed care in accordance with NMC guidelines regarding records and record keeping. Recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians were actioned appropriately.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that care was delivered and records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to access of the records.

Whilst there was evidence of regular communication with representatives within the care records and there was evidence of the involvement/consultation with patients and/or their representatives regarding the planning of care. The registered manager stated that there was regular communication with representatives and patients had an annual care review chaired by a representative of the local health and social care trust. Patients and/or their representative attend the annual care review. Patients care needs and corresponding care plans were discussed at this time.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff also confirmed that staff meetings were held, that they could contribute to the agenda and the meeting and minutes were available. The review of the minutes of staff meetings evidenced that the frequency of planned staff meetings were regular and frequent. Staff also stated the registered manager was receptive and encouraged their ideas.

Staff stated they knew they worked together effectively as a team and had strong communication skills. Comments such as, 'it's very good here and everyone is helpful,' and 'staffing levels are good and we all work well together' were received. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients spoken with expressed their confidence in raising concerns with the home's staff/ management. A representative stated, 'if I had any concerns I would go to the manager.'

There was information available to staff, patients and representatives in relation to the home's complaints procedure and various information leaflets on dementia. The activities programme was displayed throughout the home accompanied by many photographs of patients attending and enjoying entertainment and activities.

Observation of the mid-day meal arrangements was reviewed. Dining tables were attractively set, a range of condiments were available and patients, including patients who required a therapeutic diet, were afforded a choice of meals at mealtimes. Meals were delivered on trays to patients who choose not come to the dining room, the meal was appropriately covered and condiments and the patients preferred choice of fluid, for example, juice or milk were on the tray

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

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.

Activities are provided by a diversional therapist from Monday to Friday. We observed an activity in one of the lounges during the inspection and the strong relationship between the diversional therapist and patients was evident. There were many photographs of patients enjoying activities provided throughout the home and also of special occasions, for example a patient's wedding anniversary celebration which was hosted by the home.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

Comments received from relatives within compliment cards included:
"Thank you for the care and kindness you showed to my (relative)"
"You always showed my (relative) the utmost respect and genuine affection"
"I often found my (relative) dementia difficult and upsetting but you were always so supportive and reassuring"

We met with patients during the inspection, some comments received from patients were:
"It's great here."
"Couldn't be better."
'Staff are very helpful and understanding."

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. All comments on the returned questionnaires were positive. Some comments received are detailed below:

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 and relatives 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 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.

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

Discussion with the registered manager and staff, and 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 accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, 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.

Discussion with the registered manager and review of records for June, July and August 2016 evidenced that Regulation 29 monthly quality monitoring visits 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 Agnes Jainar, 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 39 **Stated:** First time	The registered provider should ensure that all staff undertake and complete training regarding adult protection and prevention and dementia awareness. **Ref: section 4.3**
To be completed by: 30 November 2016	**Response by registered provider detailing the actions taken:** All ancillary staff has now completed the Adult Protection Prevention and Dementia Awareness trainings. Staff attendance are recorded by signing in the training record form and imputted into the computerised system.

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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