The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Brooklands Healthcare Dunmurry

Provider: Brooklands Healthcare Ltd

Date of Inspection: 3 December 2024

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Brooklands Healthcare Ltd
Responsible Individual:	Mr Jarlath Conway
Registered Manager:	Mrs April Agagas
Service Profile: This home is a registered nursing home which provides nursing care for up to 57 patients. The home is divided into two units over two floors, each with its own living and dining areas. The ground floor provides general nursing care. The first floor provides care for patients living with dementia. There are a range of communal areas throughout the home and patients have access to an enclosed garden.	

2.0 Inspection summary

An unannounced inspection took place on 3 December 2024 from 9:50 am to 5:10 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 26 March 2024 and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As a result of this inspection all areas for improvement identified at the previous care inspection were assessed as having been addressed by the provider. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patient's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients told us they were happy with the care and services provided. Comments made included " I can't fault the staff, it is brilliant here" and "I can't thank the staff enough".

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

Patients told us that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Relatives told us " it is very homely here and the care has been wonderful". Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support.

Questionnaires returned from relatives indicated that they were very happy with the care, the comments included; "As a family, we are very happy with the care" and "the staff are very caring and attentive".

Following the inspection, no staff questionnaires were received within the timescale specified.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.

The manager advised supervision is ongoing and that arrangements are in place that all staff members have regular supervision and an appraisal completed. Confirmation of the appraisal planner in place was submitted by the manager after the inspection.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

Where a patient was at risk of falling, measures to reduce this risk were put in place.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was an opportunity for patients to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. It was clear that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

The importance of engaging with patients was well understood by the manager and staff.

Life story work with patients and their families helped to increase staff knowledge of their patients' interests and enabled staff to engage in a more meaningful way with their patients throughout the day.

Staff understood that meaningful activity was not isolated to the planned social events or games.

Patients' needs were met through a range of individual and group activities such arts and crafts complementary therapies, hairdressing and live music. The weekly programme of social events was displayed on the noticeboard. There was also a Christmas Planner in place advising of upcoming events.

Patients were well informed of the activities planned for the month and of their opportunity to be involved and looked forward to attending the planned events.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals.

Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy. For example, patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were suitably furnished, warm and comfortable, however; there was a number of areas in the home where the paintwork needed to be repaired. This was discussed with the manager and an action plan was submitted after the

inspection confirming there was a schedule in place for this to be addressed. This will be reviewed at the next care inspection.

Observation of the environment in the dementia unit, identified concerns regarding the maintenance of patient safety. Food and fluids were accessible in a number of patient bedrooms. This was identified as an area for improvement.

Review of records and observations confirmed that systems and processes were in place to manage infection prevention and control which included regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs April Agamas has been the acting manager since 25 January 2024. Following receipt of an application to register with RQIA, Mrs Agagas was registered with RQIA on 28 November 2024.

Patients, relatives and staff commented positively about the manager and described her as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. However, it was not clear from the care record audits reviewed who had responsibility to make improvements where deficits were noted and if the recommended actions had been addressed. An area for improvement was identified.

There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

Patients and relatives spoken with said that they knew how to report any concerns/complaints and said they were confident that the Manager would address their concerns.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs April Agagas, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for Improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 3 December 2024	The registered person shall ensure as far as reasonably practical that all parts of the home to which patients have access are free from hazards to their safety. Ref: 3.3.4
	Response by registered person detailing the actions taken: Supervision has been completed with staff across all departments in relation to ensuring food and fluids are managed appropriately within the dementia unit. Consultation was held with residents and families regarding utilising fridges within resident bedrooms which have now been appropriately secured. Home Manager maintains oversight of same through environmental auditing and daily walkaround.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)

Area for Improvement 1 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 January 2025	The registered person shall ensure that deficits identified by the homes care record audits are included in an action plan that clearly identifies the person responsible to make the improvement and the timeframe for completing the improvement. Ref: 3.3.5
	Response by registered person detailing the actions taken: Meeting and supervision was held with the home's senior nursing team in relation to appropriate management of care record auditing and the procedure to follow. The action plan template has been reviewed and staff nurses were reminded to ensure action plans are dated, signed and completed within the recommended timeframe.

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

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