The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
6 April 2017

Brooklands

Type of Service: Nursing Home
Address: 42e Cloona Park, Belfast, BT17 0HH
Tel No: 028 9060 1020
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Brooklands took place on 7 April 2017 from 09:10 hours to 16:55 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.

The registered manager and staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. We were assured that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice.

Areas for improvement were identified with recruitment information, the cleanliness of some wheelchairs and specialised seating and the appropriate storage of equipment. Three recommendations were made. Compliance with the recommendations will further drive improvements in this domain.

Is care effective?

A review of care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

We reviewed the management of catheter care and wound care. Records evidenced that prescribed care was being delivered to meet the individual needs of the patients. Care records provided assurances that referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians as required.

Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

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

Is care compassionate?

We arrived in the home at 09:10 hours and were greeted by staff who were helpful and attentive. Patients were enjoying their breakfast in the dining room or in their bedrooms as was

their personal preference; some patients remained in bed, again in keeping with their personal preference.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. All of the patients spoke highly of the staff and confirmed that living in Brooklands was a positive experience. We spoke with ten relatives; generally relatives were satisfied with the standard of care, communication with staff and spoke highly of the care. A number of their comments are included in the report.

We reviewed the provision of activities and were informed by patients that they looked forward to the different events that were planned throughout the day. Staff confirmed that there was wide a variety of activities planned each month with a focus on the Easter festivities throughout April. The activity programme included events to meet the patients' religious wishes.

Discussion with the registered manager confirmed that a satisfaction survey was conducted annually by the home to obtain the views of patients' representatives on the running of the home.

There were no areas for improvement 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 evidenced that there was a clear organisational structure in the home. In discussion, patients and relatives were aware of the roles of staff in the home and to whom they should speak to if they had a concern.

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.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the clinical governance/operations manager. An action plan was included within the report to address any areas for improvement. The action plan was reviewed at the next visit. A copy of the quality monitoring reports were available in the home.

There were no areas for improvement identified with the well led domain.

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**	**3**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Maureen Munster, registered manager, and Wendy Blakely, clinical governance/operations 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 25 August 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: Brooklands Healthcare Ltd Therese Conway acting registered person	**Registered manager:** Maureen Munster
Person in charge of the home at the time of inspection: Maureen Munster	**Date manager registered:** 22 September 2015
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 59

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 eight patients individually and with the majority in small groups, three registered nurses, five care staff, one domestic, one visiting professionals and 10 resident's visitors/representative.

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 patient representative 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
- four patient care records
- record of staff meetings
- patient register
- complaints record
- record of audits
- RQIA registration certificate
- certificate of public liability
- monthly monitoring reports

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 August 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, 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 14 April 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. A review of the staffing rota for week commencing 31 March 2017 evidenced that the

planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily. An activity co-ordinator was employed to deliver activities. Observation of the delivery of care evidenced that patients' 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; two were returned following the inspection. Both of the respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?"

Patients and relatives spoken with during the inspection commented positively regarding the staff and care delivery. Patients were satisfied that when they required assistance staff attended to them in timely manner. We sought relatives' opinion on staffing via questionnaires; none were returned in time for inclusion in this report.

A nurse was identified on the staffing rota to take charge of the home when the registered manager was off duty. 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.

Staff recruitment records were available for inspection and were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Information regarding the candidates' reason for leaving their current /most recent post was recorded; this information should be sought for all positions where candidates have worked with children or vulnerable adults. This was discussed with the registered manager and a recommendation was made.

Records evidenced 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 held 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.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager. A review of the records of NMC registration 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 did not include the expiry date of their registration with NISCC. The administrator explained that they received an e mail from the NISCC to alert them when a staff member's registration was due for renewal. As an additional safeguard the record was updated to include the expiry date prior to the conclusion of the inspection.

The registered manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

We discussed the provision of mandatory training with staff and reviewed the training records for 2016/2017. Training records evidenced good compliance; for example with the exception of one staff, all staff had attended a practical fire training session in 2017, all staff had attended safeguarding training in 2016 and 17 have attended an annual update in 2017. All staff completed infection prevention and control training in the past twelve months. Mandatory training compliance was monitored by the registered manager.

The registered manager and staff spoken were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. The company was actively trying to source training with regard to the role of the champion, record keeping and staff roles

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.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since January 2017 confirmed that these were appropriately managed. Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends.

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. Patients spoken with were complimentary in respect of the home's environment. One shower room was out of order at the time of the inspection. This was discussed with the registered manager who explained that there were a number of loose walls tiles; the issue was being addressed by the maintenance staff. Two other shower rooms were available for patients on the ground floor. Walking aids and patient equipment was stored in one bathroom. This was discussed with the registered manager who explained that this was a temporary measure. Patient equipment should not be stored in bathrooms; a recommendation was made to ensure equipment is stored appropriately. The registered manager confirmed that the equipment would be removed as a matter of priority.

We observed that a number of wheelchairs and some specialised seating were not clean. These chairs should be thoroughly cleaned and a schedule put in place to ensure they are maintained clean. A recommendation was made.

Infection prevention and control measures were adhered to. We spoke with one member of housekeeping staff who were knowledgeable regarding the National Patient Safety Agency (NPSA) national colour coding scheme for equipment such as mops, buckets and cloths. Sluice rooms and bathroom/toilets were observed to be clutter free and well organised. Personal protective equipment (PPE) such as gloves and aprons were available throughout the home and stored appropriately. A review of records of a recent outbreak of infection in the home evidenced that it was managed in accordance with regional guidelines and was reported promptly to the Public health Authority (PHA) and to RQIA. Comprehensive records were maintained to evidence the progression of the infection, management of patients and deep cleaning completed when the outbreak was declared over. Further records were maintained of communication with the local health care trust and PHA during the outbreak period.

We discussed the management of fire safety with the registered manager who confirmed that fire checks were completed weekly. Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

Recruitment records should include information to explain the reasons for leaving previous employment where candidates have worked with children or vulnerable adults.

Wheelchairs and specialised seating should be thoroughly cleaned and a cleaning schedule put in place to ensure they are maintained clean.

Patient equipment should be stored appropriately.

Number of requirements	0	Number of recommendations	3

4.4 Is care effective?

A review of care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient at the time of admission to the home. Assessments were reviewed as required and at minimum monthly. There was evidence that assessments informed the care planning process. Care records contained good details of patients' individual needs and preferences.

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 and systems were in place to alert staff to when the next change was due. One patient's care records evidenced that their catheter was changed in accordance with the prescribed frequency. The second patient reviewed had input from the local hospital for catheter changes. Records evidenced regular appointments and consultation with the identified hospital.

We observed that one patient had a do not attempt resuscitation (DNAR) directive recorded whilst in hospital. This directive was filed with the patients contemporaneous care notes on return to the home. We discussed with a registered nurse the management of DNAR directives agreed in hospital and their standing when a patient returns to the home. It was good to note that the registered nurse was knowledgeable regarding the management of these DNAR directives and the need to have them reviewed with the relevant healthcare professionals, the patient (if appropriate) and relatives on their return to the home. The registered nurse agreed to review the filing of the hospital DNAR in the patient's care records.

We reviewed the management of wound care for one patient. Care plans contained the grade and size of the wound, the prescribed dressing regime and the frequency dressing were recommended for renewal. An open wound observation chart was completed and contained an assessment of the wound as observed during change of dressings. A repositioning chart was completed to evidence the patient was regularly assisted to change their position for pressure relief. Care records evidenced the patient's refusal to accept an airflow mattress and that, at times, they were non-compliant with repositioning.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians.
The registered manager 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.
Discussion with the registered manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted. Staff reported that there was effective teamwork and that if they had any concerns, they could raise these with the nurse in charge or the registered manager

The registered manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed.

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 09:10 hours and were greeted by staff who were helpful and attentive. Patients were enjoying their breakfast in the dining room or in their bedrooms as was their personal preference; some patients remained in bed, again in keeping with their personal preference.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. 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. Discussion with patients individually and with others in smaller groups, confirmed that living in Brooklands was a positive experience. All of the patients spoke highly of the staff. It was evident that patients knew staff and the registered manager well. The following are examples of comments provided by patients:
"The staff are so cheerful."
"Marvellous, everything is marvellous."
"I am very happy in the home, although it can be noisy at times."

We spoke with ten relatives; generally relatives were satisfied with the standard of care, communication with staff and spoke highly of the care. One relative discussed what they termed as "minor" issues and confirmed that they had also discussed these issues previously with the registered manager; they were frustrated that the agreed action was not always sustained. With the relatives permission we shared their comments with the registered manager who agreed to discuss the issues further with the relative.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. A floral arrangements and thank you card were delivered to the home during the inspection from a family of a former patient. The following are examples of comments received on thank you cards:
"For all your patience and kindness in looking after … whilst in your care."
"Thank you for taking care of our … in the last weeks. She was happy there."

We reviewed the provision of activities and were informed by patients that they looked forward to the different events that were planned throughout the day. At the time of the inspection the permanent activity leader was on unplanned leave. It was good to note that temporary arrangements had been put in place to ensure the delivery of activities continued. A number of patients were involved in making Easter decoration. It was obvious from the way in which the patients spoke about the activity how much they had enjoyed it. Staff confirmed that there was wide a variety of activities planned each month with a focus on the Easter festivities throughout April. The activity programme included events to meet the patients' religious wishes.

Discussion with the registered manager confirmed that a satisfaction survey was conducted annually by the home to obtain the views of patients' relatives on the running of the home. A satisfaction survey was conducted annually by the home. This was last conducted in March 2016 and the registered manager explained that surveys were ready to be sent out in the next two weeks. The results will be reviewed at a future inspection.

We issued questionnaires for ten relatives; none were returned within the timescale for inclusion in this report.

Ten questionnaires were issued to nursing, care and ancillary staff; two were returned prior to the issue of this report. The staff members were very satisfied or satisfied with the care provided across the four domains. No additional comments were provided.

Any comments from relatives and staff in returned questionnaires received after the return date were 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.

Discussion with staff evidenced that there was a clear organisational structure in the home. In discussion, patients and relatives were aware of the roles of staff in the home and to whom they should speak to if they had a concern.

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.
Discussion with the registered manager and review of the home's complaints records evidenced that systems were in place to ensure 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.

The registered manager confirmed that monthly audits were completed, for example care records and medication audits. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement

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.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the clinical governance/operations manager. An action plan was included within the report to address any areas for improvement. The action plan was reviewed at the next visit. A copy of the quality monitoring reports were available in the home.

Areas for improvement

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

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 Maureen Munster, registered manager, and Wendy Blakely, clinical governance/operations 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 38 **Stated:** First time **To be completed by:** 05 May 2017	The registered provider should ensure that recruitment records include information to explain the reasons for leaving previous employment where candidates have worked with children or vulnerable adults. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: Current application for employment forms for all posts will now include a section allowing applicants to explain the reasons for leaving previous employment which includes working with children or vulnerable adults.
Recommendation 2 **Ref**: Standard 45 **Stated:** First time **To be completed by:** 05 May 2017	The registered provider should ensure that wheelchairs and specialised seating are thoroughly cleaned and a cleaning schedule put in place to ensure they are maintained clean. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: Recommendation addressed with immediate effect and all specialised seating has been included in a daily cleaning schedule which is monitored by Senior Nurses and Senior Care Staff.
Recommendation 3 **Ref**: Standard 47 **Stated:** First time **To be completed by:** 05 May 2017	The registered provider should ensure that patient equipment is stored appropriately. **Ref: section 4.3**
	Response by registered provider detailing the actions taken: The room identified on the day of inspection has been cleared and equipment stored appropriately as evidenced by the Nurse Manager.

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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