The Regulation and Quality Improvement Authority

Brooklands
RQIA ID: 1066
42e Cloona Park
Belfast
BT17 0HH

Inspector: Sharon McKnight
Inspection ID: IN021938

Tel:0289060 1020
Email: therese.conway.bhl@googlemail.com

Unannounced Care Inspection
of
Brooklands

17 September 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 17 September 2015 from 11 30 to 17 00 hours.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 26 February 2015.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

The details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Therese Conway, acting responsible person and Ms Maureen Munster, manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Brooklands Healthcare Ltd	**Registered Manager:** See below
Person in Charge of the Home at the Time of Inspection: Maureen Munster	**Date Manager Registered:** Maureen Munster – application received - “registration pending”.
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 57
Number of Patients Accommodated on Day of Inspection: 55	**Weekly Tariff at Time of Inspection:** £593.00 – £677.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the manager
- discussion with staff
- discussion with patients
- discussion with relatives
- review of records
- observation during a tour of the premises
- evaluation and feedback

Prior to inspection the following records were analysed:

- 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 previous care inspection report

During the inspection, RQIA met with 12 patients individually and with the majority generally, 11 staff and seven patient's visitors/representative.

The following records were examined during the inspection:

- 6 patient care records including care charts
- policies and procedures regarding communication, death and dying, palliative and end of life care
- record of complaints and compliments
- record of accidents in the home
- staff training

5. The Inspection

Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced medicines management inspection dated 11 June 2015. The completed QIP was returned and approved by the pharmacy inspector. Following discussion with the pharmacy inspector it was agreed that the management of thickening agents would be followed up during this inspection. Discussion with staff and observations made evidenced that records had been introduced to document the use of thickening agents at the point of administering. The registered nurses confirmed that work was ongoing to ensure that system in place to monitor the use of thickening agents were robust.

Review of Requirements and Recommendations from the last care (Same specialism) Inspection

<table>
<tr><th colspan="2">Last Care Inspection Statutory Requirements</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Requirement 1

Ref: Regulation 13 (1)

Stated: First time</td><td>The registered persons must ensure the management of wound care is being managed effectively and provide confirmation of that the following issues have been addressed in full:

• the evaluation process must reflect the effectiveness of prescribed analgesia prior to dressing wounds
• increased wound care evaluations are recorded
• all wound care plans evidence the involvement of the patient and or nominated representative in the development and review of the care plan
• there is improved communication with patients’ relatives to ensure they are informed and frequently updated of the progress and or non-progress of each patient’s wound. Records of these discussions are also maintained</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of the care records for wound care evidenced that this requirement has been met.</td></tr>
</table>

<table>
<tr><td rowspan="2">Requirement 2

Ref: Regulation 20(1)(c)(iii)

Stated: Second time</td><td>The registered person must confirm that all registered nurses receive the following training:

• training in wound management
• pain management

and all registered nurses and care assistants receive training covering the following topics:

• nutrition for patients with wounds
• continence management
• repositioning of patients

Confirmation is required by RQIA that the registered manager has assessed registered nurses knowledge of wound assessment, management and treatment, including wound care products and dressings.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of training records evidenced that registered nurses and care staff had attended training in the management of wound care. The manager confirmed that further sessions would be arranged to ensure that all staff received this training. RQIA were satisfied that there were systems in place to support staff to attend training. This requirement has been met.</td></tr>
<tr><th colspan="2">Last Care Inspection Recommendations</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 19.1

Stated: First time</td><td>It is recommended that:

• the type of continence pad and size of pants are recorded in the patient’s care records
• the frequency with which catheters are required to be changed should be included in the patient’s care plan
• urinary output is recorded daily.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Care records reviewed included the recommended information. This recommendation has been met.</td></tr>
</table>

Recommendation 2 **Ref**: Standard 1.1 **Stated:** First time	In keeping with patient dignity, each patient should have continence pants supplied solely for their personal use.	**Met**
	Action taken as confirmed during the inspection: Staff spoken with confirmed that continence pants were now individually named and used solely for individual, personal use. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 19.4 **Stated:** First time	Consideration should be given by the home manager for registered nurses to attended training and gain competency in male catheterisation.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and review of records evidenced that training by the local health and social care trust was arranged for 19 October 2015 and 12 November 2015; registered nurses had been identified to attend. This recommendation has been met.	

Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy was available on communicating effectively. A copy of the DHSSPS regional guidance on breaking bad news was available in the home.

Training had not been provided on breaking bad news. However, discussion with the manager, registered nurses and care staff confirmed that staff were aware of the sensitivities around breaking bad news and the importance of accurate and effective communication. Staff spoken with were knowledgeable, experienced and confident in communicating with patients and their representatives.

Is Care Effective? (Quality of Management)

Six care records evidenced that patient individual needs and wishes in respect of aspects of daily living were appropriately recorded. However, there was limited evidence that end of life issues were discussed with the exception of Do Not Attempt Resuscitation (DNAR) directives.

Care records made reference to the patients' specific communication needs including sensory and cognitive impairment. There was evidence within the care records that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

The manager and registered nurses demonstrated their ability to communicate sensitively with patients and relatives when breaking bad news and provided examples of how they had done this in the past. Care staff considered the breaking of bad news to be the responsibility of the registered nursing staff but felt confident that, should a patient choose to talk to them about a diagnosis or prognosis of illness, they would have the necessary skills to do so.

Is Care Compassionate? (Quality of Care)

Observations of the delivery of care and staff interactions with patients confirmed that communication was well maintained and patients were observed to be treated with dignity and respect. Staff were knowledgeable regarding patient need and how best to communicate with individual patients. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time.

Patients spoken with all stated that they were very happy with the quality of care delivered and with life in the home.

Patients and their representatives consulted were complimentary of staff and the care provided. Relatives confirmed that they were kept up to date with any changes to their loved ones condition. Consultation with relatives is further discussed in section 5.5.1. Good relationships were very evident between staff, patients and visitors.

Compliment cards and letters are retained by the home. Review of these indicated that relatives were appreciative of the care provided by the home.

Areas for Improvement

There were no areas for improvement identified with this standard.

Number of Requirements:	**0**	**Number of Recommendations**:	**0**

Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management on palliative care and care of the dying patient were available and referenced GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, December 2013. A copy of this best practice guidance was also available in the home.

A registered nurse had recently been identified as a link worker in palliative care. The role will include additional training in palliative care and attendance at the palliative care link nurse meetings arranged by the local health and social care trust.

The manager confirmed that registered nurses had attended training on the management of syringe drivers and that support to manage these was provide by district nursing and the palliative care nurses within the local health and social care trust.

An e-learning programme on palliative care and grief and loss was available for all staff. At the time of this inspection 75% of staff had completed the palliative care programme. The manager had systems in place to monitor compliance with mandatory training to ensure that all staff complete the required programmes.

Training entitled “Dealing with Death and Bereavement” was scheduled to take place on 24 September 2015 and staff had been identified to attend. The manager confirmed that further dates for this training will be arranged for additional staff to attend.

Discussion with staff confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the manager, registered nurses and care staff evidenced that staff were knowledgeable in identifying when a patient’s condition was deteriorating or nearing end of life and the appropriate actions to take. Arrangements were in place for timely access to specialist equipment. Discussion with the manager and registered nurses confirmed their knowledge of the procedure.

Is Care Effective? (Quality of Management)

Review of care records and discussion with the manager and registered nurse evidenced that death and dying arrangements were identified as part of the physical and social assessment completed for each patient. The care records did not contain specific details of the patients’ assessed needs or wishes with regard to end of life care. Examples of comments recorded in the section entitled “Dying” included:

“not discussed”
“no concerns discussed”
“DNAR signed”.

The manager and registered nurses acknowledged that, whilst some discussion had taken place regarding the wishes of patients and relatives with the DNAR directives, there was a need to create further opportunities to discuss end of life care in greater detail; in particular in the event of patients becoming suddenly unwell.

Whilst RQIA acknowledges there will be occasions when patients and/or their relatives do not wish to discuss end of life care, opportunities, to discuss end of life care, should be created by the registered nurses and any expressed wishes of patients and/or their representatives formulated into a care plan for end of life care. A recommendation was made.

Discussion with staff evidenced that environmental factors, which had the potential to impact on patient privacy, had been considered. Staff confirmed that facilities were made available for family members to spend extended periods with their loved ones during the final days of life. Meals, snacks and emotional support were been provided by the staff team.

A review of notifications of death to RQIA during the previous inspection year evidenced that these had been reported appropriately.

Is Care Compassionate? (Quality of Care)

The religious, spiritual or cultural need of the patients had been identified in patient care records but there was no evidence of consideration of these areas in respect of end of life care. Discussion with patients and staff evidenced that arrangements were in place on a day to day basis to support patients' to meet their religious and spiritual needs within the home. The contact numbers of the local priests and ministers were prominently displayed at the nurses' station on each floor for ease of reference in the event of an emergency.

Arrangements were in place in the home to facilitate family and friends to spend as much time as they wish with the patient who was ill or dying. Staff discussed openly a number of deaths in the home and how the home had been able to support the family members in providing refreshments and facilitating staying overnight with their loved ones.

Staff spoken with confirmed that they were given an opportunity to pay their respects after a patient's death.

From discussion with the manager, 11 staff and a review of the compliments record, there was evidence that there were sound arrangements in the home to support relatives during this time. Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"The family would like to thank you all for the love, care and attention given to our father and husband during the last six months of his life. It was a great comfort knowing he was being cared for so well."

"To all the lovely staff at Brooklands. Thank you so very much for looking after my mother."

"To all the staff at Brooklands – we would wish to express our deepest thanks for all loving care shown."

Areas for Improvement

It was recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan for end of life care. This should include any wishes with regard to the religious, spiritual or cultural need of patients'.

Number of Requirements:	0	Number of Recommendations:	1

Additional Areas Examined

5.5.1 Consultation with patients, their representatives and staff.

Discussion took place with 12 patients individually and with the majority of patients in smaller groups. Comments from patients regarding the quality of care, food and in general the life in the home were positive. Patients did not raise any issues or concerns about care delivery in the home.

Seven patients' representatives confirmed that they were happy with the standard of care and communication with staff in the home. There were no issues or concerns raised about standards of care within the home.

Staff commented positively with regard to staffing and the delivery of care. Staff were knowledgeable regarding their patient's needs, wishes and preferences.

Ten questionnaires were issued to nursing, care and ancillary staff. None were returned prior to the issue of this report.

5.5.2 Care practices

During a tour of the building it was noted that, whist the majority of patients had their nurse call bell left within reach, a number of patients did not. All of the patients spoken with were aware of the nurse call system and reported that generally staff would remind them of it before leaving the room. It is recommended that prior to leaving patients in their bedroom staff check that the nurse call lead is within easy reach.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Therese Conway, acting responsible person and Ms Maureen Munster, manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that any requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 20.2 **Stated:** First time **To be Completed by:** 27 October 2015	It was recommended that further opportunities, to discuss end of life care, are created by the registered nurses. Any expressed wishes of patients and/or their representatives should be formulated into a care plan. This should include any wishes with regard to the religious, spiritual or cultural need of patients'. **Response by Registered Person(s) Detailing the Actions Taken:** Recommendation discussed with all Nursing Staff, who are aware of the sensitivities surrounding the area of death and dying. Opportunities arising re discussion of any specific wishes regarding end of life care are documented and incorporated as part of the individual care plan.
Recommendation 2 **Ref**: Standard 7.3 **Stated:** First time **To be Completed by:** 15 September 2015	It is recommended that prior to leaving patients in their bedroom staff check that the nurse call lead is within easy reach. **Response by Registered Person(s) Detailing the Actions Taken:** Recommendation communicated to all staff. Nurse Manager can confirm this has been implemented through regular spot checks.

Registered Manager Completing QIP	Maureen Munster	**Date Completed**	5/11/15
Registered Person Approving QIP	Therese Conway	**Date Approved**	5/11/15
RQIA Inspector Assessing Response	Sharon McKnight	**Date Approved**	5-11-15

Please ensure the QIP is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address