Unannounced Care Inspection Report
16 August and 6 October 2016

Bohill House

Type of Service: Nursing Home
Address: 69 Cloyfin Road, Coleraine, BT52 2NY
Tel no: 028 7032 5180
Inspector: Lyn Buckley

1.0 Summary

An unannounced inspection of Bohill House took place on 16 August and 6 October 2016 from 09:00 to 16:00 hours on day one and from 09:50 to 15:00 hours on day two. On day one of this inspection the Public Health Authority (PHA) had required the home to limit visiting due to a potential outbreak of infection. The decision was made by the inspector not undertake an inspection of the home's environment or to consult with patients and staff on day one; this was undertaken on day two. The inspection was unannounced on both days.

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.

The term 'patients' is used to describe those living in Bohill House which provides both nursing and residential care.

Is care safe?

Following discussion with management, staff, patients and relatives; and a review of records it was evident that systems and processes were in place and monitored by the registered manager and her senior team to ensure the delivery of safe care. Staffing levels were monitored and adjusted to ensure patient needs were met. Training was provided and the learning from it was monitored to ensure the staff were enabled to provide the right care safely. Refer to section 4.3 for further details.

There were no areas for improvement identified.

Is care effective?

Observation of care practices, review of records and discussion with patients, relatives and staff evidenced that there were systems and processes in place to ensure the timely delivery of effective care. Staff consulted were knowledgeable and confident in their role. Patients and relatives said they were assured that staff would deliver the right care at the right time.
The registered manager implemented systems and processes to ensure effective communication throughout all grades of staff was maintained. Refer to section 4.4 for further details.

There were no areas for improvement identified.

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.

There was evidence of good communication in the home between staff and patients. Patients and relatives spoken with were complimentary regarding staff and the registered manager; comments are included in section 4.5.

There were no areas for improvement identified.

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff confidently described their role and responsibility in the home. In discussion patients were aware of the roles of the staff in the home and to whom they should speak to if they had a concern. Patients, relatives and staff spoke in very positive terms in relation to the registered manager and their confidence in her leadership skills. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Based on the inspection findings detailed in the preceding domains, review of records, systems and processes; and comments from patients, relatives and staff it was evident that Bohill House was well led. The registered manager has consistently demonstrated how she manages and leads her team to ensure the delivery of safe, effective and compassionate care as part of her day to day operational control of the home. This was commended.

There were no areas for improvement identified.

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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Tracey Henry, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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

1.2 Actions/enforcement taken following the most recent medicines management inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 24 May 2016. There were no issues identified during this inspection, and a QIP was not required, nor included, as part of this inspection report. 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.
There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Priory Care Homes Number 2 Ltd/ Mrs Caroline Denny	**Registered manager:** Mrs Tracey Henry
Person in charge of the home at the time of inspection: Mrs Tracey Henry	**Date manager registered:** 15 August 2011
Categories of care: NH-I, DE and PH RC-DE A maximum of 39 patients in category NH-DE(ground floor dementia unit); maximum of 26 patients in category NH-I and a maximum of 18 residents in category RC-DE (first floor). Category NH-PH for 1 identified patient only.	**Number of registered places:** 80

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 spoke with 14 patients individually and greeted others in small groups, seven care staff, four registered nurses, two members of staff from housekeeping, three relatives and a member of the administrative staff.

In addition questionnaires were provided for distribution by the registered manager; 10 for relatives, eight for patients and 10 for staff. Eight relatives, two patients and six staff questionnaires were returned. Refer to section 4.5 for details.

The following information was examined during the inspection:

- three patient care records
- two patients' care charts such as food and fluid intake records or reposition records
- staff roster 7 to 21 August 2016
- staff training and planner/matrix for 2016
- one staff recruitment record
- complaints record
- incident and accident records
- record of quality monitoring visits carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records of audit/governance
- staff appraisal and supervision planners 2016
- records pertaining to consultation with staff, patients and relatives

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 May 2016

The most recent inspection of the home was an unannounced medicines management inspection. There were no issues identified during this inspection, and a QIP was not required, nor included, as part of this inspection report.

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 24 February 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time	The registered manager should ensure that staff record the delivery of care contemporaneously over the 24 hour period to evidence care has been delivered as planned.	**Met**
	Action taken as confirmed during the inspection: Staff consulted were aware of the importance of contemporaneous record keeping. Review of a selection of patient records confirmed that this recommendation had been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subjected to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 7 to 21 August 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

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. New staff were supported through their induction by a dedicated mentor. Review of one staff member's induction evidenced the record to be completed in full and signed/dated appropriately.

Review of the training planner/matrix for 2016 indicated that training was planned to ensure that mandatory training requirements were met. Staff confirmed that they were required to complete mandatory training through the 'e-learning' and by attending 'face to face' training. The records reviewed confirmed that 92.6% of staff had, so far this year, completed mandatory training; this was commended by the inspector.

Observation of the delivery of care evidenced that training had been embedded into practice.

A planner was in place to manage staff supervision sessions and annual appraisals. Discussion with staff and the registered manager confirmed that supervision sessions were meaningful and relevant to their role and function in the home.

The registered manager and staff spoken with demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding and the management of restraint. Staff described their role and responsibilities with enthusiasm and said that they were enabled to 'make a difference'. Patients and relatives spoken with confirmed that they were assured and confident of the staffs' ability to care for their loved ones and that they 'trusted' staff to always do the right thing.

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). Safety and medical alerts were reviewed on a regular basis and relevant notices were 'actioned' and/or disseminated to staff as required.

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 3 February 2016 confirmed that these were managed appropriately.

Audits of falls and incidents were maintained and clearly evidenced analysis of the data to identify any emerging patterns or trends and action plans were in place as required. This information also informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

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. Housekeeping staff were commended for their efforts. One bedroom had a detectable malodour. RQIA were assured that the registered manager had systems in place to manage this.

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

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

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. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer a care plan was in place to direct staff on the management of this risk. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate and of regular communication with representatives on a day to day basis as required. Relatives confirmed that they were kept informed of any changes in their loved ones' care.

Care charts such as repositioning records and food and fluid intake records evidenced that 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 the storage of records.

Observations evidenced that call bells were answered promptly and patients requesting assistance in one of the lounge areas or their bedrooms were responded to in a calm, quiet and caring manner. Patients able to converse with the inspector were confident of the ability of staff to meet their needs effectively and in a timely manner.

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the handover reports at the beginning of their shift. Staff also confirmed that regular staff meetings were held, that they contributed to the agenda and that minutes were made available. In addition to the planned staff meetings, the registered manager held a 'heads of department meeting' on a daily basis at 10:00 hours to ensure all relevant staff and herself were kept informed of changes in the home and also to enable the sharing of ideas to improve the patient experience. This is good practice.

Staff stated that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were 'proud' to be a part of their team and to 'make a difference'. Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their representatives was evident on a one to one basis as recorded in the care records and through observations of interactions. Patients confirmed that the registered manager was available to them on a daily basis.

There was information available to staff, patients, representatives in relation to advocacy services.

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. As stated in section 4.4 patients and relatives were positive in their comments regarding the staffs' ability to deliver care and respond to needs and or requests for assistance.

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.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. For example, patients, relatives, visitors to the home and staff were invited to provide feedback on an ongoing basis through an 'open door' approach to speaking with the registered manager, by completing surveys and attending resident and relatives meeting held on a regular basis. Minutes were available.

All patients and relatives spoken with commented positively regarding the care they received and the staffs' caring and kind 'nothing is any trouble' attitude from everyone. In particular the registered manager was mentioned for her calm, quiet, caring and professional attitude. It was evident good relationships had been developed and that there was a high level of confidence in the staffs' ability to deliver care and to address concerns effectively.

It was evident that the home provided a varied and comprehensive programme of activities which was considerate of various levels of participation. Patients and relatives spoke highly in relation to the activity therapists.

In addition to speaking with patients, relatives and staff RQIA provided questionnaires for distribution by the registered manager. At the time of writing this report eight relatives, two patients and six staff had returned their questionnaires.

Comments and outcomes were as follows:

Patients: respondents indicated that they were either very satisfied or satisfied with the care they received in relation to questions asked about, is care safe, effective and compassionate and is the service was well led.

Relatives: six respondents indicated that they found the home provided very satisfactory care in relation to all four areas questioned. Two respondents indicated that they were satisfied. Only two comments were recorded:

- "The manager Tracey is excellent and has sorted out any issues immediately just like she promises. She sets a high standard for the home."
- "Mum likes to stay in the living/common room where the others are."

Staff: four respondents indicated that they found the care provided was very satisfactory. Two staff indicated they were satisfied. Only one staff member commented negatively and indicated concerns that staffing levels were poor and communication was inadequate. These comments were contrary to the inspection findings. Refer to the previous sections for details.

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 confidently described their role and responsibility in the home. In discussion patients were aware of the roles of the staff in the home and to whom they should speak to if they had a concern. Patients, relatives and staff spoke in very positive terms in relation to the registered manager and their confidence in her leadership skills. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would address any concern raised by them appropriately.

Staff were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function. A review of notifications of incidents to RQIA since 3 February 2016 confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager 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, incidents/accidents. Records also evidenced that 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.

Review of reports and discussion with the registered manager evidenced that Regulation 29 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 was an effective system in place to ensure nursing staff were registered with the nursing and Midwifery Council; and that care staff were registered with the Northern Ireland Social Care Council (NISCC). New care staff not registered with NISCC were required and supported to register.

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.

Based on the inspection findings detailed in the preceding domains, review of records, systems and processes; and comments from patients, relatives and staff it was evident that Bohill House was well led. The registered manager has consistently demonstrated how she manages and leads her team to ensure the delivery of safe, effective and compassionate care as part of her day to day operational control of the home. This was commended.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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