Unannounced Care Inspection Report
17 January 2017

Brooklands

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Inspector: Sharon McKnight and John McAuley

1.0 Summary

An unannounced inspection of Brooklands took place on 17 January 2017 from 10:15 hours to 15:00 hours.

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

Is care safe?

A review of the staffing roster for week commencing 13 January 2017 evidenced that the planned staffing levels were adhered to. Nursing and care staff spoken with were satisfied that there were 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.

A random selection of accidents and incidents recorded since the previous inspection evidenced that we were appropriately notified of events in the home.

The home was fresh smelling, clean and appropriately heated. All of the responses we received in the returned questionnaires confirmed that this was normal for the home. There were no issues identified with infection prevention and control practice.

No areas for improvement were identified during the inspection with the delivery of safe care.

Is care effective?

We reviewed the care records of seven patients throughout the home. They included a comprehensive assessment of needs, a range of risk assessments and care plans. We were assured through a review of records and discussion with staff and patients that there were processes in place to support the effective delivery of care.

Areas for improvement were identified with care records and three recommendations were made.

Is care compassionate?

Patients spoken with were complimentary regarding to the care they received. Comments provided are included in section 4.5 of this report.

We spoke with one relative; they commented positively with regard to the standard of care and communication in the home.

Questionnaires were issued to relatives and staff. The one relative who returned a questionnaire indicated that they were very satisfied that care was safe, effective, compassionate and well led. Two staff completed questionnaires and were very satisfied that care was safe, effective compassionate and well led.

No areas for improvement were identified during the inspection with the delivery of compassionate care.

Is the service well led?

Patients, relative and staff commented positively regarding the registered manager and her role within the home. Discussion with staff confirmed that there were good working relationships and that management were responsive to suggestions and/or concerns raised.

A regular audit of accidents and incidents was undertaken and was reviewed as part of the inspection process. Learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice. The registered manager had systems in place to monitor and report on the delivery of care in the home.

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

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

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 Liz Bonelllo, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection.

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 1 September 2017. 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 Limited Therese Elizabeth Conway	**Registered manager:** Elizabeth Bonello
Person in charge of the home at the time of inspection: Elizabeth Bonello	**Date manager registered:** 17 February 2016
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI, RC-DE A maximum of 31 residents in category RC-DE accommodated on the Ground Floor	**Number of registered places:** 62

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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 thirty patients individually and with the majority of others in small groups, the deputy manager, a registered nurse, one senior care assistant, seven care staff, the activity leader and one patient's relative.

The following information was examined during the inspection:

- Staffing rota for week commencing 13 January 2017
- Access NI recruitment records
- accident records
- seven patients' care records.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 01 September 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/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 28 April 2016

Last care inspection Recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 4.1 **Stated:** Second time	It is recommended that detailed plans of care to meet patients' individual needs are in place	**Met**
	Action taken as confirmed during the inspection: The four care records reviewed had detailed plans of care which included details of patients' individual needs. This recommendation has been met.	
Recommendation 2 **Ref**: Standard 41 **Stated:** First time	It is recommended that the registered nurse in charge of the home when the registered manager is off duty should be clearly identified on the staff duty roster in the nursing and residential units.	**Met**
	Action taken as confirmed during the inspection: The registered nurse in charge of the home when the registered manager is off duty was clearly identified on the off duty. This recommendation has been met.	
Recommendation 3 **Ref**: Standard 38.3 **Stated:** First time	It is recommended that the record of Access NI checks is further developed to include the date that the certificate is viewed; this would evidence that the registered manager has checked the certificate prior to the candidate commencing employment.	**Met**
	Action taken as confirmed during the inspection: A review of the record of Access Ni checks evidenced that the date the check received was recorded. This recommendation has been met.	

4.3 Is care safe?

A review of the staffing roster for week commencing 13 January 2017 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, the registered manager confirmed that administrative, catering, domestic and laundry staff were also on duty daily. Nursing and care 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. We sought relatives' opinion on staffing via questionnaires; one completed questionnaires was returned. The respondents indicated that staff had enough time to care for their relative.

A random selection of accidents and incidents recorded since the previous inspection evidenced that we were appropriately notified of events in the home.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The home was fresh smelling, clean and appropriately heated. All of the responses we received in the returned questionnaires confirmed that this was normal for the home.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for improvement

No areas for improvement were identified with the delivery of safe care.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

A review of care records was undertaken in the nursing and residential unit.

Nursing unit:

We reviewed the care records of two patients recently admitted to the nursing unit. A comprehensive assessment of patient need and a range of risk assessments had been commenced at the time of admission to the home. A range of care plans were in place. The assessments and care plans were reviewed regularly. The section within one care record entitled "skin integrity" indicated that the patient had a pressure ulcer; however this was not recorded anywhere else in the care records and there was no record to confirm if any treatment had been prescribed or administered. Records indicated that the patient's skin was prone to redness, the prescribed care was detailed and records to evidence delivery. The registered nurses spoken with reported that the patient did not have a pressure ulcer. Staff spoken with were knowledgeable of the patient's skin care needs. The recording of skin integrity should be

reviewed to ensure care records consistently and accurately identify patients' skin care. A recommendation was made.

Residential unit:

We reviewed the care records of three residents in the residential unit. Records were generally maintained in line with the legislation and standards. They included an up to date assessment of needs, risk assessments, care plans and daily/regular statement of health and well-being of the resident. The records did not have up to date details of the resident's spiritual needs and associated contact arrangements. A recommendation was made for these to be put in place.

The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Issues of assessed need had a recorded statement of care / treatment given and effect of same, which included referral to the appropriate health professional.

Minutes of the most recent care review meetings were not maintained in an accessible manner in the resident's active care records; maintaining this accessibility would help ensure that any agreed actions at these meetings were acted upon and that significant changes in need are reviewed with the aligned named worker. A recommendation was made for these minutes to be maintained in an accessible manner in the resident's active care records.

Areas for improvement
The recording of skin integrity should be reviewed to ensure care records consistently and accurately identify patients' skin care needs.

Spiritual needs and associated contacts details should be recorded in the patients care records**.**

The minutes of the most recent care review should be maintained in an accessible manner in the resident's active care records,

Number of requirements	**0**	**Number of recommendations**	**3**

4.5 Is care compassionate?

We arrived in the home at 10:15 hours. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were sitting in the lounges or their bedrooms as was their personal preferences. Staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preference to sit throughout the day.

We spoke at length with the activity leader who explained that she delivered activities on a group and one to one basis in an effort to include everyone in activities. A programme of the weekly activities planned was displayed throughout the home. The activity leader advised that they reminded patients, especially those who chose to remain in their rooms, what activities were planned for that day. One patient spoken with confirmed that they were informed of the planned activities and, whilst they did not always attend, liked to know what was planned so they could decide if they wished to join in.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:

"I think it's wonderful."
"I would never have believed you could get care like this."

We spoke with the relative of one resident in the residential unit. This relative spoke with praise and gratitude for the care provided for and the kindness and support received from staff. The following comment was provided:

"I honestly couldn't praise the staff enough. They are all so kind to everyone and always keep me very well informed of what is going on".

Ten relative questionnaires were issued; one was returned within the timescale for inclusion in this report. The respondent was very satisfied that care was safe, effective, compassionate and well led. No additional comments were provided.

Ten questionnaires were issued to staff; two were returned within the timescale for inclusion in this report. Both staff were very satisfied that care was safe, effective, compassionate and well led. No additional comments were provided.

Areas for improvement

No areas for improvement with the delivery of compassionate care.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Patients, relative and staff commented positively regarding the registered manager and her role within the home. Staff reported that they were well supported in their role and that management were approachable.

There was an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. An inspection of accidents/incidents/notifiable events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. A regular audit of accidents and incidents was undertaken and was reviewed as part of the inspection process. Learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

Review of records and discussion with the registered manager and staff confirmed that any adult safeguarding issues were managed appropriately and that reflective learning had taken place. The registered manager confirmed that there were effective working relationships with internal and external stakeholders

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised.

The registered manager confirmed that they received good support from the operational manager who visited the home regularly to provide support and assistance as required.

The registered manager had systems in place to monitor and report on the delivery of care in the home.

Areas for improvement

No areas for improvement were identified with the delivery of compassionate care.

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 Liz Bonello, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements: No requirements were made as a result of this inspection.

Recommendations

Recommendation 1 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 14 February 2017	It is recommended that the recording of skin integrity is reviewed to ensure care records consistently and accurately identify patients' skin care and, where required, wound care needs. **Ref section 4.4**
	Response by registered provider detailing the actions taken: Skin care records have been reviewed and updated. These are regularly audited as part of the home's governance arrangements.
Recommendation 2 **Ref**: Standard 32.8 **Stated:** First time **To be completed by:** 14 February 2017	It is recommended that the spiritual needs and associated contacts details need to be recorded**.**
	Response by registered provider detailing the actions taken: Spiritual needs and associated contacts are recorded in residents care plans.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 14 February 2017	It is recommended that the minutes of the most recent care review needs to be maintained in an accessible manner in the resident's active care records,
	Response by registered provider detailing the actions taken: Minutes of Health & Social Trust care reviews are filed in the designated section within the care records.

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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