Unannounced Care Inspection Report
28 April 2016

Brooklands

Address: 50 Bush Road, Antrim BT41 2QB
Tel No: 02894460444
Inspector: Sharon McKnight

1.0 Summary

An unannounced inspection of Brooklands took place on 28 April 2016 from 09:25 to 17:00 hours.

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

For the purposes of this report, the term 'patients' will be used to described those living in Brooklands which provides both nursing and residential care.

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 and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. A general inspection of the home confirmed that the premises and grounds were well maintained.

Two areas for improvement were identified; one to ensure that the registered nurse in charge of the home in the absence of the registered manager was clearly identified on the staff duty roster. The second was to ensure that records of the Access NI checks evidence that the registered manager had checked the certificate prior to the candidate commencing employment. Two recommendations were stated.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that the outcome of care delivery was positive for patients. A review of care records confirmed that patients were subject to a comprehensive assessment of need which was then used to develop appropriate care plans. There was evidence to confirm that there was regular communication with patients and their relatives regarding their care. There were arrangements in place to monitor and review the effectiveness of care delivery. Patients, relatives and staff reported that they were happy with the care. We examined the systems in place to promote communication between staff, patients and relatives and were assured that these systems were effective.

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

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. 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. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding day to day issues affecting them. Patients spoken with commented positively in regard to the care they received.

There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure and staff were aware of their roles and responsibilities. A review of care confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

There was evidence of good leadership in the home, effective governance and arrangements to ensure good communication between the registered manager and acting registered person. There were systems in place to monitor the quality of the services delivered and where areas for improvement were identified, for example as an outcome of audit, a re-audited to check that the any required improvements were addressed was completed.

There were no areas of improvement identified in the domain of well led.

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 QIP within this report were discussed with Ms Liz Bonello, 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.

Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents, 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 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 eleven patients individually and with the majority in small groups, two registered nurses, one team leader, four care staff, a domestic supervisor and four relatives. Ten questionnaires were also issued to relatives and staff with a request that they were returned within one week of the date of this inspection.

The following records were examined during the inspection:

- five patient care records
- staff duty roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- record of managers weekly report
- reports of monthly visits undertaken in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 3 November 2015

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector and will be validated at the next medicines management inspection. There were no areas of concern required to be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 15 October 2015.

Last care inspection statutory requirements		**Validation of compliance**
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 4.1 **Stated:** First time	It is recommended that detailed plans of care to meet patients' individual needs are in place.	**Partially Met**
	Action taken as confirmed during the inspection: Two care records reviewed in the residential unit contained good detail of patients' individual needs. Care records in the nursing unit were maintained on a computerised system; some contained individual plans of care but others were generic. This recommendation is assessed as partially met and has been stated for a second time.	
Recommendation 2 **Ref**: Standard 20.2 **Stated:** First time	It is 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'.	**Met**
	Action taken as confirmed during the inspection: A review of one care record evidenced that discussion had taken place regarding the patient's end of life wishes.	

Recommendation 3 **Ref**: Standard 39.4 **Stated:** First time	The provision of dementia training for staff in the residential unit should be reviewed and incorporated in the home's written training and development plan. This review should give consideration to the method of delivering the training, for example, a face to face session as opposed to an e learning programme, and the frequency with which staff require to have this training.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of training records evidenced that face to face training in dementia had been provided by the local health and social trust on 15 and 17 February 2016; a total of 32 staff attended. The registered manager confirmed that further dates would be arranged. This recommendation has been met.	
Recommendation 4 **Ref**: Standard 12.21 **Stated:** First time	It is recommended that the serving of meals in the nursing unit is reviewed to ensure that it is a positive experience for patients.	**Met**
	Action taken as confirmed during the inspection: The serving of lunch in the nursing unit was observed to be calm and well organised with patients receiving their meals and assistance in a timely manner. This recommendation has been met.	
Recommendation 5 **Ref**: Standard 44.1 **Stated:** First time	It is recommended that the stains and malodours in the carpets in the sensory room and adjacent corridor area are addressed. If the odours and staining cannot be eliminated the carpets should be replaced.	**Met**
	Action taken as confirmed during the inspection: It was observed that the carpet in the sensory room has been replaced. The carpet in the adjacent corridor area was clean and stain free. There were no malodours present. This recommendation has been met.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 22 April 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic and laundry staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Patients commented positively regarding the staff and care delivery.

The registered manager, registered nurses and team leader spoken with were aware that a nurse was identified to be in charge of the home when the registered manager was off duty. The nurse in charge was not identified on the staffing roster. This was discussed with the registered manager and a recommendation stated.

A review of records evidenced that a competency and capability assessment had been completed with all 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.

A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. The two references in one file were printed and did not contain signatures. This was discussed with the registered manager who explained that the references had been received by electronic mail. The importance of ensuring authenticity of referees and references provided was discussed and it was agreed that the registered manager would consider measures to achieve this.

The record maintained of Access NI checks was reviewed and evidenced that the employees had been subject to an Access NI check with a satisfactory outcome. The issue date on the certificates preceded the date of commencement of both employees. It was recommended that the record of checks should be further to developed to include the date the certificate was checked by the home; this would evidence that the registered manager had checked the certificate prior to the candidate commencing employment. A recommendation has been stated.

Discussion with staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme the registered manager signed the record to confirm that the induction process had been satisfactorily completed.

Training was available via an e learning system known as “EVO training” and internal face to face training arranged by Brooklands Healthcare. Training opportunities were also provided by the local health and social care trust. The registered manager had systems in place to monitor staff attendance and compliance with training.

These systems included a print out of which staff had completed an e learning training and signing in sheets to evidence which staff had attended face to face training in the home. A review of the print out of mandatory training evidenced good compliance with mandatory training; for example 100% of staff had completed adult safeguarding training in the past 12 months. Training on skin assessment and pressure ulcer prevention was attended by 28 staff during September and October 2015 and, as previously discussed dementia training was delivered by the local health and social care trust in February 2016.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of falls to identify any trends or patterns.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated.

The team leader in the residential unit explained that the activity room was currently being decorated in the style of an old fashioned tea room which can be used when patients have visitors. This will be a positive additional to the home for both patients and their relatives.

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

The registered nurse in charge of the home when the registered manager is off duty should be clearly identified on the staff duty roster on the nursing and residential units.

The records of Access NI checks should be further developed to include the date the certificate was checked by the home.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.4 Is care effective?

A review of six patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information. A comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home for those patients admitted for long term care. A range of assessments were completed for patients admitted for intermediary care with input from the referring health care trust. As previously discussed validated risk assessments were completed as part of the admission process for all patients.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) and dieticians.

There was a programme of active rehabilitation, involving the appropriate healthcare professionals, for example physiotherapist and occupational therapist, to support and enable patients in the intermediary care scheme to return home. Discharge planning was included in the care plans for these patients.

Care records were regularly reviewed and updated, as required, in response to patient need. Patient confidentiality in relation to the storage of records was maintained.

There was evidence within the care records that patients and/or their representatives were involved in the care planning process. There was also evidence of regular, ongoing communication with relatives. Registered nurses spoken with 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. Weekly meetings took place with staff from the local health and social care trust to review the care and progress of patients receiving intermediate care.

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. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

The registered manager confirmed that staff meetings were held regularly, and staff were enabled to contribute to the agenda. The most recent meeting was held on 19 April 2016; the minutes of this meeting were still in note form. The previous meeting was held on 21 January 2016 with the registered nurses. The names of the staff who attended, issues discussed and any agreed outcomes were recorded. The record of each meeting was made available to staff.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff in the nursing unit spoke positively of improvements in the organisation of care and, in particular, the serving of meals. As previously discussed in section 4.2 the serving of lunch in the nursing unit was observed to be calm and well organised with patients receiving their meals and assistance on a timely manner. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Staff also confirmed that if they had any concerns, they would raise these with the registered manager.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. The registered manager explained that they had regular, daily contact with the patients and visitors and were available, throughout the day, to meet with both on a one to one basis if needed. Patients and relatives spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with.

Four patient questionnaires were issued; one was returned prior to the issue of this report. The patient commented that "I am very happy here and wish to stay longer."

Ten relative questionnaires were issued; two were returned prior to the issue of this report. The respondents indicated a high level of satisfaction with the delivery of safe, effective and compassionate care and with the domain of well led.

Ten questionnaires were issued to nursing, care and ancillary staff; three were returned prior to the issue of this report. Staff responses were positive with regard to the delivery of safe, effective and compassionate care and the leadership with the home.

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?

Throughout the inspection there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Patients were sitting in the lounges, or in their bedroom, as was their personal preference.

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. Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings.

Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. A quality assurance questionnaire is sent out annually to relatives of each patient. These have been sent for 2016. The registered manager explained that, currently, the results were being prepared for inclusion in the annual quality report; a copy of the report will be available in the home once completed.

The registered manager confirmed that they have regular, daily contact with the patients and visitors and that they were available throughout the day, and some evenings, to meet with both on a one to one basis if needed. Patients and relatives spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with. Two relatives spoken with were highly complementary of the recent support the registered manager and staff had given them to help them adjust to the changing circumstances of their loved one.

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:

"Mum is so happy in Brooklands and we thank everyone for the exceptional care shown to her." (residential unit)

"How do we begin to thank you for the care and support that you provided for Dad together with the friendship that you so generously offered to us as a family." (nursing unit)

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

"They couldn't be better than they are here."
"Staff couldn't be more civil or pleasant, they're just lovely."
"No complaints."

Relatives spoken with confirmed that they were made to feel welcome into the home by all staff. They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

A member of domestic staff provided examples of how they planned their routine around the patients. They discussed if a patient did not recognise the need to have their room cleaned, due to cognitive impairment, how they cleaned the room when the patient was participating in an activity or in the dining room; thereby not upsetting the patient by doing something they did not believe necessary. The example provided demonstrated a compassionate understanding of dementia and was commended.

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.

Staff spoken with were knowledgeable regarding line management and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint, details of the investigation and a copy of the letter sent to the complainant. The record also indicated how the registered manager had concluded that the complaint was closed. There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A deputy manager has recently been appointed. The registered manager explained that this addition to the management structure in the home would allow for a wider programme of audit to be completed; a more detailed audit of care records has been implemented from 13 April 2016. A review of these records evidenced that the audit findings were formulated into an action plan which included the area for improvement, the date for completion and the registered nurse responsible for completing the action. Records evidenced that the deputy manager re-audited the care record for compliance. Other areas for audit included accidents, complaints, wound management and medication. The importance of the registered manager maintaining oversight of the audit activity in the home was discussed. The report of the unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 included a review of the audit activity in the home.

Communication between the acting registered person and registered manager was discussed. The registered manager explained that a weekly report was completed and sent by electronic mail every Monday to the acting registered person and relevant senior personnel within Brooklands Healthcare. The report is a summary of patients' conditions, for example infections and significant weight loss, pressure ulcers and wounds, admissions to hospital and occupancy. Management issues such as staffing, complaints, adult safeguarding, serious adverse incidents (SAI) and any inspections completed in the home were also commented on.

The registered manager confirmed that the acting registered person was present in the home regularly and this formal report ensured they were kept informed of the operational issues.

The unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. A copy of the report was maintained and available in the home; the report included an action plan to address any identified areas for improvement. There was evidence in the reports that the action plan was reviewed during the next visit.

Areas for improvement

No areas for improvement were identified with domain of well led.

Number of requirements	0	Number of recommendations:	0

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Liz Bonello, registered 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the 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 by the registered manager. 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 service. 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 the 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 service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 4.1 **Stated:** Second time **To be completed by:** 7 June 2016	It is recommended that detailed plans of care to meet patients' individual needs are in place **Ref: section 4.2**
	Response by registered person detailing the actions taken: Residents' care plans are detailed to meet individual needs. These are audited as part of the home's governance arrangements.
Recommendation 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 12 May 2016	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. **Ref: section 4.3**
	Response by registered person detailing the actions taken: The nurse in charge is clearly recorded on the staff duty roster.
Recommendation 3 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 12 May 2016	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. **Ref: section 4.3**
	Response by registered person detailing the actions taken: Access NI checks now include the date that the certificate is viewed.

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews