

Unannounced Care Inspection Report 24 January 2017



Brookmount

Type of Service: Nursing Home
Address: 4 Lower Newmills Road, Coleraine, BT52 2JR
Tel no: 0287032 9113
Inspector: Aveen Donnelly

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Brookmount took place on 24 January 2017 from 10.00 to 16.00 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.

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	*3	*2

*The total number of requirements and recommendations above includes one requirement that has been stated for the second time; and two recommendations that have been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ann Bannister, 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 19 January 2017. There were no further actions required to be taken following the most recent 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: Apex Housing Association Gerald Kelly	Registered manager: Ann Bannister
Person in charge of the home at the time of inspection: Ann Bannister	Date manager registered: 19 May 2014
Categories of care: NH-LD(E), NH-I	Number of registered places: 48

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- 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 returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit.

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with four patients, three care staff, two registered nurses. No patients' representatives were consulted during the inspection.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- staff training records for 2015/2016
- accident and incident records
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- one agency staff induction record
- one competency and capability assessment for the registered nurses who are in charge of the home in the absence of the registered manager
- records pertaining to NMC and NISCC registration checks
- minutes of staff meetings held since the previous care inspection
- monthly quality monitoring reports 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 19 January 2017

The most recent inspection of the home was an unannounced medicines management inspection. No requirements or recommendations were made during the medicines management inspection and there were no issues required to be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 18 October 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 Ref: Regulation 20 (1) (a) Stated: First time	<p>The registered persons must ensure that staffing arrangements in the home are reviewed, taking into account the dependency levels of patients, the deployment of staff and the layout of the building.</p> <p>Action taken as confirmed during the inspection: The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 16 January 2017 evidenced that the planned staffing levels were adhered to.</p>	Met
Requirement 2 Ref: Regulation 20 (c) (i) Stated: First time	<p>The registered persons must ensure that training on adults safeguarding is provided to all staff. Current records of staff attendance must also be retained in the home, to evidence compliance with mandatory training requirements.</p> <p>Action taken as confirmed during the inspection: Although all staff consulted with stated that they had received training in relation to adult safeguarding, the records available did not reflect recent training that had been provided. RQIA acknowledges that the home had recently developed a training matrix, to provide the registered manager with oversight in relation to staff compliance with mandatory training requirements. An updated matrix was forwarded to RQIA by email on 27 January 2017. This was satisfactory.</p>	Met

<p>Requirement 3</p> <p>Ref: Regulation 20 (1) (c) (ii)</p> <p>Stated: First time</p>	<p>The registered persons should ensure that a robust system is implemented, to ensure that registered nurses' registration with the Nursing and Midwifery Council (NMC) is checked on a regular basis.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing staff were appropriately managed in accordance with the NMC.</p>		
<p>Requirement 4</p> <p>Ref: Regulation 30 (1) (c)</p> <p>Stated: First time</p>	<p>The registered persons must ensure that any head injuries sustained in the home are notified to RQIA.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.</p>		
<p>Requirement 5</p> <p>Ref: Regulation 15 (2) (a)</p> <p>Stated: First time</p>	<p>The registered persons must ensure that patients' needs are assessed and that a treatment plan is developed, implemented accordingly and recorded to evidence all care provided, with particular reference to wound care. Wound care records should also be supported by the use of photography in keeping with the home's policies and procedures and the NICE guidelines.</p>	<p>Not Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>A review of two patient care records evidenced a lack of consistency in relation to which section of the electronic record, entries were to be recorded. Assessments were not fully completed to include wound measurements, care plans did not include the specific dressing regimen and where a patient had been non-compliant there was no evidence that this had been referred to the tissue viability nurse specialist. This requirement was not met and has been stated for the second time. Refer to section 4.3.3 for further detail.</p>		

Last care inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 39.1 and 39.9 Stated: First time	The registered persons should ensure that agency staff inductions are completed and records retained in the home. Agency staff profiles, which evidence the training and competency level achieved, should also be retained.	Met
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of records evidenced that there was a system in place to ensure that agency staff inductions were completed. Agency staff profiles were also retained in line with this recommendation.	
Recommendation 2 Ref: Standard 39 Stated: First time	The registered persons should ensure that competency and capability assessments are completed on an annual basis, for registered nurses who have the responsibility of being in charge of the home, in the absence of the registered manager.	Met
	Action taken as confirmed during the inspection: A review of records confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home.	
Recommendation 3 Ref: Standard 22.4 Stated: First time	The registered persons should ensure that the falls risk assessment is reviewed in response to patients' falls.	Not Met
	Action taken as confirmed during the inspection: A review of care records evidenced that risk assessments for falls had not been updated after a patient had fallen. This meant that patients were not being adequately protected against further risks of falls. This recommendation was not met and has been stated for the second time.	

<p>Recommendation 4</p> <p>Ref: Standard 44.1</p> <p>Stated: First time</p>	<p>The registered persons should ensure that the identified resident's bedroom carpet is replaced.</p> <hr/> <p>Action taken as confirmed during the inspection: The flooring had been replaced in the identified patient's bedroom.</p>	Met
<p>Recommendation 5</p> <p>Ref: Standard 4</p> <p>Stated: First time</p>	<p>The registered persons should ensure that care plans are developed in response to acute infections.</p> <hr/> <p>Action taken as confirmed during the inspection: The review of the care records evidenced that care plans were not consistently developed in relation to acute infections.</p>	Not Met
<p>Recommendation 6</p> <p>Ref: Standard 7.1</p> <p>Stated: First time</p>	<p>The registered persons should review the methods available for engagement with patients and relatives to ensure they are effective.</p> <hr/> <p>Action taken as confirmed during the inspection: There had been no complaints made by relatives from the last inspection. Discussion with the registered manager confirmed that plans were in place to hold a relatives' meeting in February 2017 and that this would be facilitated by the organisation's head office. Plans were in place to write to all the patients' representatives, in effort to have improved attendance.</p>	Met
<p>Recommendation 7</p> <p>Ref: Standard 35.4</p> <p>Stated: First time</p>	<p>The registered persons should ensure that the systems in place to monitor and report on the quality of nursing and other services provided are further developed, to include auditing of wound care management.</p> <hr/> <p>Action taken as confirmed during the inspection: Although there was evidence that the care record audits had been further developed, to include sections relating to wound assessments and care plans, this was not effective in giving the registered manager oversight of wound care management in the home overall. Following the inspection, the registered manager submitted a proposed wound audit which they had developed. RQIA was satisfied with the changes made to the auditing process. Refer to section 4.3.5 for further detail.</p>	Met

Recommendation 8 Ref: Standard 21 Stated: First time	The registered persons should ensure that the monthly monitoring reports are received by the registered manager within a meaningful timeframe, to enable the actions identified in the action plan to be addressed in a timely manner.	Met
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that the monthly quality monitoring report was received, in draft, on the day of the visit.	

4.3 Inspection findings

4.3.1 Staffing arrangements

As discussed in section 4.2, the registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for the week commencing 16 January 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients 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 number and skill mix of staff on duty.

The registered manager explained there was currently only one registered nurse vacancy and that recruitment plans were in place to fill this post. A number of care staff had recently been recruited and were going through the appropriate checks before starting in post. These vacancies were being filled by agency staff or permanent staff working additional hours.

4.3.2 Care practices

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. 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.

One identified patient required a pressure relieving mattress on their bed due to having pressure damage to their skin. Observation of the specific pressure relieving mattress evidenced that staff had to 'set' the pressure according to the patient's weight. Too high or too low a pressure setting has the potential to cause pressure damage rather than relieving it. We found the patient, whose weight was 34 kgs using a mattress that was set for a patient of more than 100 kgs. This meant the mattress was not effective in protecting the patient from the risks associated with pressure damage to their skin. Specific details of the findings were discussed with the manager who immediately responded to the concern by ensuring the mattress setting was adjusted appropriately. There was no formal process for monitoring or recording pressure mattress settings and discussion with staff evidenced that they were not knowledgeable in relation to mattress settings. This was discussed with the registered manager. A requirement has been made in this regard.

4.3.3 Care records

The home used an electronic system for assessing, planning and evaluating patients' care needs. A review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and were generally reviewed as required. However, deficits continued particularly in relation to wound care records. For example, wound assessments did not consistently include wound measurements and the daily progress notes did not reflect that the dressings had been changed consistently. For example, a review of the daily progress notes evidenced that one patient's dressing had not been changed in an eight day period. When raised with the staff, they explained that the identified patient was noncompliant with the dressing regime. Although the review of this patient's care record did evidence non-compliance with other areas of personal care, the progress notes did not reflect the patient had been refusing to have their wound dressing changed and there was no evidence that this difficulty had been communicated to the tissue viability nurse specialist (TVN). Following the inspection, the registered manager confirmed to RQIA by email on 27 January 2017 that this matter had been referred to the TVN.

One patient did not have a specific care plan for the management of their wound. However, the registered nurse explained that wound care was documented in a number of different places on the electronic record. This meant that it was difficult to ascertain which prescribed dressing regime was the most up to date. Another care plan stated 'redress as per hospital discharge letter'; however, when this was reviewed there was no evidence of any instructions in relation to the wound care regime. This was followed up by the registered nurse on the day of the inspection. A requirement that was previously made in this regard has been stated for the second time.

4.3.4 Consultation

During the inspection, we met with four patients, three care staff and two registered nurses. No patients' representatives were consulted during this inspection. Some comments received are detailed below:

Staff

"It is a good nursing home, I like working here".
 "We give good care, we have extra time with the residents".
 "The care is good, I left another job to come here".
 "Things are beginning to improve here, I like it very much".
 "The care is good".

Although all those consulted stated that they received a 'run down' of patients care needs in the morning, two staff members commented that the written handover report was not consistently printed for them to read. This was discussed with the registered manager who agreed to address the matter.

Patients

"Everything is fine, they treat me well".
 "All is fine"
 "I have no concerns".

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. No patients returned questionnaires. Four staff and seven relatives had returned their questionnaires, within the timeframe for inclusion in this report. Some comments received are detailed below:

Staff respondents indicated that they were either 'very satisfied' or 'satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led.

Responses from relatives similarly indicated that they were generally either 'very satisfied' or 'satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. However, one respondent indicated that they were 'unsatisfied' that the care in the home was effective. Although the respondent indicated that they felt that their relative was getting the right care at the right time and that appropriate action would be taken if there was a change in their condition; the respondent provided written comment in relation to not being involved in planning their relative's care; not being kept up to date about the care and treatment of their relative; and never being asked about suggestions for improvement in the home. Two respondents provided written comment in relation to wanting the staff to have more time to spend with the patients. Comments included 'sometimes they are short staffed and carers are under pressure, generally the home is clean, but if someone has an accident, it takes time to get it sorted'. Following the inspection, these comments were communicated to the registered manager, to address.

4.3.5 Management and governance arrangements

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff commented positively in relation to her being 'very approachable' and 'supportive'. The registered manager confirmed that plans were in place for senior nurses to work supernumerary hours, which would assist them in undertaking audits more frequently.

Discussion with the registered manager and observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed 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, wound management, care records, infection prevention and control, environment, complaints, incidents/accidents and bed rails. As discussed in section 4.2, the care records auditing process had been further developed following the last inspection; however these improvements were not sufficiently robust. For example, the care record audit would have identified deficits in relation to the wound care management of the particular record that was being audited; however it did not give the registered manager oversight of the overall management of wounds in the whole home. This was discussed with the registered manager. Following the inspection, the registered manager submitted a proposed wounds auditing template to RQIA by email on 30 January 2017. RQIA was satisfied that this process would identify any shortfalls in the care records and in the delivery of care.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives.

The monthly quality monitoring report provided a comprehensive overview of areas that were meeting standards and areas where improvements were required.

4.3.6 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. A number of patients' bedrooms were personalised with photographs, pictures and personal items. However, the sluice room door on the first floor was observed to be unlocked. Cleaning chemicals were also stored in this room in an unlocked cupboard. This posed a potential risk to patients as a number of patients were ambulant and may have entered the sluice room. A requirement has been made in this regard.

There was also an unlabelled spray bottle observed in the unlocked cupboard. This meant that the staff using this spray bottle may not have been aware of any precautions that may have been needed. This was discussed with the registered manager, who agreed to address the matter with staff.

Areas for improvement

A requirement has been made that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use.

A requirement has been made that any chemicals used within the home are labelled correctly and stored securely in accordance with COSHH regulations.

Number of requirements	2	Number of recommendations	0
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ann Bannister, 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	
Requirement 1 Ref: Regulation 15 (2) (a) Stated: Second time To be completed by: 21 March 2017	<p>The registered persons must ensure that patients' needs are assessed and that a treatment plan is developed, implemented accordingly and recorded to evidence all care provided, with particular reference to wound care. Wound care records should also be supported by the use of photography in keeping with the home's policies and procedures and the NICE guidelines.</p> <p>Ref: Section 4.2 and 4.3.3</p> <p>Response by registered provider detailing the actions taken: . This has been highlighted with all nursing staff A Wound Care Audit tool has been developed and is being used to audit all wounds on a monthly basis ensuring that every wound has an assessment and careplan which are updated weekly, that a photograph is in place and that dressings are renewed as per care plan and in keeping with Nice Guidelines</p>
Requirement 2 Ref: Regulation 13 (1)(a) Stated: First time To be completed by: 21 March 2017	<p>The registered persons must ensure that the settings of pressure relieving mattresses are monitored and recorded, to ensure their effective use.</p> <p>Ref: Section 4.3.2</p> <p>Response by registered provider detailing the actions taken: A tool has been developed and has now been implemented in the home where settings on pressure relieving mattresses are monitored and recorded on a daily basis</p>
Requirement 3 Ref: Regulation 14 (2) (c) Stated: First time To be completed by: 21 March 2017	<p>The registered person must ensure that any chemicals used within the home are labelled correctly and stored securely in accordance with COSHH regulations.</p> <p>Ref: Section 4.6</p> <p>Response by registered provider detailing the actions taken: All chemicals are labelled correctly and stored securely in accordance with COSHH regulations. COSHH refresher training will be provided for all housekeepers by end of April 2017</p>
Recommendations	
Recommendation 1 Ref: Standard 22.4 Stated: Second time To be completed by:	<p>The registered persons should ensure that the falls risk assessment is reviewed in response to patients' falls.</p> <p>Ref: Section 4.2</p> <p>Response by registered provider detailing the actions taken: The falls risk assessment will be reviewed and updated for every fall</p>

21 March 2017	that takes place. If there are recurrent falls and no change is evident following review this will be documented in the resident's daily progress.
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<p>Recommendation 2</p> <p>Ref: Standard 4</p> <p>Stated: Second time</p> <p>To be completed by: 21 March 2017</p>	<p>The registered persons should ensure that care plans are developed in response to acute infections.</p> <p>Ref: Section 4.2</p> <hr/> <p>Response by registered provider detailing the actions taken: Care plans are developed in response to acute infections. This has been highlighted with all nurses at a recent staff meeting. The QIP is a standard item on the agenda at all staff meetings.</p>
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