Unannounced Care Inspection

Name of Establishment:	**Brookmount**
RQIA Number:	**1188**
Date of Inspection:	**27 January 2015**
Inspector's Name:	**Aveen Donnelly and Sharon Loane**
Inspection ID:	**20240**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of Establishment:	Brookmount
Address:	4 Lower Newmills Road Coleraine BT52 2JR
Telephone Number:	028 70329113
Email Address:	a.bannister@apexhousing.org
Registered Organisation/ Registered Provider:	Apex Housing Association Gerald Kelly
Registered Manager:	Ann Bannister
Person in Charge of the Home at the Time of Inspection:	Ann Bannister
Categories of Care:	NH-LD(E), NH-I
Number of Registered Places:	48
Number of Patients Accommodated on Day of Inspection:	43
Scale of Charges (per week):	£606
Date and Type of Previous Inspection:	3 December 2013 Primary Unannounced Care Inspection
Date and Time of Inspection:	27 January 2015 10:00 – 16:15
Name of Inspector:	Aveen Donnelly and Sharon Loane

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the Provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process

4.0 Methods/Process

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

- Discussion with the registered nurse manager
- Discussion with staff
- Discussion with patients individually and to others in groups
- Consultation with relatives
- Review of a sample of policies and procedures
- Review of a sample of staff training records
- Review of a sample of staff duty rotas
- Review of a sample of care plans
- Review of the complaints, accidents and incidents records
- Review of the regulation 29 visits
- Review of the records pertaining to activities
- Review of staff/relatives meetings
- Observation during a tour of the premises
- Evaluation and feedback.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients/Residents	**5**
Staff	**4**
Relatives	**2**
Visiting Professionals	**0**

Questionnaires were provided by the inspector, during the inspection, to patients / residents, their representatives and staff to seek their views regarding the quality of the service.

Issued To	**Number Issued**	**Number Returned**
Patients/Residents	**8**	**3**
Relatives/Representatives	**8**	**4**
Staff	**10**	**7**

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report.
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report.
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report.
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report.
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Brookmount Nursing Home is owned and operated by Apex Housing association and is situated in a quiet residential area on the outskirts of Coleraine. It is within easy distance of the main bus and train routes and local public amenities. The premises share a site with Brookhill House, which is also managed by North and West Housing Limited.

The current registered manager is Ms Ann Bannister.

The home is registered by the Regulation and Quality Improvement Authority (RQIA) to provide care for a maximum of 48 persons, under the following categories:

Nursing Home (maximum 48 persons)

NH-I	Old age not falling into any other category
NH-LD(E)	Learning disability - over 65 years for 1 identified individual only.

Accommodation is provided in single rooms on both floors of the home. All areas of the home are accessible via the passenger lift or the stairs. There are adequate numbers of lounges, dining rooms, toilets, bathrooms and shower rooms throughout the home. The main foyer is spacious and offers alternative seating to the main lounges on both floors. Throughout the home, and in addition to the lounges, there are quiet seating areas where patients can relax and visit with friends and family if desired. A relatives' room which includes a small kitchen is also provided.

A garden with shaded and seating areas is available and accessed through the grounds of the home and from the ground floor dining room.

The home's RQIA 'Certificate of Registration' was appropriately displayed in the entrance hall of the home.

8.0 Executive Summary

This summary provides an overview of the services examined during an unannounced secondary care inspection. The inspection was undertaken by Aveen Donnelly and Sharon Loane on 27th January 2015 from 10:00 to 16:15. The inspectors were welcomed into the home by Ann Bannister, registered manager, who was available throughout the inspection, and received verbal feedback at the conclusion of the inspection.

The focus of the inspection was in relation to DHSSPS Nursing Homes Minimum Standard 19 – Continence Management. Inspection sought to assess progress with the issues raised, during and since the previous inspection.

As a result of the previous inspection conducted on 3 December 2013, three requirements and three recommendations were made. These were reviewed during this inspection. One requirement had been fully complied with. One requirement made regarding fluid intake monitoring had not been addressed for the second time. Given that this requirement would be stated for the third time, enforcement action was considered in discussion with the Head of Nursing. It was concluded that enforcement action would not be taken at present and the requirement was stated for the third and final time. A new requirement has also been made, to address how fluids are managed in care plans. A requirement has also been stated for the second time, with regards to monitoring the dependency levels of patients.

One previously stated recommendation was fully complied with. One recommendation made regarding the use of the Bristol Stool Chart had not been addressed. A requirement has been made to address this matter. The recommendation with regards to the provision of an activities co-ordinator has not been addressed and a requirement has been made. Details can be viewed in the section immediately following this summary.

With regards to Standard 19, continence management care practices were deemed to be substantially compliant and areas identified for improvement. Except for an issue regarding one patient, practices observed and care records reviewed confirmed that patients' continence needs were met with dignity and respect: refer to inspector's comments in section 11.3. A recommendation has been made with regards to the need for the current policy on catheter care to be further developed and for additional guidelines on continence care to be made available to staff. There is a specific focus in the requirement regarding care plans for the development of continence management.

The general environment was inspected. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was clean and comfortably heated throughout. Consultation with patients and visiting relatives and comments from completed questionnaires indicated a general satisfaction with care. However, some concerns were raised by patients/relatives about staff being under pressure and the use of agency staff.

Staffing arrangements were reviewed and were found to be in accordance with the minimum standards. However, consultation with staff identified frustrations with high use of agency staff and increased dependency levels. Discussions with the registered manager confirmed that recruitment plans are in place to reduce the number of agency staff used. Reassurances were provided by the registered manager that the dependency levels would be kept under review and that staffing arrangements would be reviewed accordingly. A requirement has been made that the recruitment plan is forwarded to RQIA with the returned QIP.

Care practices over the lunch time meal were observed. A requirement has been made to review the dining experience of patients to ensure that meals are served in accordance with best practice, in a dignified manner and that mealtimes are a positive experience for patients.

A significant weight loss was identified in one patient. There was no evidence in the patient record to indicate the action taken. The registered manager confirmed that audits of patients' weights had not been conducted. An urgent action letter was issued with regards to the needs of the one patient and for an audit of all patients' weights to be conducted. An audit of patients' weights was forwarded to RQIA on 30 January 2015. However, a requirement has been made to address this issue.

A recommendation is made that the record of complaints includes the detail of the action taken to resolve all of the issues raised and the subsequent outcome. The process used to ascertain the complainant's level of satisfaction should be further developed.

A tour of the premises was undertaken. The home presented as comfortable and all areas were maintained to a high standard of hygiene. Numerous containers that contained thickening agent were observed to have the label removed. A requirement is made in this regard to address this.

As a result of this inspection, nine requirements, one of which has been stated for the second time and one of which has been stated for the third and final time, have been made. Two recommendations have also been made. These requirements and recommendations are detailed throughout the report and in the quality improvement plan (QIP).

The inspectors would like to thank the patients, visiting relatives, visiting professionals, the registered manager and staff for their assistance and co-operation throughout the inspection process.

8.4 Post Inspection

An urgent actions letter was issued on the day of inspection, regarding the monitoring of an identified patient's weight and for the all the patients currently accommodated in the home. Confirmation that this had been addressed was forwarded to RQIA on 30 January 2015.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	16 (2) (b)	Where a nursing assessment is made to monitor a patient's daily fluid intake, then the patients daily (24hour) fluid intake should be recorded in their daily progress record in order to show that this area of care is being properly monitored and validated by the registered nurse.	A review of four care records identified that the daily fluid intake had been recorded in the progress notes. However, inconsistencies were identified. In three care records, fluid intake had not been recorded for two days. Records were maintained on a fluid recording chart and these were maintained consistently. However, there was no evidence that these were being properly monitored and validated by the registered nurse and there was no evidence of appropriate action having been taken, when deficits were identified. Given that this requirement has been stated for the third time, enforcement action was considered in discussion with the Head of Nursing. It was concluded that enforcement action would not be taken at present. The requirement is assessed as moving towards compliance and has been stated for the third and final time. A Review of records also revealed that fluid targets were not entered consistently on care plans. The	Not compliant

			formula used to determine fluid intake was discussed with the registered manager, who was advised of the updated information provided in the nutritional guidelines. Care plan evaluations contained meaningless entries. Fluid targets on care plans differed from those entered on the fluid recording charts. A new requirement is made in relation to care planning.	
2.	20 (1) (a)	It is required that the registered person continues to monitor the dependency levels of patients using the Rhys Hearn (1970) dependency tool to ensure that staffing provision and care hours provided meets the needs of the patients accommodated.	A review of the care records confirmed that dependency levels were reviewed on a monthly basis. However the tool used was not the Rhys Hearn (1970) dependency tool and there was no evidence that the tool used by the home informed the management of staffing levels. Following the inspection, the registered manager forwarded a copy of the dependency levels, utilising the Rhys Hearn model. Assurances were provided by the registered manager that this would continue to be monitored on a monthly basis. This requirement has not been fully addressed and is stated for the	Not compliant

			second time.	
3	13 (7)	A pressure relieving cushion in a patient's bedroom had a torn covering, in the interest of infection control the cushion should be recovered to provide an impermeable surface which can be effectively cleaned.	The pressure relieving cushion involved had been replaced.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	10.7	The registered person should provide a policy and procedure on the management of restraint suited to the needs of patients accommodated in the nursing home. The policy should be reflective of legislative guidance that restraint is only used as a last resort and is the only practicable means of securing the welfare of that or any other patient. Guidance on the identified the types/methods of restraint used in the home should also be included.	The policy and procedure on the management of restraint had been reviewed since the previous inspection. The policy content reflected legislative guidance and the types/methods of restraint used in the home were contained in the policy.	Compliant
2.	5.6	The registered person should ensure that bowel function, reflective of the Bristol Stool Chart should be recorded on admission as a baseline measurement and thereafter in patients' daily progress records.	A review of the care records confirmed that patients' daily bowel movements were being documented on a bowel recording sheet. However, normal bowel pattern was not ascertained on initial assessment and this was not documented in the care plans or progress notes. A review of care records identified gaps of between 14 and 22 days when bowel activity was not recorded. The use of the Bristol Stool Chart was used to describe diarrhoea. A requirement has been made to address this.	Not compliant

3.	13	It is recommended that the registered person considers the appointment of a dedicated individual to organise and co-ordinate a programme of activities and events as stated in Standard 13 of the Nursing Homes Minimum Standards (January 2008). A record should be maintained to evidence the decision making process regarding the provision of activities and events for patients accommodated in the nursing home.	There is no activity coordinator in post. The activity display board confirmed that a formalised plan for the week was in place. The home provides activities by using external entertainment and by assigning care staff to provide activities on other days. However, inspection revealed that staffing arrangements in the home had impacted on the capacity of staff to provide a programme of activities based on the identified needs and interests of patients. Refer to inspector's comments in section 11.2 and 11.4 of the report. The activity records confirmed that musical entertainment, church services and hairdressing services had been provided. However, the activity records did not identify the level of engagement or enjoyment level of service users. There was no evidence of the activities that were offered / provided to patients who were unable to participate in group activities. Activities were repetitive and there was no evidence to indicate that this was due to patient preference. There was a nine day period where there was no activities recorded. In view of the lack of progress and the	Moving towards compliance

			constraints on staff to carry out activities, a requirement has been made to ensure that this matter is fully addressed to ensure patients' needs are fully met and their quality of life in the home enhanced	

9.1 Follow-up on any Issues/Concerns Raised with RQIA since the Previous Inspection such as Complaints or Safeguarding Investigations

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Since the previous inspection on 3 December 2013, RQIA have not been notified by the home of any ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussion with staff and observation during the inspection confirmed that there were adequate stocks of continence products available in the nursing home. Five care records were reviewed. Continence assessments had been completed in all of the care records reviewed. However, the information provided in the continence assessments did not contain sufficient detail, in order for a person-centred care plan to be formulated. One assessment stated that the patient may be incontinent. There was no evidence of the patients' normal bowel pattern having been identified. The need for continence assessments to be more comprehensive was discussed with the registered manager. There was evidence that patients and / or their representatives had been involved in the care planning process. There was evidence that care plans had been updated regularly. With regards to the care plan content, there was no evidence of normal bowel patterns or the required actions to be taken, if patients were to become constipated. A care plan for a urinary catheter did not specify cleansing of entry site. Two care plans incorporated skin integrity and incontinence into the one care plan. However, the monthly evaluations referenced only one of the identified problems. The evaluations of care plans were not comprehensive and did not reflect the information documented in the daily progress notes or the bowel records. There will be a specific focus in the requirement regarding care planning, on the development of continence care plans.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
Policies, procedures and guidelines in the promotion of continence and the management of incontinence were available in the home. However, the policy needs to be further developed to include catheter and stoma care. The RCN continence care guidelines were available. However, a recommendation is made for that the following additional guidelines are made readily available to staff and are used on a daily basis: • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence The need to review the continence policy and the provision of additional guidelines are incorporated into one recommendation.	Substantially compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Not examined	Not applicable
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
A discussion with the registered manager and a review of the training records confirmed that all relevant staff were trained in continence care. Two registered nurses were trained and deemed competent in male and female catheterisation. Staff spoken with, were knowledgeable about aspects of continence care, including privacy and dignity, skin care and infection control. There was a continence link nurse. The role of the continence link nurse in reviewing continence management and training for staff was discussed with the manager.	Substantially compliant

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

11.0 Additional Areas Examined

11.1 Patients/Residents and Relatives Comments

The inspectors spoke with five patients individually and with the majority of others in smaller groups. Patients confirmed and the questionnaire responses affirmed that patients were treated with respect and dignity. A number of patients identified that their care needs were not always met in a timely manner and that the staff appeared to be rushed and under pressure. Patients commented that the food was good and plentiful and that if they were unhappy with the available choices, an alternative meal would have been provided.

Some comments received from patients included:

- "My care needs are not being met, simple things, for example, they don't take time to shave me or wash my teeth".
- "Have to wait when using call bell".
- "When I use my buzzer, may have to wait if the staff are with other patients".
- "An example, of how rushed they are, is that one time they only washed under one arm, but then dried under both arms".
- "They are rushed, but they have to be done with me by 9:30am".
- "No complaints here. Staff are very good to me".
- "I get what I need".

Four relatives' completed questionnaires were returned to the inspectors. The majority identified a high level of satisfaction with the services and care provided. One relative responded that they had not been made to feel part of their relative's care. Relatives' comments were as follows:

- "We are very happy with the care here. We have placed two relatives here at different times and would not have done so, if we were not happy".
- "It is a lovely home; staff are very caring".
- It gives me peace of mind that (they) are cared for properly".
- "The staff are most caring".
- "The staff are under pressure. There is a lot of agency staff".

Issues identified were discussed with the registered manager at the conclusion of the inspection who gave assurances that all matters would be addressed.

11.2 Staffing/Staff Comments

Three weeks' duty rotas were reviewed. The overall numbers of staff were in accordance with RQIA's recommended minimum staffing guidelines for the number of patients accommodated. However, there was a high number of agency staff employed in the home on the day of the inspection. This was to cover in-house training. A review of staff duty rotas confirmed that the planned staffing levels had been adhered to. Deficits in staffing were attributed to short notice sick leave.

A review of the care records confirmed that dependency levels were reviewed regularly. However, the tool used was not the Rhys Hearn (1970) dependency tool as required following the last inspection in December 2013. The registered manager also confirmed that the tool

used by the home was not being used to determine appropriate staffing levels. Following the inspection, the registered manager forwarded a copy of the dependency levels, utilising the Rhys Hearn model. Assurances were provided by the registered manager that dependency levels would be regularly monitored and that the staffing arrangements would be reviewed accordingly. A requirement to address this has been stated for the second time.

Staff interviewed and the responses from the completed questionnaires confirmed that the majority of staff were satisfied or very satisfied with the quality of care provided to patients. All staff stated that they were provided with a variety of relevant training. Staff commented positively on the home's management and delivery of care. However, a number of staff were concerned regarding the high dependency levels of patients and the high use of agency staff within the home. Some staff provided examples of feeling frustrated at having to rush patients through aspects of personal care and not having time to spend talking to patients or carrying out activities. One staff member stated that they only had time to carry out basic care delivery.

Examples of staff comments were as follows:

- "Not enough staff".
- "Staff are too rushed".
- Time to listen and talk to patients can be restricted due to increased dependency level of patients and existing staffing levels".
- "Staff continue to strive hard to provide a high quality of care for residents. We regularly receive positive comment and feedback from the patients' relatives".
- "Increased dependency levels of residents in recent years and no increase in staffing levels".
- "There is too much agency staff".
- "We have an excellent home manager and excellent staff nurses".

In view of the comments made by patients and staff, inspectors discussed staffing arrangements and care practices with the registered manager at the conclusion of the inspection. Assurances were provided by the registered manager that dependency levels would be regularly monitored and that staffing arrangements would be reviewed accordingly. The registered manager also provided assurances that consideration would be given to the number and deployment of agency staff throughout the home, to improve the quality of care practice to patients. The home's recruitment plan to reduce agency usage was also discussed further with the registered manager. The inspectors were satisfied with the information outlined in the recruitment plan; however, a requirement has been made for the recruitment plan to be forwarded to RQIA with the completed QIP. Refer also to inspector's comments below under Care Practices.

11.3 Care Practices

Staff were observed carrying out their duties. A high number of patients were nursed in bed, one of whom was observed to have been incontinent of faeces and confirmed to the inspector that their personal care needs had not been attended to. The patient's needs were attended to, after prompting by the inspector. Care staff spoken with confirmed that they could not meet patients' needs, and were observed to be under pressure. This was discussed with the registered manager, who agreed to monitor the deployment of agency staff to ensure that they were being assigned appropriately. With reference to section 11.2 above, two requirements have been made with regards to the monitoring of dependency levels and the recruitment plan.

Meals were provided to patients in their rooms, if this was their preference. Meals were delivered to the rooms on plates that were covered with cling film. The mealtime experience was observed in two dining rooms and included the preparation and serving of the lunchtime meal. The dining tables were set in advance. Two kitchen staff who served the meals were not wearing complete uniforms. A range of issues were observed including examples of negative interactions between staff members and patients. These included:

- No engagement with patients
- Plate guards were not provided to those who needed them.
- One staff member not responding to a patient's request for a fork
- Condiments not routinely offered to patients and delay in providing salt for a patient
- Putting plates down with patients without verbal contact
- Fluids not being consistently provided
- Assisting patients to eat whilst staff were standing.

These areas of concern were discussed with the staff present, who responded immediately. The registered manager agreed to review the mealtime experience. A requirement has been made to address this.

11.4 Care Records

A review of patient care records identified that one patient had a significant weight loss. There was no evidence in the patient's record to confirm that the required action had been taken. The registered manager confirmed that audits of patients' weights had not been conducted regularly. An urgent action letter was issued to the home on the day of inspection with regards to the needs of the one patient and for an audit of all patients' weights to be conducted. An audit of patients' weights was forwarded to RQIA on 30 January 2015. A requirement has been made to address this issue.

The activities provided within the home were discussed with the registered manager who stated that the home had been attempting to seek a grant for this. Activities were provided on an external basis and by the care staff who were assigned to carry this out. A review of the activity records did not identify the level of engagement or enjoyment level of service users. There was no evidence of the activities that were offered/provided to patients who were unable to participate in group activities. Activities were repetitive and there was no evidence to indicate that this was due to patient preference. Comments made by staff as highlighted in section 11.2 confirmed that staff did not have the capacity to undertake additional duties, such as providing activities. There was a nine day period where there was no activities recorded.

A review of the minutes of the relatives' meeting that was held on 4 December 2014 identified that relatives were concerned that an activities coordinator had not been put in place, as had been previously recommended by RQIA. A requirement has been made to address this (see section 9.0).

11.5 Accidents

Records in relation to the management of falls were reviewed and were deemed to be appropriately maintained.

11.6 Complaints

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. Since the previous inspection on 3 December 2013, RQIA have not been notified of any complaints.

The minutes of the relatives' meeting identified that the registered manager had discussed the complaints procedure during the meeting. Issues raised during the relatives' meeting included delays in answering call bells, drinks being left outside of reaching distance of patients and patients wearing laddered tights. Assurances were provided to relatives by the registered manager that the issues raised would be addressed.

A review of the complaints record identified that complaints were dealt with in a timely manner. There were three complaints recorded in the six month period preceding the inspection. The complaints related to staffing levels, long delays in answering call bells and staff manner. The outcome of one complaint was recorded. A recommendation has been made to ensure that the record of complaints should include the detail of the action taken to resolve the issues raised and the subsequent outcome. The process used to ascertain the complainant's level of satisfaction should be further developed.

11.7 Environment

A tour of the premises was undertaken. The home presented as comfortable and all areas were maintained to a high standard of hygiene. Some incontinence pads had been removed from their original packaging; and several incontinence pads and gloves had been placed on handrails throughout the home. This was discussed with the registered manager, who agreed to address this.

Numerous 'Nutrilis' containers were observed with the labels having been removed. A requirement has been made to address this.

Bed sheets were not ironed in one bedroom. Staffing problems in the laundry were discussed at the relatives' meeting on 4 December, in which the registered manager stated that the home was attempting to recruit a second staff member. This second staff member is now in place.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with the registered manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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.

Enquiries relating to this report should be addressed to:

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

Appendix 1

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Following a referral from the Care Manager, a pre-admission assessment is carried out for each patient. On admission to the home, a nurse carries out a holistic assessment using validated assessment tools and a Care Plan is developed to meet assessed needs and risks within 11 days.	Compliant

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All patients have a named Primary Nurse who will discuss and draw up a nursing care plan in liaison with family/significant others and the multi-disciplinary team, promoting independence for each patient. Referral arrangements are in place for patients identified as being at risk.	Compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
We have daily ongoing assessment and care plans which are updated monthly or, when care needs change.	Compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standards. A validated tool is used to assess and manage plan of care. Guidelines are available and accessible for staff to implement care on an ongoing basis.	Compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are maintained and recorded within NMC guidelines based on outcomes for patients. A detailed record is held of all meals provided. Referral arrangements are in place for patients identified as being at risk and specific care plans implemented.	Compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patient's care and outcomes are monitored and recorded on an ongoing basis and are reviewed in collaboration with the patient, relevant multi-disciplinary team and family.	Compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Patients and/or families participate in their multi-disciplinary care review meetings arranged by the local HSC Trust. Agreed outcomes and objectives are recorded and a copy of the care review form is maintained in the care plan and distributed to all relevant parties.	Compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A detailed record is held of all meals provided. Referral arrangements are in place for patients identified as being at risk and specific care plans implemented. Following nutritional guidelines, a nutritious and varied diet is provided, taking into account patient choice, likes or dislikes and any specific dietary requirements.	Compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	

Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	Section compliance level
Nurses and Caring staff are knowledgeable in feeding techniques for patients and adhere to recommendations set out by Speech and Language therapists. Meals, drinks and snacks are provided at conventional times or as requested by patients. Fresh drinking water is available at all times. Individual Care Plans and risk assessments are developed and tailored according to eating and drinking needs, outlining any assistance and aids required. The Tissue Viability and Link Nurse shares their knowledge and expertise to fellow colleagues in relation to wound care assessment and management of dressings.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Compliant

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic care: (BC) – basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.**
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	Examples include: Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) – communication which is disregarding of the residents' dignity and respect.**
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Unannounced Care Inspection

Brookmount

27 January 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the registered manager during and after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	16 (2) (b)	Where a nursing assessment is made to monitor a patient's daily fluid intake, then the patients daily (24hour) fluid intake should be recorded in their daily progress record in order to show that this area of care is being properly monitored and validated by the registered nurse. Given that this requirement has been stated for the third time, enforcement action was considered in discussion with the Head of Nursing. It was concluded that enforcement action would not be taken at present. The requirement is assessed as moving towards compliance and has been stated for the third and final time. **Ref 9.0 Follow up on previous issue**	Three	An optimal daily fluid target of 1200mls in 24 hours as stated in the new nutritional guidelines has been set for each patient. Consideration has also been given to patients historic normal fluid intake prior to admission. The rational is that some patients never achieve their optimal target of 1200mls in 24 hours.The daily fluid intake is being monitered by the Staff Nurses and fluid intake is encouraged for every patient..If a patient fails to reach their target over a 48 hour period the GP will be contacted.	12 April 2015
2	20 (1) (a)	The registered person must continue to monitor the dependency levels of patients using the Rhys Hearn (1970) dependency tool, to ensure that staffing provision and care hours provided meets the needs of the patients accommodated. **Ref 9.0 Follow up on previous issue and 11.2**	Two	The Rhys Hearn (1970) dependancy tool is being used for each patient. It is monitered on a monthly basis to ensure that staffing provision and care hours provided meet the needs of our patients.	12 April 2015

3	16 (2)(b)	The registered person must ensure the development of care plans as follows: • Care plans regarding continence management must be person-centred. • Care plan evaluations must reflect information documented in progress notes and bowel records. • Care plans regarding fluid intake management must contain the patients' fluid target and this target must be entered onto the fluid recording record. **Ref 9.0 and 10.0**	One	New care plans regarding incontinence management have been developed using the new Epicare system.. Care plan evaluations reflect information documented in progress notes and bowel records Care plans regarding fluid management now contain the patients' fluid target.	12 April 2015
4	15 (2)(a)&(b)	The registered person must ensure that bowel function, reflective of the Bristol Stool Chart should be recorded on admission as a baseline measurement and thereafter in patients' care plans and daily progress records. **Ref 9.0 Follow up on previous issue**	One	Bowel function reflective of the Bristol Stool Chart is recorded on admission as a baseline and thereafter in the patients' care plan and daily progress notes.	12 April 2015
5	20(1)(a)	The registered person must ensure that a dedicated individual to organise and co-ordinate a programme of activities and events, is appointed to ensure patients' individual needs are fully met and their quality of life in the home enhanced	One	A review of nursing care is being undertaken. This will consider provision of a dedicated individual to organise and co-ordinate a programme of activities in Brookmount Nursing Home.	12 June 2015

		A record must be maintained to evidence the decision making process regarding the provision of activities and events for patients accommodated in the nursing home. This record should include the level of participation and enjoyment and the activities provided to patients who cannot or do not wish to partake in group activities. **Ref 9.0 Follow up on previous issue and 11.4**		A record is being developed to evidence the decision making process regarding the provision of activities and events for patients.	
6	20(1)(a)	The registered person must ensure that the recruitment plan is provided to RQIA with the returned QIP and no later than 1 April 2015. **Ref 11.2**	One	The current recruitment plan for Brookmount is attached to this QIP	12 April 2015
7	12 (4)(a)(b)	The registered person must review the serving of meals to ensure that: • meals are served in a timely manner to meet patients' needs • meals are served at a temperature which is in accordance with the nutritional guidelines • staff provide appropriate supervision to patients during mealtimes The deployment of staff at mealtimes and issues in relation to respect and dignity, when assisting patients to eat, must be included in this review. **Ref 11.3**	One	Meals are served in a timely manner and at a temperature which is in accordance with the national guidelines. Adequate staff are allocated at each mealtime. Issues in relation to respect and dignity when assisting patients to eat have been adressed with all relavent grades of staff.	12 April 2015

8	13 (1)(b)	The registered persons must ensure that patients' weights are monitored on a regular basis and appropriate action taken when significant decreases/increases are identified. **Ref 11.4**	One	The MUST tool is now implemented in Brookmount for all patients. All patients are weighed on a monthly basis or as and when required, and appropriate action taken when significant issues are identified.	12 April 2015
9	13 (4)(b)	The registered persons must ensure that thickening agents are not used for patients, for whom they have not been prescribed. **Ref 11.7**	One	Thickening agents have not and will never be used for patients for whom they have not been prescribed.	12 April 2015

Recommendations

These recommendations are based on The Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	19.2	The policy for continence should be further developed to include catheter and stoma care. The following guidelines should be made available to staff and used on a daily basis: • British Geriatrics Society Continence Care in Residential and Nursing Homes • NICE guidelines on the management of urinary incontinence • NICE guidelines on the management of faecal incontinence **Ref 10.0**	One	The policy for continence is being reviewed and further developed to include catheter and stoma care. The British Geriatric Society Continence Care in Residential and Nursing Homes, Nice Guidelines on the management of urinary incontinence and NICE guidelines on the management of faecal incontinence are available for all staff.	12 April 2015
2	17.6, 17.10 & 17.16	The registered manager should record the outcome of all complaints. A process should be developed, to ascertain and record the complainant's satisfaction with actions taken. Information should also be provided to complainants with regards to their rights if they remain dissatisfied with the outcome of the complaints procedure. **Ref 6.1**	One	A process has now been developed to assertain the complainant's satisfaction with action taken. Information with regard to outlining the measures which can be taken if the complainant remains dissatisfied with the outcome of the complaint is available within Apex Housing Association's Complaints policy. A copy is contained in the residents	12 April 2015

				guide and is displayed on the resident's notice board.	

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Ann Bannister
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Muriel Sands

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Aveen Donnelly	21/04/2015
Further information requested from provider			