Unannounced Care Inspection Report
5 April 2017

Brooklands

Type of Service: Nursing Home
Address: 66 Hospital Road, Magherafelt, BT45 5EG
Tel no: BT45 5EG
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Brooklands took place on 5 April 2017 from 09.15 to 16.15 hours. The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding. The premises and grounds were well maintained. There were no areas of improvement identified in the delivery of safe care.

Is care effective?

Evidenced gathered during this inspection confirmed that there were systems and processes in place to ensure that that the outcome of care delivery was positive for patients. A review of care records confirmed that a range of risk assessments were completed. Care plans were created to prescribe care. There were arrangements in place to monitor and review the effectiveness of care delivery. We examined the systems in place to promote effective communication between staff, patients and relatives and were assured that these systems were effective. One area for improvement was identified to ensure that bowel records were maintained accurately. A recommendation was made.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Systems were in place to ensure that patients, and relatives, were involved and communicated with regarding issues affecting them. Patients spoken with commented positively in regard to the care they received. There were no areas of improvement identified in the delivery of compassionate care.

Is the service well led?

There was a clear organisational structure evidenced within the home and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide. There was evidence of good leadership in the home and effective governance arrangements. Staff spoken with were knowledgeable regarding the line management structure and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty.

There was evidence that systems were in place for incident reporting, auditing and management of medical alerts. Monthly quality monitoring visits were carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. One area for improvement was identified in relation to the management of alerts regarding staff who had sanctions imposed on their employment by professional bodies. A recommendation has been made in this regard.

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

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Deirdre Monaghan, 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 finance inspection undertaken on 5 January 2017. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Brooklands Healthcare Ltd Ms Therese Elizabeth Conway (Acting)	**Registered manager:** Mrs Deirdre Mary Monaghan
Person in charge of the home at the time of inspection: Mrs Deirdre Mary Monaghan	**Date manager registered:** 30 September 2014
Categories of care: NH-I, NH-PH, NH-PH(E), RC-I, RC-MP(E), RC-PH(E), NH-TI, RC-DE A maximum of 8 residents in category RC-DE	**Number of registered places:** 55

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 six patients, four care staff, two registered nurses and two patients' representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- seven patient care records
- staff training records for 2016/2017
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 5 January 2017

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider, as recorded in the QIP will be validated at the next finance inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 9 November 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 14 (2) (c) **Stated:** Second time	The registered persons must ensure that all cleaning chemicals are securely stored in keeping with COSHH legislation, to ensure that patients are protected from hazards to their health.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that all cleaning chemicals were securely stored in keeping with COSHH legislation.	
Requirement 2 **Ref:** Regulation 13 (1) (a) **Stated:** First time	The registered persons must ensure that the home is conducted so as to promote and make proper provision for the nursing, health and welfare of patients. It is therefore required that where nursing needs are identified care must be delivered to ensure individual patient needs are met. This refers specifically to the repositioning records of patients who are at risk of developing pressure sores and require regular repositioning, in keeping with their care plan.	**Met**
	Action taken as confirmed during the inspection: A review of care records confirmed that patients were repositioned according to their care plans.	
Requirement 3 **Ref:** Regulation 12 (4) (a) **Stated:** First time	The registered persons must ensure that the provision of food and fluids to patients in the home is available at appropriate intervals and the lack of this provision does not exceed 12 hours.	**Met**
	Action taken as confirmed during the inspection: A sampling of food and fluid intake charts confirmed that patients' fluid intakes had been monitored by registered nurses and were consistently recorded in the daily progress notes.	

Requirement 4 **Ref:** Regulation 12 (1) (a) **Stated:** First time	The registered persons must ensure that where patients are prescribed a modified diet, the information specified in the care plan must be accurate and reflective of the most recent SALT assessment.	**Met**
	Action taken as confirmed during the inspection: Patients who were identified as requiring a modified diet, had the relevant choke risk and malnutrition risk assessments completed. The prescribed modified diet was included in the assessment, together with recommended strategies for ensuring correct feeding techniques.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 38.1 **Stated:** Second time	The registered persons should ensure that the recruitment and selection processes are reviewed; and that there are robust systems in place, to address the deficits identified in this inspection.	**Met**
	Action taken as confirmed during the inspection: A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.	
Recommendation 2 **Ref:** Standard 12.19 **Stated:** Second time	The registered persons should ensure that the serving of meals is reviewed to ensure that the food is kept covered and hot until served to patients.	**Met**
	Action taken as confirmed during the inspection: Observation of the serving of the mid-day meal confirmed that this recommendation had been met.	

Recommendation 3 **Ref:** Standard 35.13 **Stated**: First time	The registered persons should evidentially review the system for managing absenteeism levels in the home. This review should also include contingency arrangements for when the staffing levels fall below those required, to meet the needs of the patients.	**Met**
	Action taken as confirmed during the inspection: Consultation with patients, relatives and staff did not evidence any concerns regarding the staffing levels. Discussion with the registered manager confirmed that any casual absenteeism had been managed in line with the home's policy and procedures. Contingency arrangements were also in place to access additional staff from other homes within the group.	
Recommendation 4 **Ref:** Standard 12.25 **Stated:** First time	The registered persons must ensure that patients are offered appropriate clothing protectors which respect their dignity and protect their clothing.	**Met**
	Action taken as confirmed during the inspection: Observation of mealtimes and discussion with staff confirmed that this recommendation had been met.	
Recommendation 5 **Ref:** Standard 22.4 **Stated:** First time	A recommendation has been made that the patients' falls risk assessments and care plans are updated in response to each time a patient falls.	**Met**
	Action taken as confirmed during the inspection: A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and 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 week commencing 31 March 2017 evidenced that the planned staffing levels were adhered to. The registered manager explained there was currently only one permanent nurse and three care staff vacancies in the home and that recruitment was ongoing. These vacancies were being filled by bank staff or permanent staff working additional hours.
Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels.

Staff consulted confirmed that staffing levels met the assessed needs of the patients; however, two staff commented in relation to the high dependency of patients, particularly in relation to the number of patients who required assistance at mealtimes. All those consulted with stated that the registered manager had reviewed the work practices on the first floor and that changes had been made to the timings of meals as a result.

The staff comments were discussed with the registered manager, who agreed to similarly review the dependency levels of patients/working practices, to address the comments made by staff.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. There were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals.

Discussion with the registered manager and review of training records evidenced that there was a robust system in place to ensure staff attended mandatory training. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). One area for improvement was identified in relation to the management of alerts regarding staff who had sanctions imposed on their employment by professional bodies. This is further discussed in section 4.6.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. Where any shortcomings were identified safeguards were put in place.

Review of seven patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Where patients required the used of bedrails, there was evidence of regular safety checks to ensure their safe use.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounge/s, dining room/s and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients/representatives/staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

The home used an electronic system for assessing, planning and evaluating patients' care needs. Review of seven patient care records evidenced that records were maintained in accordance with NMC guidelines. A range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer a care plan was in place to direct staff on the management of this risk. The care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans. There were clear records maintained regarding the on-going management of urinary catheters and care plans for acute infections were updated appropriately.

Personal care records evidenced that records were generally maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored. However, a review of the patient's bowel charts evidenced that patients' bowel motions were not consistently recorded. This meant that we were not assured about the accuracy of the records. This was discussed with the registered manager. A recommendation has been made in this regard.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005. A review of the Patient Register evidenced that it was up to date.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the registered manager confirmed that staff, patients and relatives meetings were held on a regular basis and records were maintained. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager. Patient and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives were aware of who their named nurse was and knew the registered manager.

Areas for improvement

A recommendation has been made that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information and confidentiality.

We observed the lunch time meal in the dining room. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Menus were displayed at the entrance to the dining room and were correct on the day of inspection. The lunch served appeared very appetising and patients spoken with stated that it was always very nice

A dedicated staff member was employed to provide activities in the home. Patients consulted with stated that there were always different activities they could participate in. There was evidence of regular church services to suit different denominations. Patients on the day of the inspection participated in a prayer service. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. Care plans detailed the 'do not attempt resuscitation' (DNAR) directive for patient's as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner. We read some recent feedback from patients' representatives. Comments included: 'the care is fabulous' and 'we are very happy with the care'.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Surveys were in the process of being sent to patients and their representatives, as appropriate. The annual quality report will be followed up at future inspection.

During the inspection, we met with six patients, four care staff, two registered nurses and two patients' representatives. Some comments received are detailed below:

Staff

"The care is good, the staff are very thorough and we have a good reputation for that".
"I am happy enough".
"It is satisfactory here".
"The care is very good".
"The patients are well cared for, but I would like to do extra wee things for them".

As previously discussed, two staff members commented in relation to the dependency levels of patients, particularly at mealtimes. This matter was referred to the registered manager to address. Refer to section 4.3 for further detail.

Patients

"They couldn't do better".
"It is a good home".
"They are some craic here, I get on the very best".
"The staff are very nice".
"They are very nice, a good bunch of girls".
"It is alright".

Patients' representatives

"'It is not 100 percent, but as near to it, as you will find anywhere".
"They are all very sociable, the staff never stop cleaning, you can't get better than that".

We also issued ten questionnaires to staff and relatives respectively; and eight questionnaires were issued to patients. Four staff, eight relatives and eight patients had returned their questionnaires, within the timeframe for inclusion in this report. All respondents indicated that they were either 'very satisfied' or 'satisfied' that the care was safe, effective and compassionate; and that the home was well-led. No written comments were received.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to identify the person in charge of the home in the absence of the registered manager if concerns raised. This was also displayed at the main reception of the home, for patients and their representatives. Consultation with staff evidenced that there were good working relationships and that management were responsive to any suggestions or concerns raised. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

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. A certificate of public liability insurance was current and displayed.

Following the last inspection, it was evident that action had been taken to improve the effectiveness of the care. All the requirements and recommendations previously made had been met.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure and that they were confident that staff/management would manage any concern raised by them appropriately. A copy of the complaints procedure was displayed/available near the front entrance to the home.

A review of notifications of incidents to RQIA during the previous inspection year/or since the last care inspection confirmed that these were managed 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. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner. These included medication and equipment alerts. However, discussion with the registered manager and a review of records evidenced that the system for managing alerts regarding staff who had sanctions imposed on their employment by professional bodies, was not sufficiently robust. A recommendation has been made in this regard.

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. An action plan was generated to address any areas for improvement.

Areas for improvement

A recommendation has been made that they system for managing alerts regarding staff who had sanctions imposed on their employment by professional bodies, is reviewed to ensure that a robust.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Deirdre Monaghan, 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

Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 3 June 2017	The registered persons should ensure that registered nurses review patients' bowel records on a daily basis and record any actions taken in the patients' daily progress notes. Entries should also be made when there have been no bowel movements, to ensure the accuracy of the records. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Patient bowel records are monitored daily by the registered nurse. Appropriate actions required are documented in the patient's daily progress notes. This includes when a patient has had no bowel movement. Daily progress notes are regularly audited by the Sister and Home Manager.
Recommendation 2 **Ref**: Standard 35.18 **Stated:** First time **To be completed by:** 3 June 2017	The registered persons should ensure that the system for managing alerts, regarding staff who had sanctions imposed on their employment by professional bodies, is reviewed to ensure that it is robust. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: The system for managing alerts in the Home has been reviewed to ensure these records are maintained appropriately for staff who have had sanctions imposed or cancelled on their employment by professional bodies.

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

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