Unannounced Care Inspection Report
1 October 2018

Braefield

Type of Service: Nursing Home (NH)
Address: 2-6 Carncomb Road, Connor, Ballymena, BT42 3LA
Tel No: 028 2589 2233
Inspector: Sharon McKnight

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 49 persons and residential care for one named patient.

3.0 Service details

Organisation/Registered Provider: Healthcare Ireland (Belfast) Limited **Responsible Individual:** Amanda Celine Mitchell	**Registered Manager:** Philomena McIlwaine
Person in charge at the time of inspection: Philomena McIlwaine	**Date manager registered:** 12 May 2017
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 50 There may be a maximum of 13 patients accommodated within category NH-DE and located in the designated dementia unit. There shall be a maximum of 2 named residents receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 1 October 2018 from 09.30 to 16.10 hours.

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.

The term ‘patient’ is used to describe those living in Braefield which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to staffing, staff recruitment, induction, training, adult safeguarding, infection prevention and control and risk management. There were examples of good practice found in relation to the culture and ethos of the home and the dignity and privacy of patients. Good practice was evidenced in relation to governance arrangements, management of complaints and incidents and maintaining good working relationships.

Areas requiring improvement were identified in relation to the décor within the home and the dating and archiving of care records.

Patients said they were happy living in the home. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	**0**	**4**

Details of the Quality Improvement Plan (QIP) were discussed with Philomena McIlwaine, 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.

4.2 Action/enforcement taken following the most recent inspection dated 23 July 2018.

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 23 July 2018 . Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with ten patients individually and with others in small groups, three patients' relatives and ten staff. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line.

The inspector provided the registered manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

A poster informing visitors to the home that an inspection was being conducted was displayed on the front door.

The following records were examined during the inspection:

- duty rota for staff from 24 September – 7 October 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- six patient care records
- two patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 23 July 2018

The most recent inspection of the home was an unannounced medicines management inspection.

The completed QIP was returned and approved by the pharmacist inspector.

This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 17 February 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that care plans are reviewed and updated to reflect changes to patients' diets.	**Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that this area for improvement has been met.	
Area for improvement 2 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that the review how the menu is displayed is reviewed to ensure it is effective in informing patients.	**Met**
	Action taken as confirmed during the inspection: The menu was clearly displayed in both dining rooms of the home. This area for improvement has been met.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 the period 24 September – 7 October 2018 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients.

We spoke with the relatives of three patients during the inspection who were complimentary regarding staff. Two questionnaires were received from relatives following the inspection; both indicated that they were very satisfied with staffing. The following comment was provided: "Staff are polite and helpful."

Review of two staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work. A review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC.

We discussed the provision of mandatory training with staff and reviewed staff training records. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training was delivered through face to face interactive sessions and via an electronic learning programme. Records evidenced good compliance with mandatory training. The registered manager confirmed that systems were in place to ensure staff received annual appraisal and regular supervision.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the registered manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

Review of five patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

We reviewed a sample of accidents/incidents records in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the registered manager and review of records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. From a review of records, observation of practices and discussion with the registered manager and staff there was evidence of proactive management of falls. Records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example; bed rails and alarm mats.

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control measures were adhered to. We observed that personal protective equipment, for example gloves and aprons, were available throughout the home and used appropriately.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges and dining rooms. Fire exits and corridors were observed to be clear of clutter and obstruction. The home was found to be warm and clean throughout. An application to upgrade a number of rooms was submitted to RQIA in 2017. The registered

manager confirmed that no timescale had been agreed to commence the planned improvement work to the environment. In the interim the décor in a number of rooms requires to brought up to an acceptable standard; this was identified as an area for improvement.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control and risk management.

Areas for improvement

One area was identified for improvement in relation to the environment.

	Regulations	Standards
Total number of areas for improvement	**0**	**1**

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of six patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of nutrition, patients' weight, management of falls, healthcare associated infections (HCAI) and wound care. Care records contained details of the specific care requirements in each of the areas reviewed.

We discussed the monitoring of patients' weights and were informed that all patients were weighed a minimum of monthly. We reviewed the management of nutrition for three patients. A nutritional risk assessment and choking risk assessment were completed and reviewed monthly; a care plan for nutritional management was in place. Food and fluid charts were maintained for all patients and evidenced the quantity of each meal the patient consumed and foods offered but refused. Fluid intake was totalled on a 24 hour period and entered into the patients daily evaluation notes. However there were minor variances noted between the totals entered into the patients' notes and the quantities recorded on the food and fluid charts. This was identified as an area for improvement.

We reviewed the management of falls for two patients. Falls risk assessments were completed and reviewed regularly. Care plans for falls management were in place and were reviewed for each patient following a fall.

We reviewed the management of wound care for two patients. Care plans contained a description of the wound, location, the prescribed dressing regime and the frequency with which dressing were required to be renewed. A review of care records evidenced that dressings were renewed in accordance with the prescribed care. A review of repositioning charts for two patients evidence that patients were assisted to change their position for pressure relief regularly and in accordance with their care plans. We asked to review completed charts for the seven days prior to the inspection. A number of charts did not contain the date they were completed and a number of charts could not be located. This was identified as an area for improvement. Each patient had a

file for completed charts and care records. The files contained records dating back to March 2018, there was no systematic archiving of completed records. This also was identified as an area for improvement.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), the speech and language therapist (SALT) and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), SALT or the dietician.

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 the registered manager or the nurse in charge.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the assessment of patient need and creation of care plans, the management of nutrition, falls and wound care and the communication of patient needs between staff.

Areas for improvement

The following areas were identified for improvement in relation to the recording of fluids and the dating and archiving of care records.

	Regulations	Standards
Total number of areas for improvement	**0**	**3**

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 10:00 hours and were greeted by staff who were helpful and attentive. Patients were finishing breakfast in the dining rooms, lounges or in their bedroom, as was their personal preference. Some patients remained in bed, again in keeping with their personal preference or their assessed needs.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs. Patients said that they were generally happy living in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

We observed the serving of the lunchtime meal. Patients were assisted to the dining room or had trays delivered to them as required. Staff were present in the dining room throughout the meal and were observed assisting patients with their meal as required. Patients able to communicate indicated that they enjoyed their meal.

Cards and letters of compliment and thanks were displayed in the home. This is an example of one of the comments recorded received:

"It is apparent to anyone walking into Braefield that it is maintained beautifully and provides extremely comfortable and caring environment for all residents. We have witnessed the exceptional caring nature of the team…" (July 2018)

We spoke with the relatives of three patients during the inspection who were complimentary regarding staff and the delivery of care. Ten relative questionnaires were provided; two were returned within the timescale. Both of the relatives responded that they were very satisfied or satisfied with the care provided across the four domains. The following additional comments were provided:

"I believe as a nurse myself that the standards in Braefield are excellent."
"Nursing care excellent. Parts of the home could improve i.e. painting, curtains, furniture…."

Staff spoken with stated they were well supported to deliver the care patients required. Staff were asked to complete an on line survey, we had no responses within the timescale specified.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, mealtimes and the caring manner of staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	**0**	**0**

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been a no change in management arrangements. The registered manager continues to be supported by the deputy manager and nursing sister.

A review of the duty rota evidenced that the registered manager's hours were clearly recorded. Discussion with staff evidenced that the registered manager's working patterns supported effective engagement with patients, their relatives and the multi-professional team.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The service did not collect any equality data on service users and the registered manager was advised of the role of the Equality Commission for Northern Ireland and their guidance on best practice in relation to collecting the data.

Review of the home's complaints records evidenced that systems were in place to ensure 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.

Discussion with the registered manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, complaints and care records. In addition systems were also in place to provide the manager with an overview of the management of infections, wounds and patients' weight.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	**0**	**0**

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Philomena McIlwaine, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 44.1 **Stated:** First time **To be completed by:** 5 November 2018	The registered person shall ensure that the décor in a number of rooms is brought up to an acceptable standard. Ref: Section 6.4
	Response by registered person detailing the actions taken: Work to upgrade the Nursing Station in older side has commenced. A phased decoration plan is in place to upgrade the bedrooms and the day space .
Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 29 October 2018	The registered person shall ensure that fluid intake is consistently recorded in care records. Ref: Section 6.5
	Response by registered person detailing the actions taken: Supervision has been carried out with staff out by the registered manager regarding accurate recording of fluid intake. This has also been discussed at staff meetings. This will be monitored though internal audit by the home manager and appropriate action taken with relevant staff if not complying .
Area for improvement 3 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 29 October 2018	The registered person shall ensure that care records contain the date they are completed. Ref: Section 6.5
	Response by registered person detailing the actions taken: Supervision has been carried out with staff on the importance of dating all charts. Staff have been reminded of the standards we have to meet This will be monitored though internal audit by the home manager and appropriate action taken with relevant staff if not complying .
Area for improvement 4 **Ref**: Standard 37 **Stated:** First time **To be completed by:** 29 October 2018	The registered person shall ensure that completed records are archived regularly and stored appropriately. Ref: Section 6.5
	Response by registered person detailing the actions taken: Staff in each unit have been advised to file their charts in order of date. The Administrator will be allocated to archive all files in archive store each month. This will be montored by the registered manager to ensure compliance

Please ensure this document is completed in full and returned via Web Portal

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