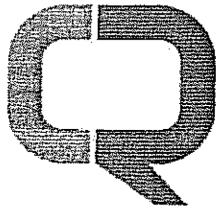

Braefield
RQIA ID: 1428
2-6 Carncomb Road
Connor
Ballymena
BT42 3LA

Inspector: Lyn Buckley
Inspection ID: IN023435

Tel: 0282589 2233
Email: lesley.mckillen@carecircle.co.uk

Unannounced Care Inspection
of
Braefield Nursing Home

24 August 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 24 August 2015 from 19:10 to 21:15 hours.

This inspection was carried out in response to information received by RQIA from a whistle blower on 21 July 2015. Further information is available in sections 3 and 5 of the report.

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no areas of concern. A Quality Improvement Plan (QIP) is not included in this report.

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

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 14 December 2014.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Care Circle Ltd Ciaran Sheehan – responsible person	Registered Manager: Lesley McKillen
Person in Charge of the Home at the Time of Inspection: Registered nurse A Gordon – day duty Registered nurse J George – night duty	**Date Manager Registered:** 24 July 2014
Categories of Care: NH – I, PH, PH(E), and DE RC – I Maximum of 13 patients within NH-DE	**Number of Registered Places:** 50
Number of Patients Accommodated on Day of Inspection: 45	**Weekly Tariff at Time of Inspection:** £470 - £637

3. Inspection Focus

Whistle blowing information was received by RQIA on 21 July 2015 regarding concerns in the following areas:

- care practices around day/night duty handover
- staffing levels and retention of staff
- cleanliness of environment
- management of staff
- patients 'assisted early' in evening and morning to aid home routine
- provision of activities
- lack of review of information recorded on care charts.

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential 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.

Following discussion with senior management, it was agreed that the responsible individual/provider would be asked to investigate the concerns raised and provide a written report of their findings to RQIA. In addition the responsible individual/provider was required to undertake an unannounced visit to the home outside the normal working hours and to provide RQIA with a report of this visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

RQIA were satisfied, following review of the reports submitted, that the concerns raised by the whistle blower had been robustly investigated and any learning or actions identified for improvement were being addressed by management. However, as an inspection to Braefield Nursing Homes was already scheduled, it was decided that this would be conducted in the late evening to review care delivery and practices.

The inspection focus was extended to include the following areas:

- care practices around day/night duty handover
- staffing levels
- cleanliness of the environment
- patients preferences with the evening routine
- lack of review of information recorded on care charts.

4. Methods/Process

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

- discussion with the deputy manager
- discussion with the registered nurses in charge of the home for day and night duty
- discussion with care staff on duty both day and night duty
- discussion with patients
- a general tour of the home and review of a random selection of patients' bedrooms, bathrooms and communal areas
- examination of a selection of care records
- observation of care delivery
- evaluation and feedback.

During the inspection, the inspector met with six patients individually and with the majority in smaller groups; eight care staff, four registered nurses and two relatives.

Prior to inspection the following records were analysed:

- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- responsible persons investigation report into whistle blower concerns
- the returned quality improvement plans (QIP) from the last care inspection
- the previous care inspection report.

The following records were examined during the inspection:

- duty rotas for week commencing 24 August 2015
- three patient care records
- patient care charts for example, food and fluid intake and repositioning records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced pharmacy inspection dated 4 June 2015. This inspection resulted in no requirements or recommendations being made.

5.2 Review of Requirements and Recommendations from the last care inspection dated 14 December 2015.

<table>
<tr><th colspan="2">Last Care Inspection Statutory Requirements</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Requirement 1

Ref: Regulation 30 (1) (c)

Stated: First time</td><td>The registered person shall give notice to the RQIA without delay of the occurrence of –
(c) any serious injury to a patient in the nursing home;

Reference to this is made in that RQIA must be notified of any accident that an injury is sustained and in particular facial type bruising.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of notifications received by RQIA and discussion with registered nurses confirmed that this requirement had been met.</td></tr>
<tr><th colspan="2">Last Care Inspection Recommendations</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 19.2

Stated: First time</td><td>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.

Reference to this is made in that all care staff should receive training in continence management.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of three patient care records and discussion with registered nurses confirmed that staff were knowledgeable of the promotion of continence and the management of incontinence. The registered manager confirmed by email, post inspection, that staff had received continence training on 24 March 2015. This recommendation has been met.</td></tr>
</table>

5.3 Care practices during handover period from day to night staff

The atmosphere in the home was relaxed and calm. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. In some areas quiet music was playing or the television was on. Patients were observed to be relaxing in one of the lounges or seating areas throughout the home or in their bedroom. Patients spoken with confirmed that they could choose when to go to bed. One patient stated that she enjoyed sitting up late and could 'lie in to lunchtime' if wished.

Staff spoken with were knowledgeable regarding individual patient need and commented positively with regard to care delivery.

Those patients in bed were identified as requiring bed rest and this was reflected in their care plan. Review of care charts in bedrooms evidenced that those patients who were nursed in bed, and unable to summon help, were attended by staff on a regular basis.

Three patients, seated in one of the lounges, were observed to be dressed in their night attire. Patients were warmly and modestly dressed in their night attire with appropriate footwear. One patient stated that they liked to get ready for bed following their evening shower. Following discussion and review of care records the inspector was satisfied that the reasons for the three patients observed to be in their night attire were valid.

Care staff served the supper at approximately 19:30 hours. Supper consisted of a selection of breads, cereals, milk puddings, biscuits/ /buns and a selection of beverages such as tea, coffee, Horlicks, milk, hot or cold and hot chocolate.

Night staff spoken with confirmed that it was usual practice for them to 'clear up' the supper dishes. One staff member stated 'sure we have all night to wash the dishes'.

During the serving of supper night staff started to arrive. Night staff spoken with confirmed that all grades of staff received a 'handover report'. During handover day staff remained on the floor to provide support and care to patients if required.

Within one of the units a registered nurse from a nursing agency was coming on duty for the first time. The agency nurse was provided with a structured induction to the unit and the home by the registered nurse on day duty. The induction included a guided tour of the unit and the home, introductions to the registered nurse in charge of the home, fire safety and actions to be taken in the event of the fire alarm sounding, administration of medicines, the use of call bells and telephones. Both the home's nurse and the agency nurse completed the induction record signed and dated it.

Following the handover the agency nurse confirmed that they were impressed with the detail of the induction and handover and felt able to take charge of the unit.

Areas for Improvement

There were no areas for improvement made in this area.

Number of Requirements:	0	Number of Recommendations:	0

5.4 Staffing

Staffing levels for 37 nursing patients and eight residential residents were as follows:

<u>Evening shift</u>
Registered nurses 2
Senior care assistant 1
Care assistants 5

<u>Night duty</u>
Registered nurses 2
Care assistants 4

As discussed in section 5.3 the atmosphere in the home during the inspection was relaxed and calm and staff were assisting patients as required. Staff spoken with on both shifts confirmed that the staffing levels met the assessed needs of the patients. Some staff said they were busy all night and had some household tasks to perform but as previously stated one care assistant stated that they had 'all night to do so'.

During discussion the deputy manager confirmed that staffing levels were determined by the dependency /assessed needs of patients and kept under review. Senior management within the home have the autonomy to adjust staffing to meet patients' needs. For example, the provision of additional catering staff during the day time shifts to ensure patients mealtimes were not disrupted while the catering lift was being repaired.

Review of the nursing and care staff duty rota for week commencing 24 August 2015 confirmed that the staffing levels discussed were adhered to and clearly identified who was in charge of the home in the absence of the registered manager. Discussion with the deputy and review of the responsible individual's investigation report evidenced that the registered manager ensured that staff vacancies were covered by bank or agency staff and where possible agency nursing and care staff were booked in a block to ensure consistency of approach to patient care.

Areas for Improvement

There were no areas for improvement made in this area.

Number of Requirements:	0	Number of Recommendations:	0

5.5 Cleanliness of the environment

A general tour of the home and review of a selection of patients' bedrooms, bathrooms and communal areas was undertaken. The home was found to be warm, clean and tidy. There was no evidence of toiletries or prescribed creams 'sitting around' as described by the whistle-blower.

The kitchen and laundry areas were observed to be clear of dishes and laundry respectively.

Following handover the nurse in charge of the home that night was observed to undertake a walk around the whole home to ensure it was safe and secure.

Areas for Improvement

There were no areas for improvement made in this area.

Number of Requirements:	0	Number of Recommendations:	0

5.6 Evaluation of care/record keeping

Review of three patient care records including care charts such as food and fluid intake records and repositioning records evidenced that care was delivered as planned and evaluated on a daily basis.

Daily evaluation records reviewed evidenced that registered nurses referred to and recorded the outcome of the care delivered and as recorded on care charts. For example, patients requiring monitoring of their fluid intake had a care plan in place which indicated the minimum fluid intake required on a daily basis, care charts recorded the daily intake of fluids, fluid intake was totalled over 12 and 24 hours respectively, daily evaluation records indicated the total amount of fluid intake along with a comment if action was required to address any deficit identified. In addition a weekly overview of the patient's daily total fluid intake was recorded and reviewed by registered nurses.

Care staff spoken with confirmed that they were required to complete care charts accurately to evidence the care delivered.

Areas for Improvement

There were no areas for improvement made in this area.

Number of Requirements:	0	Number of Recommendations:	0

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that any requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

6. **No requirements or recommendations resulted from this inspection.**

I agree with the content of the report.			
Registered Manager	[signature]	**Date Completed**	29/9/15
Registered Person	[signature]	**Date Approved**	29/9/15
RQIA Inspector Assessing Response		**Date Approved**	

Please provide any additional comments or observations you may wish to make below:

Please complete in full and returned to Nursing.Team@rqia.org.uk from the authorised email address

RQIA Inspector Assessing Response	Lyn Buckley	Date Approved	01/10/2015