The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rockfield Care Home

Provider: Burnview Healthcare Ltd

Date of Inspection: 12 October 2024

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Burnview Healthcare Ltd
Responsible Individual:	Mrs Briege Agnes Kelly
Registered Manager:	Mr Gabriel Neculau

Service Profile –
This is a registered nursing home which provides general nursing care for up to 35 patients. Patients have access to communal lounge and dining areas. There is a well maintained garden surrounding the home.

2.0 Inspection summary

An unannounced inspection took place on 12 October 2024 from 9.40am to 4.00pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led. However, improvements were required to ensure the safe storage of cleaning chemicals and the recording of patient repositioning. Full details can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patient's, relatives, staff or the Commissioning Trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "I like it here", "Staff are nice", "Food is good", and, "It's very good here".

Patients told us that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options and where and how they wished to spend their time.

Visitors spoke very positively in regard to the care delivery in the home. One told us that they felt the care was "very good'' while another stated, "The staff are all lovely; they really spend time with the patients".

We did not receive any questionnaire responses from patients or their visitors or any responses from the staff online survey.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Patients said that there was enough staff on duty to help them. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences.

Staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles. An allocation sheet directed staff to the areas in which they were to work and identified tasks to be completed and by whom.

The nurse in charge would complete a shift report at the end of their shift and 24 hour shift reports were given to the manager daily to oversee, for example, any changes in care, incidents/accidents, significant events, staffing concerns or complaints received.

Patients may require special attention to their skin care. For example, some patients may need assistance to change their position in bed or get pressure relief when sitting for long periods of time. These patients were assisted by staff to change their position regularly and records maintained. Although, the records did not always identify the position the patient was repositioned to and an area for improvement was identified.

Where a patient was at risk of falling, measures to reduce this risk were put in place. In addition, falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented. A review of accident records evidenced that the correct actions were taken following a fall in the home and the appropriate persons notified of the fall.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Patients were safely positioned for their meals and the mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Patients confirmed that activities took place in the home. An activities planner was available for review. Activities included games, exercises, arts and crafts, pamper sessions, sing-a-longs, movies and making sandwiches for homeless people. Patients, relatives and staff had recently enjoyed a McMillan Coffee Morning to raise funds for the charity.

Relatives and staff had access to a Facebook page for Rockfield Care Home. Patients gave consent if they wished to have pictures shared on the Facebook page. Staff were aware of their responsibilities in relation to social media in the home.

Patients enjoyed visits from friends and relatives when and where in the home that they wished. Patients were free to leave the home with their friends or relatives.

Patients spoken with told us they enjoyed living in the home and that staff were friendly. One patient told us, "I like it here; it is a good place". Another commented, "The staff are really lovely; it is very nice living here". A relative told us, "We know that xxx is safe here and we are content. The activities are excellent; there is always something going on".

Patients could share their views of the service delivery through one of the patients' meetings held. Minutes were maintained of these meetings and included details of discussions around the topics held, such as, care delivery, activity provision, food provision and laundry facility.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs.

Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

3.3.4 Quality and Management of Patients' Environment Control

The home was clean and tidy and patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Cleaning chemicals were found accessible to patients in several areas within the home. This was discussed with the manager and identified as an area for improvement.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance. Minor infection control issues identified were managed during the inspection.

3.3.4 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mr Gabriel Neculau has been the Registered Manager in this home since 6 January 2023. Staff commented positively about the manager and described them and the management team as supportive, approachable and always available to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place.

A system was in place to manage complaints received in the home. A compliments folder was maintained and compliments received shared with staff.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further. Patients and their relatives spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Eileen Valente, Nurse in Charge, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a)(c) **Stated:** First time **To be completed by:** With immediate effect (12 October 2024)	The registered person shall ensure that unattended cleaning chemicals are not accessible to patients at risk. Ref: 3.3.4
	Response by registered person detailing the actions taken: Staff meetings were conducted, all staff were reminded about the COSHH policies and procedures. Also, a clinical supervision for all staff was done regarding this topic. Home manager is monitoring this on a daily basis.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** With immediate effect (12 October 2024)	The registered person shall ensure that repositioning charts are completed accurately and include the position in which the patient has been repositioned to. Ref: 3.3.2
	Response by registered person detailing the actions taken: Meeting has been done with the care assistants and focused on the importance of accurate documentation on the residents' care records. Daily monitoring was done by the Home manager and the nurse in charge to ensure that the reposioning charts are completed accurately including the position that the residents have been repositioned to.

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

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