The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Beechvale Nursing Home

Provider: Beechvale Nursing Home Limited

Date of Inspection: 19 November 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:	Beechvale Nursing Home Limited
Responsible Individual	Mr Richard Porter
Registered Manager:	Kathie-Anne Walker

Service Profile –
This home is a registered nursing home which provides nursing care for up to 52 patients. Patients bedrooms are located over two floors. There are a range of communal areas throughout the home.

2.0 Inspection summary

An unannounced inspection took place on 19 November 2024, between 9.30 am to 5.10 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 22 August 2023; 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. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

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.

As a result of this inspection, five areas for improvement were assessed as having been addressed by the provider; and one area for improvement has been carried forward for review at a future inspection. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

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 told us they were happy with the care and services provided. Patients who were less able to share their views were observed to be at ease in the company of staff and to be content in their surroundings.

Patients told us that staff offered choices to them 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.

Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support.

Relatives spoken with told us that they were very happy with the care provided and that there was good communication from staff.

Following the inspection, there were no responses received from the staff questionnaires or patient/relative questionnaires.

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 there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role. Staff told us that the patients needs and wishes were important to them. It was clear through observation of the interactions between the patients and staff that the staff knew the patients well.

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 met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

It was observed that 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.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records reflected the patients' assessed needs.

Observation of the lunch time meal, review of records and discussion with patients, staff and the manager evidenced that there were robust systems in place to manage patients' nutrition and mealtime experience. It was clear that staff made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

The importance of engaging with patients was well understood by the manager and staff. A weekly programme of social events was displayed at the main entrance advising of future events. Activities for patients were provided which involved both group and one to one activities; and arrangements were in place to meet the patients social, religious and spiritual needs within the home. Patients told us they were looking forward to Christmas events and relatives also echoed this sentiment.

3.3.3 Management of Care Records

Patients' needs were assessed by a suitably qualified member of staff 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

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

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Kathie-Anne Walker has been the Manager in this home since October 2017.

Patients, relatives and staff commented positively about the management team and described them as supportive and approachable.

There was evidence of auditing across various aspects of care and services provided by the home.

The manager had a system in place to monitor accidents and incidents that happened in the home; however it was identified that some incidents had not been notified to RQIA in a timely manner; an area for improvement was identified.

There was evidence that the management team responded to any concerns, raised with them or by their processes, and took measures to improve practice and the quality of services provided by the home.

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*

* the total number of areas for improvement includes one that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with the management 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 30 **Stated:** First time **To be completed:** Immediate and ongoing	The registered person shall ensure that all applicable accidents and incidents are notified to RQIA in a timely manner. Ref: 3.3.5 **Response by registered person detailing the actions taken:** All accidents and incidents are notfified to RQIA in a timely manner.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref**: Standard 30	The registered person shall ensure that insulin pen devices are always labelled with the patient's name and that the dates of opening are recorded.

Stated: First time **To be completed by:** Immediate and ongoing	Ref: 5.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.

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

The Regulation and Quality Improvement Authority

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