The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Bloomfield Care Homes Limited

Provider: Bloomfield Care Homes Limited

Date of Inspection: 5 June 2025

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:	Bloomfield Care Homes Limited
Responsible Individual:	Mr Desmond McLaughlin
Registered Manager:	Mrs Jincy Mathew
Service Profile – This home is a registered nursing home which provides nursing care for up to 36 patients living with dementia. The home is a purpose built, two storey building with a range of bedrooms, bath/shower rooms, toilets, a lounge and dining room provided on both floors. There is an enclosed garden to the front of the home and an enclosed patio area adjacent to the main entrance door which provide patients with outside space.	

2.0 Inspection summary

An unannounced inspection took place on 5 June 2025 from 9:15 am to 4 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 30 May 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

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.

While we found care to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

As a result of this inspection four areas for improvement have been stated again. 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. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

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. Comments made included "things are good and the food is nice" and "everything is fine".

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

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.

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

Families spoken with told us that they were very happy with the care provided and that there was good communication from staff with comments such as "there is really good communication" and "my ……..'s room is always clean".

No responses were received from the resident/patient or staff questionnaires following the inspection.

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.

Review of agency staff documentation evidenced that although inductions had been carried out, individual staff profiles were not available for review. This was identified as an area for improvement.

Patients said that 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 and that they were satisfied with the staffing levels.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

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. Review of the restrictive practice audits evidenced that they required further detail in regards to the type of restraint in place. This was discussed with the manager and assurances were given that this would be addressed. This will be reviewed at the next inspection.

Wound care records were reviewed, in one record reviewed, there was no recommended frequency of dressing changes in the care plan. In another record reviewed, there were gaps in the recording of the ongoing assessment and evaluation of the wound. This area for improvement was stated for a second time.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was an opportunity for patients to socialise, the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. It was clear that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

Care plans were in place for patients who required their diets to be modified. However, choking risk assessments reviewed were incomplete or lacked detail of the patients' diet and the care required. This area for improvement was stated for a second time.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The activity schedule was on display. Activities planned for the week included hairdressing, arts and crafts, cake decorating and bingo.

Staff were observed sitting with patients and engaging in discussion. Patients who preferred to remain private were supported to do so and had opportunities to listen to music or watch television or engage in their own preferred activities.

The home has an activity therapist. There was no time allocated on the duty rota for activity provision on the days when the activity therapist was on leave. Examination of activity records evidenced gaps in recording and lacked detail in regards to patient participation. An area for improvement was identified.

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.

Daily records were kept of how each patient spent their day and the care and support provided by staff. However, patients' records were not stored in a confidential manner and could be accessed by unauthorised persons. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment Control

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 well decorated, suitably furnished, warm and comfortable.

Observation of the environment identified that a fire door was propped open with a chair preventing it from closing in the event of the fire alarm being activated, this was discussed with the manager and this area for improvement was stated for a second time.

Observation of the environment identified concerns that had the potential to impact on patient safety; food, fluids and toiletries were observed unsecured and accessible to patients in a number of bedrooms. This area for improvement was stated for a second time.

In a number of bedrooms, it was identified that prescribed topical creams were not stored securely. This was identified as an area for improvement.

Review of records and observations confirmed 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.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Jincy Mathew has been the manager in this home since 14 March 2016.

There was evidence that a number of audits were being completed on a regular basis to review the quality of care and other services within the home. However, as stated above in section 3.3.2, a number of areas for improvement were identified in relation to care records which had not been identified by the management team. An area for improvement was identified.

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

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home. It was noted that not all notifiable accidents and incidents were reported to RQIA. Retrospective notifications were submitted to RQIA following the inspection. An area for improvement was identified.

Patients and their relatives said that they knew who to approach if they had a complaint.

Compliments received about the home were kept and shared with the staff team

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	3*	7*

* the total number of areas for improvement includes two regulations and two standards that have been stated for a second time

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Jincy Mathew, Manager 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 27 (4) (b) **Stated:** Second time **To be completed by:** 5 June 2025	The registered person shall ensure that the practice of propping open fire doors ceases immediately. Ref: 2.0 & 3.3.4
	Response by registered person detailing the actions taken: The practice has been stopped immediately and all staff were informed not to prop open any doors at any time. Notice in place as a reminder to staff.
Area for improvement 2 **Ref:** Regulation 14 (2) (a) and (c) **Stated:** Second time **To be completed by:** 5 June 2025	The registered person shall ensure as far as reasonably practical that all parts of the home to which patients have access are free from hazards to their safety. Ref: 2.0 & 3.3.4
	Response by registered person detailing the actions taken: All families have been informed not to leave any food or fluid items unattended in the bedrooms and also advised to limit drinks and snacks or only bring a small amount each visit. If family members wish to leave snacks then they must store them in the residents drawer. All staff to ensure no drinks or snacks left in rooms are visible. All staff to ensure that all store rooms are locked at all times.
Area for improvement 3 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** 5 June 2025	The registered person shall ensure that all notifiable accidents and incidents are reported to RQIA in a timely manner. Ref: 3.3.5
	Response by registered person detailing the actions taken: All notifiable accidents and incidents will be reported 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 4.8 **Stated:** Second time **To be completed by:** 31 July 2025	The registered person shall ensure that wound care plans reflect the recommended dressing frequency and care plans in place reflect the current needs of the patient. Ref: 2.0 & 3.3.2
	Response by registered person detailing the actions taken: The Nursing staff were reminded again that after a wound has healed, the care plan and wound chart should be discontinued immediately to avoid confusion. Any alterations in dressing frequency should be documented clearly as to why it was changed in their dressing regime.The wound care audit will be revised in detail by Nurse Manager.
Area for improvement 2 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** 31 July 2025	The registered person shall ensure that choking risk assessments are recorded accurately and reflect the current needs of the patient. Ref: 2.0 & 3.3.2
	Response by registered person detailing the actions taken: A choking risk assessment is already place for all residents who are on modified diet or fluids. Since Inspection a more detailed Audit of the care assessments and care plans has been implemented.
Area for improvement 3 **Ref:** Standard 41.2 **Stated:** First time **To be completed by:** 5 June 2025	The registered person shall ensure staff profile records are retained for agency staff who work in the home. Ref: 3.3.1
	Response by registered person detailing the actions taken: Agency staff records and profiles are already in place from the date of inspection and this practice will continue.
Area for improvement 4 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 31 July 2025	The registered person shall ensure that the provision of activities in the home is reviewed to make sure meaningful activities are provided to patients in the absence of an activity coordinator. A contemporaneous record of activities delivered must be retained. Ref: 3.3.2
	Response by registered person detailing the actions taken: All staff advised that a contemporaneous record of activities must be retained and all entries must be made in progress notes on a regular basis regarding residents activities.

Area for improvement 5 **Ref:** Standard 37 **Stated:** First time **To be completed by:** 5 June 2025	The registered person shall ensure that patients' confidential records are securely stored. Ref: 3.3.3
	Response by registered person detailing the actions taken: IT have adjusted computers so that they will lock after 60 seconds and users are required to input password to gain access.
Area for improvement 6 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 30 June 2025	The registered person shall ensure that prescribed topical creams are stored safely and securely. Ref: 3.3.4
	Response by registered person detailing the actions taken: All staff have been informed to put away all creams and emollients after use into the residents individual wardrobe, out of sight of resident and not leave out in the bedroom or in the ensuite bathroom or communal bathrooms.
Area for improvement 7 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 July 2025	The registered person should evidence that there is robust monitoring and oversight of care records. Ref: 3.3.5
	Response by registered person detailing the actions taken: The Care Records Audit has been remodified to include a thorough evaluation of individual care records to ensure that they are up to the standard required.

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

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