

Inspection Report

Name of Service: Brooklands Healthcare Kilkeel

Provider: Brooklands Healthcare Ltd

Date of Inspection: 22 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:	Brooklands Healthcare Ltd
Responsible Individual:	Mr Jarlath Conway
Registered Manager:	Miss Sharon Troughton
<p>Service Profile – This home is a registered nursing home which provides nursing care for up to 50 persons. The home is divided in two units. The Moss Rose Suite, on the ground floor which provides care for people with dementia and the first floor unit which provides general nursing care. Patients' bedrooms are located over both floors. Patients have access to communal dining and lounge areas within each unit and patients have access to a garden area. There is a separate registered residential care home which occupies the same building and the registered manager for this home manages both services.</p>	

2.0 Inspection summary

An unannounced inspection took place on 22 November 2024 from 9.20am to 5.15pm 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. There were no areas for improvement from the previous care inspection to review.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led. However, improvements were required with the recording of wound care and the monitoring of patients' pressure mattress settings. Full details, including the areas for improvement identified, 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 patients, 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: "Staff are very good", "Food is good", "They do good activities here" and, "I'm happy 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.

A visitor spoke very positively in regard to the care delivery in the home. They told us that they felt, "The care is very good. The staff do all they can for the patients. My relative is very happy here. We have no concerns".

Staff felt they worked well together and enjoyed engaging with the patients. There was a good working relationship between staff and the home's management team.

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 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.

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. Handover sheets containing the pertinent patient details were updated daily and shared with staff.

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. A restrictive practice register was monitored and reviewed monthly.

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. Records of repositioning had been maintained well. Many of these patients were nursed on a pressure relieving mattress. However, on examination, we found several of the mattresses not set in accordance with the patients' weights. This was discussed with the manager and

identified as an area for improvement. The manager arranged for the mattresses to be correctly set immediately during the inspection.

Where a patient was at risk of falling, measures to reduce this risk were put in place. In addition, falls were reviewed and analysed monthly for patterns and trends to identify if any further falls could be prevented. Staff consulted were aware of the actions to take if they came across a patient who had fallen. A review of accident records confirmed that the appropriate actions had been taken following a fall in the home and the correct persons notified of the accident.

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. A patient told us, "I like it here. The food is good and there is always plenty to eat and drink. We have good access to tea and water when we want".

Patients confirmed that activities took place in the home. An activities planner was available for review. Activities included games, painting, bingo, hairdressing, colouring, café, mass, table tennis and baking. Each patient's activity engagement was recorded on their electronic care records. Activities were audited.

Patients spoken with told us they enjoyed living in the home and that staff were friendly. One patient told us, "The staff here are very very good; I like it here".

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. However, a patient who had two separate wounds did not have each wound care planned or evaluated separately. In addition, the wound evaluation, completed at the time of wound dressing, did not include wound dimensions as part of the evaluation. This was discussed with the manager and identified as an area for improvement. 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 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. The home had been tastefully decorated for Christmas and patients had been involved in decorating. There were several Christmas Trees strategically placed around the home.

Fire safety measures were in place to protect patients, visitors and staff in the home. Actions required from the most recent fire risk assessment had been completed in a timely manner. Staff had been involved in fire drills as part of their training.

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.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Sharon Troughton has been the Registered Manager in this home since 18 June 2020. Staff commented positively about the manager and described them 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.

There was a system in place to manage any complaints received. A compliments log was maintained and any compliments received were 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 Sharon Troughton, Registered Manager and Claire Coen, Governance and Compliance 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	
<p>Area for improvement 1</p> <p>Ref: Regulation 12 (1) (a) (b)</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (20 November 2024)</p>	<p>The registered person shall ensure that each wound is recorded separately from any additional wounds so that progress can be monitored with each one.</p> <p>Regular records of wound dimensions should be recorded as part of the wound evaluation.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: The registered person will ensure via auditing that each wound will be recorded separately including wound dimensions and progress of the wound.</p>
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
<p>Area for improvement 1</p> <p>Ref: Standard 16</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (20 November 2024)</p>	<p>The registered person shall ensure that patients' pressure mattress settings are maintained in accordance with the patients' weights.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: The registered person will ensure pressure mattress settings are maintained in accordance with the patients weights, by monitoring and checking on a daily basis, and monitored via audits.</p>

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