

Inspection Report

Name of Service: Kilbroney House
Provider: Ms Jacqueline Ann Campbell
Date of Inspection: 27 May 2025

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

1.0 Service information

Registered Provider:	Ms Jacqueline Ann Campbell
Responsible Person:	Ms Jacqueline Ann Campbell
Registered Manager:	Ms Jacqueline Ann Campbell
<p>Service Profile – This home is a registered nursing home which provides nursing care for up to eighteen patients. The home provides care for a range of patients; those living with dementia or who require general nursing care and for those living with a mental disorder or a physical disability who are under or over the age of 65. The home is spread over two floors and there are a range of communal areas throughout the home and patients have access to an enclosed garden.</p>	

2.0 Inspection summary

An unannounced inspection took place on 27 May 2025, between 9.00 am and 5.20 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 inspection; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection found 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 three areas for improvement were assessed as having been addressed by the provider. Other areas for improvement have either been stated again or will be reviewed 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. 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 that "staff are good and friendly", "the food is good", "it's lovely here", "staff are great" and "the staff are fantastic". Patients also said they were able to choose if they engaged in group activities or outing. Those who wished to not engage in these and spend time in their room or without company, were able to do this.

Patients told us they appreciate being able to maintain their independence in various aspects of their daily or weekly routines; 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.

There were four service user and relative surveys received following the inspection, and one staff survey expressing positive feedback and gratitude. This was shared with the manager.

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 effective systems in place to manage staffing.

Staff told us they really enjoyed their job, their team and felt very supported by management.

Patients said that there was enough staff on duty to help them and spoke highly of the staff. 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; they said they were confident in the induction process for new staff.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty. Staff knew what they were doing and they had confidence in staffs' ability to provide good care.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day. For example, patients were able to rise and get ready for the day at their preferred later time and staff were able to support them in this.

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 also offered patients choice in how they wanted to engage socially with others for example, some like to watch TV together in the lounge and others in their own bedroom, some liked to eat their meals at a later time or stay up late at night and sleep later in the morning. Patients spoke positively of being supported by staff to go on trips, or to attend the shops.

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 accurately reflected the patients' assessed needs.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, appropriate foot wear was worn and walking aids were encouraged to be used and staff 'checked -in' with patients to support them to mobilise around the home if they wished. Patients were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy if this was beneficial.

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.

Observation of the lunch time meal, review of records and discussion with patients and staff indicated that there were robust systems in place to manage patients' nutrition and mealtime experience.

The dining experience was an opportunity for patients to socialise, and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. Observation confirmed that a 'mealtime coordinator' was appointed for each meal to ensure good communication across the team about changes in patients' needs and to ensure that people received the correct meal. It was evident that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed; assistance given with meals was focused on the individual, asking patients which foods they wanted to eat first and providing assistance in a dignified way. Patients who requested to try a new food, have a smaller portion, or have seconds were facilitated readily.

The importance of engaging with patients was well understood by the manager and staff. Patients were able to choose to go on trips or to stay in the home and engage in group or individual activities. Staff knew and understood patients' preferences and wishes and helped patients to participate in planned activities or to remain in their bedroom with their chosen activity such as reading or watching TV.

Staff understood that meaningful activity was not isolated to the planned social events or games.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home.

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.

Review of care records identified that there was not a comprehensive risk assessment for persons who smoke. An area for improvement was identified.

Where a person is supported in skin care by being assisted to change their position, these records did not clearly identify the frequency of repositioning and records reviewed were not in keeping with the prescribed regime. This area for improvement was stated for a second time and a new area for improvement was identified.

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.

Review of a sample of patient care plans identified that nursing staff had been regularly reviewing care plans to ensure they reflected the patients' current care needs. Care plans reviewed were based on patients' individual wishes and preferences. Discussion with the management team identified ways in which essential information, which was recorded, could be more easily accessible. This will be reviewed at a future inspection.

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. Art work undertaken by patients as part of the activity programme provided were on display in communal areas.

Review of the home's environment and records confirmed that the manager had a refurbishment plan in place to address usual wear and tear of the walls, furniture or patient equipment. Patients spoke of how clean they felt the home was.

Review of records and discussion with staff confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home's was safe to live in, work in and visit. For example, fire safety checks.

Staff wore Personal Protective Equipment (PPE) appropriately and demonstrated effective Hand Hygiene throughout the home.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection.

Patients and staff commented positively about the management team and described them as supportive, approachable and able 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 evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

Cards and letters received from relatives expressing gratitude to staff were maintained and shared with staff.

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*	3*

* the total number of areas for improvement includes one Standard which has been stated for a second time and two Regulations and one Standard which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with the person 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 13 (4) Stated: First time To be completed by: 18 July 2023	The registered person shall ensure that a controlled drug record book is maintained. The receipts, administrations and disposals of controlled drugs should be recorded in the controlled drug record book. Ref: 5.1 Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 Ref: Regulation 13 (4) Stated: First time To be completed by: 18 July 2023	The registered person shall ensure that records are maintained of the prescribing and administration of thickeners. Ref: 5.1 Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 3 Ref: Regulation 15 (2) Stated: First time To be completed by: 27 May 2025	The registered person shall ensure that for all patients who smoke, there is a comprehensive risk assessment in place; regularly reviewed and reflects the current assessed risk. Ref: 3.3.3 Response by registered person detailing the actions taken: All residents who smoke now have a Comprehensive risk assessment, including detailed smoking care plan. This will be regularly reviewed
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: 18 July 2023	The registered person shall ensure that care plans are in place to direct staff when patients are prescribed medicines for chronic pain. 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.

<p>Area for improvement 2</p> <p>Ref: Standard 23</p> <p>Stated: Second time</p> <p>To be completed by: 27 May 2025</p>	<p>The registered person shall ensure that where a patient has been assessed as requiring repositioning, frequency regime of repositioning is recorded within patient care records.</p> <p>Ref: 3.3.3</p>
<p>Area for improvement 3</p> <p>Ref: Standard 4.9</p> <p>Stated: First time</p> <p>To be completed by: 27 May 2025</p>	<p>Response by registered person detailing the actions taken: The repositioning template and repositioning care plans now reflect the frequency regime in the patients care records correctly, this is audited and reviewed monthly or more frequently if required by management</p> <p>The registered person shall ensure that where repositioning records are maintained, the care provided is in keeping with the prescribed regime.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: Meeting was held with all care staff to discuss the importance of keeping to the prescribed repositioning routine, this is now audited weekly or more frequently if required by management</p>

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