

Inspection Report

8 August 2024



Bohill House Nursing Home

Type of Service: Nursing Home
Address: 69 Cloyfin Road, Coleraine, BT52 2NY
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

<p>Organisation: Healthcare Ireland (No. 4) Limited</p> <p>Responsible Individual: Ms Andrea Louise Campbell</p>	<p>Registered Manager: Mrs Andrea McCook</p> <p>Date registered: 10 January 2023</p>
<p>Person in charge at the time of inspection: Mrs Andrea McCook</p>	<p>Number of registered places: 62</p> <p>A maximum of 36 patients in category NH-DE (ground floor dementia unit) and a maximum of 26 patients in categories NH-I and NH-PH.</p>
<p>Categories of care: Nursing Home (NH) I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment</p>	<p>Number of patients accommodated in the nursing home on the day of this inspection: 60</p>
<p>Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 62 patients. The home is divided into two units over two floors.</p> <p>There is a Residential Care Home which is in the same building and the manager for this home manages both services.</p>	

2.0 Inspection summary

An unannounced inspection took place on 8 August 2024 from 9.30 am to 5.00 pm by a Care Inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

As a result of this inspection, four areas for improvement were met and one was carried forward for review at a future inspection. There were no new areas for improvement identified. Please refer to the quality improvement plan in section 6.0 for further detail.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service 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, and a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

A poster was provided to the manager detailing how staff could provide their views and opinions by completing an online questionnaire. Questionnaire leaflets were also provided, to allow patients and those who visit them, the opportunity to provide feedback after the inspection with their views of the home.

The daily life within the home was observed and how staff went about their work.

A range of documents and records were examined to determine that effective systems were in place to manage the home.

4.0 What people told us about the service

The inspector spoke with a number of staff, patients, and the management team during the inspection.

Patients spoke positively about the care that they received, and patients who were less able to tell us about how they found life in the home were seen to be relaxed in their surroundings.

Discussions with staff confirmed they were generally positive about their roles and duties, provision of care and managerial support; where comments were made, these were shared with management for review and action as appropriate.

Relatives consulted with reported that they were satisfied with the care and services provided, where comments were made, these were shared with the management for review and action as appropriate.

As stated in section 3.0, questionnaires and a poster with a link to an online survey were left with the management, to allow residents, relatives, visitors and staff unable to meet with the inspector the opportunity to provide feedback on the home. Three questionnaires were returned, two responses indicated satisfaction with the care and services provided in Bohill House Nursing Home, comments included, “care good” “knowing my relative is safe and well looked after”; and one questionnaire reported some dissatisfaction with the care and services provided, comments made were shared with the management for review and action as appropriate.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 12 January 2024		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 14 (2) (a) (c) Stated: First time	The registered person shall ensure that all parts of the home to which patients have access, are free from hazards to their safety.	Met
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		Validation of compliance
Area for improvement 1 Ref: Standard 4 Stated: First time	The registered person shall ensure that all persons involved in a patient’s care, sign the care record and that the frequency of repositioning is recorded on the patient’s repositioning record.	Met
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 Ref: Standard 37	The registered person shall ensure that staff use, manage and dispose of records in line with good practice and legislative requirements.	Met

Stated: First time	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 3 Ref: Standard 12 Stated: First time	The registered person shall ensure that, where applicable, patients are provided with the correct utensils as detailed in the recommendations of the speech and language therapist.	Met
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 4 Ref: Standard 43 Stated: First time	The registered person shall ensure that the flooring in the identified area is repaired or replaced.	Carried forward to the next inspection
	Action taken as confirmed during the inspection: 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.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a system was in place to ensure staff were recruited correctly to protect patients.

The staff duty rota accurately reflected the staff working in the home over a 24-hour period and identified the nurse in charge when the manager was not on duty. Registered nurses taking charge of the home in the absence of the manager are required to have undertaken a competency and capability assessment prior to commencing in the role; review of a sample of these records confirmed these had been completed as required.

Discussion with the manager confirmed that a system was in place to monitor the dependency levels of patients and ensure the number of staff on duty was regularly reviewed to assist in meeting the needs of patients.

Review of records provided assurances that a system was in place to ensure all nursing staff were registered with the Nursing and Midwifery Council (NMC). There was also a system in place to monitor registration status of care staff with the Northern Ireland Social Care Council (NISCC).

There were systems in place to ensure staff were trained and supported to do their job. Mandatory training was progressing for staff and the manager confirmed that training compliance was kept under review.

A system was in place for staff supervision and appraisals to record staff names and the date that the supervision had taken place.

Staff were seen to attend to patients' needs in a timely manner, and patients' were offered choices throughout the day.

5.2.2 Care Delivery and Record Keeping

Staff met for a handover at the beginning of each shift to discuss any changes in the needs of the patients, and a handover record was available and included detailed meaningful information pertaining to patients' individual needs.

Staff demonstrated their knowledge of individual patient's needs, preferred daily routines and likes and dislikes, for example, where patients preferred to sit and what they liked to eat. Staff were seen to be skilled in communicating with the patients and to treat them with patience and understanding.

Patients' needs were assessed 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. Care plans included any advice or recommendations made by other healthcare professionals and were maintained, reviewed and updated as required.

Daily records were kept of how each patient spent their day and the care and support provided by staff.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails or alarm mats. It was established that systems were in place to manage this aspect of care.

Patients who were less able to mobilise were assisted by staff to mobilise or change their position as required, and care plans were in place to direct care for the prevention of pressure ulcers.

Patients who required care for wounds had this clearly recorded in their care records and records evidenced that wound care was managed in keeping with their assessed needs.

Falls in the home were monitored on a regular basis to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to reduce further falls from occurring. Care records for patients who experienced a fall evidenced that care plans and risk assessments were reviewed and updated.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients' needs determine that they may require a range of support with eating and drinking; this may include simple encouragement through to full assistance from staff. Some patients may require their food to be modified and/or may require specific utensils to aid eating and drinking following assessment by the Speech and Language Therapist.

The serving of the lunchtime meal was observed. Staff ensured that patients were comfortable throughout their meal. The daily menu was displayed showing patients what was available at each mealtime. A choice of meal was offered and the food was attractively presented and smelled appetising. An effective system was in place to identify which meal was for each individual patient, to ensure patients were served the right consistency of food and their preferred menu choice. Meals were appropriately covered on transfer whilst being taken to patients' rooms. There was a variety of drinks available. Patients wore clothing protectors if required and staff wore aprons when serving or assisting with meals. Patients told us that they enjoyed their meal.

Discussion with staff identified that a number of patients required meal modification and one to one staff assistance during mealtimes. Observation confirmed that staff were busy during the mealtime service to ensure patients received their meals as prescribed; and whilst no issues were identified during the inspection, a discussion took place with the management to review the meal time audit and experience; this will be reviewed at a future care inspection.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain, if required, records were kept of what patients had to eat or drink daily.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms and communal areas such as lounges. The home was warm, clean and comfortable. Many patient's bedrooms were personalised with items of importance to each patient.

Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible.

Review of records and discussion with staff confirmed that training on infection prevention and control measures and the use of personal protective equipment (PPE) had been provided. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with regional guidance.

5.2.4 Quality of Life for Patients

It was observed that staff offered choices to patients throughout the day which included preferences for what clothes they wanted to wear and where and how they wished to spend their time. Patients could have a lie in or stay up late to watch TV if they wished and they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of the time in their room and staff were observed supporting patients to make these choices.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, emotional and psychological wellbeing. The programme of activities was displayed on the noticeboard advising patients of forthcoming events. Patients' needs were met through a range of individual and group activities. Activity records were maintained which included the patient engagement with the activity sessions.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Andrea McCook is the Registered Manager of the home.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients.

The manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

The Manager maintained records of regular staff and departmental meetings. Meeting minutes were available for those staff who could not attend.

Systems were in place to ensure that complaints were managed appropriately.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans were put in place, these were followed up to ensure that the actions were correctly addressed. These were available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (December 2022)

	Regulations	Standards
Total number of Areas for Improvement	0	*1

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

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with the management.

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
<p>Area for improvement 1</p> <p>Ref: Standard 43</p> <p>Stated: First time</p> <p>To be completed by: 29 March 2024</p>	<p>The registered person shall ensure that the flooring in the identified area is repaired or replaced.</p> <p>Ref: 5.1</p>
	<p>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>

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