The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Brooklands Healthcare Antrim**

Provider: Brooklands **Healthcare Ltd**

Date of Inspection: **4 December 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 Limited
Responsible Individual	Mr Jarlath Conway
Registered Manager:	Mrs Perla Balmes

Service Profile –

This home is a registered residential care home which provides health and social care for up to 13 residents living with dementia. The home is located on the second floor of the building. There are a range of communal areas throughout the home and residents have access to an enclosed garden.

There is a separate registered nursing home which occupies the same building and the registered manager for this home manages both services.

2.0 Inspection summary

An unannounced inspection took place on 4 December 2024, between 9.05 am and 5.50 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 21 May 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection evidenced that safe, effective and compassionate care was delivered to residents 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 residents and that staff were knowledgeable and well trained to deliver safe and effective care. Residents said that living in the home was a good experience. Residents 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 the previous area for improvement was assessed as having been addressed by the provider. 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 resident'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

Residents spoken with who were able to make their wishes known told us they enjoyed residing in the home. Comments shared included; "the staff are all very pleasant" and "you can ask the staff for anything, they are all very sociable." Those residents who were unable to make their wishes known appeared to be relaxed and comfortable in their surroundings.

Discussion with residents confirmed that they were able to choose how they spent their day. For example, residents could have a lie in or stay up late to watch TV. Comments shared included, "there are activities but I prefer to stay in my room to watch TV and sleep."

Residents explained that they could have birthday parties with family and friends in their room or one of the lounges, could go out to church, local shops, or other activities in the community.

There was evidence of staff offering choices to residents 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.

Resident questionnaires returned confirmed that they found the care to be; safe, effective, compassionate and well-led. Some of the comments shared in the feedback included; “I think the care is very good, I like the staff the most” and “I think my care is excellent here, I am happy and settled here.” Other comments included were shared with the management team for review and action as appropriate.

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 residents. There was evidence of systems in place to manage staffing. The staff duty rota did not always clearly identify the person in charge in the absence of the manager, assurances were provided by the management team that this would be addressed.

There was evidence that those staff who were required to be registered with the Northern Ireland Social Care Council (NISCC) had this in place. A discussion took place with the management team to enhance the current system by ensuring staff registration is accurately recorded from the NISCC portal, this will be reviewed at a future inspection.

Residents 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. Staff responded promptly to call bells and evidenced they had good knowledge of residents needs.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day. For example; residents were offered the opportunity to attend the communal areas to listen to a musician who was in attendance. Residents who wished to attend were supported to do so and provided positive feedback about this entertainment.

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 residents. Staff were knowledgeable of individual residents’ needs, their daily routine wishes and preferences. Throughout the day observation confirmed that staff attended ‘safety pauses’ prior to mealtimes to ensure good communication across the team about changes in residents’ needs.

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

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly. Staff were also observed offering resident choice in how and where they spent their day or how they wanted to engage socially with others.

At times some residents 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 residents and to manage this aspect of care.

Residents may require special attention to their skin care. Records in place did not always evidence that any changes to residents skin were recorded appropriately, for example; bruising. A discussion took place with the management team and assurances were provided that systems would be implemented to ensure any changes in the resident's skin is recorded appropriately, documentation will be reviewed regularly to ensure the embedding of this into practice.

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. For example, residents were referred to their General Practitioner (GP).

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents 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 residents to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed that residents were enjoying their meal and their dining experience. Prior to the mealtime staff held a safety pause to consider those residents who required a modified diet. It was evident that staff had made an effort to ensure residents were comfortable, had a pleasant experience and had a meal that they enjoyed.

The importance of engaging with residents was well understood by the management team and staff.

Staff understood that meaningful activity was not isolated to the planned social events or games. Arrangements were in place to meet residents' social, religious and spiritual needs within the home.

The home has recently recruited a designated activity therapist and residents told us there was a range of activities taking place in the home daily. The weekly programme of social events was displayed on the noticeboard and shared with residents, families and staff advising of future events.

Residents' needs were met through a range of individual and group activities such as bingo, board games, arts and crafts or hand massage, hairdressing, one to one reading or listening to plays on the radio.

3.3.3 Management of Care Records

Residents' 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 residents' needs and included any advice or recommendations made by other healthcare professionals.

Residents care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. Care staff recorded regular evaluations about the delivery of care. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

3.3.4 Quality and Management of Residents' Environment

The home was generally clean, tidy and well maintained. For example, residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. There was evidence of homely touches across the home, for example; flowers, newspapers, magazines, snacks and drinks were also available.

Residents toiletries were stored in residents bathroom cabinets. A discussion took place with the management team to ensure systems are in place to risk assess the management of individuals toiletries to ensure these are stored appropriately. Assurances were provided by the management team this would be put into place.

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

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 Perla Balmes has been the Registered Manager in this home since 20 September 2024.

Residents 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 system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the management team 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.

The home is required to receive a monthly monitoring visit by the registered provider or a representative of the registered provider. These reports were not available on the day of inspection. An area for improvement was identified.

There was evidence that a log of compliments was maintained and shared with the staff, this is good practice.

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	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Perla Balmes, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Findings of the inspection were discussed with Mrs Perla Balmes, Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 29 (1) **Stated:** First time **To be completed by:** 4 December 2024	The Registered Person shall ensure that a monthly monitoring visit is carried out in the home and reports are made available for inspection. Ref: 3.3.5
	Response by registered person detailing the actions taken: In accordance with Regulation 29 unannounced monioring visits are completed monthly on behalf of the Registered Person by a delegated member of the management team who will ensure that a printed copy is available in the home at all times.

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

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