The Regulation and Quality Improvement Authority

Inspection Report

9 July 2024

Brooklands Healthcare Kilkeel

Type of Service: Residential Care Home
Address: Residential Dementia Unit, 10 Newry Road Kilkeel, BT34 4DT
Tel No: 028 4176 4968

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:** Ms Sharon Troughton **Date registered:** 18 June 2020
Person in charge at the time of inspection: Ms Isimeme Agbovi – Nurse in Charge	**Number of registered places:** 9
Categories of care: Residential Care (RC) DE – Dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 9
Brief description of the accommodation/how the service operates: This home is a registered residential care home which provides health and social care for up to nine residents who have a dementia. The home is situated on the ground floor. Residents have access to a communal dining room/lounge area. There is a nursing home which occupies part of the ground floor and the second floor of the building. The registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 9 July 2024 from 9.40am to 2.50pm by a care inspector.

The inspection determined if the home was delivering safe, effective and compassionate care and if the service was well led.

Residents were well presented in their appearance and enjoyed meaningful engagements with the staff. Residents told us that they were happy living in the home and spoke freely on how they spent their day. Staff told us that they enjoyed working in the home and enjoyed interacting with the residents. Comments from both residents and staff are included within the main body of this report.

The inspection resulted in no areas for improvement being identified. RQIA was satisfied that the care in the home was safe, effective and compassionate and that the home was well led.

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 registration information and any other written or verbal information received from residents, relatives, staff or the commissioning Trust.

Throughout the inspection RQIA will seek to speak with residents, 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.

Questionnaires were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the nurse in charge (NIC) at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with residents and staff. Residents were comfortable in their environment and in their engagements with staff. One told us, "The staff are very good to us", and another commented, "Staff will get you whatever you need". Staff told us that they worked well together and enjoyed engaging with the residents. Staff also confirmed that there were good working relationships between staff and the home's management team.

We received no questionnaire responses or feedback from the online staff survey.

5.0 The inspection

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

The last inspection to Brooklands Healthcare Residential Care Home, Kilkeel, was undertaken on 17 August 2023 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Staffing Arrangements

A comprehensive pre-determined list of pre-employment checks had been completed and verified prior to any new employee commencing work in the home. All staff completed an induction to become more familiar with the homes' policies and procedures. The staff were allowed supernumerary time in which to complete their inductions. A booklet was completed to record the topics covered on induction. A list of training was identified for completion as part of the induction process.

Staff had a suite of mandatory training topics to complete annually to maintain their knowledge and skills in order to provide safe and effective care. Training was completed face to face and electronically. Training topics included adult safeguarding, deprivation of liberty, dementia awareness, infection control, first aid and fire safety. A system was in place to ensure staff completed their training and evidenced 92.3 percent compliance on last check. In addition to this training, staff completed competencies on medication management and taking charge of the home.

Staff confirmed that they received an annual appraisal to review their performance and, where appropriate, identify any training needs. A 2024 appraisal planner was in use to aid with this. Staff also confirmed that they received recorded supervisions on a range of topics.

Checks were made to ensure that care staff applied for and maintained their registrations with the Northern Ireland Social Care Council (NISCC).

Staff were content that the staffing levels in the home met the needs of the residents accommodated in the home at any given time. The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked.

Staff were complimentary of the teamwork in the home. One told us, "It's very good; we all work as a team". Another commented, "I love it; we are all very close". Staff were observed to work well and communicate well with one another during the inspection.

5.2.2 Care Delivery and Record Keeping

Residents' 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 residents' needs and included any advice or recommendations made by other healthcare professionals. Care plans were personalised for each resident and reviewed monthly to ensure that they remained relevant to the residents.

Supplementary care records were completed to capture the care delivered to residents during the day and night. The care recorded was in relation to personal care delivered, continence management, diet and fluid intake and application of topical preparations. Daily records were completed and recorded after each shift evaluating the care given to residents and how they presented during the day/night.

Staff confirmed that they received a detailed handover at the commencement of each shift to ensure that residents were getting the right care; especially if care needs had changed. A handover sheet was given to staff to refer to and included pertinent residents' details, such as, allergies status, medical history, mobility, nutritional requirements and daily fluid targets. Some of the fluid targets listed appeared to be high. This was discussed with the NIC who agreed to review each target individually.

Staff were fully aware of residents' nutritional requirements. Each resident had their own food and drink preferences and had access to food and fluids throughout the day. Daily menus were displayed in written and pictorial formats to aid in the choice of meals at mealtimes. Food served appeared appetising and nutritious. Staff wore aprons when serving meals. All residents dined together in the dining area. The dining experience was audited on a monthly basis. Staff had attended first aid training and were aware of the actions to take should a patient choke.

Incident forms were completed following any accident or incident which occurred in the home. Accidents and incidents were reviewed monthly for any patterns or trends to see if any future accident/incident could be prevented in the future.

It was observed that staff provided care in a caring and compassionate manner. It was clear through resident and staff interactions that they knew one another well and were comfortable in each other's company. One resident commented, "There is always someone there when you need them".

5.2.3 Management of the Environment and Infection Prevention and Control

During the inspection we reviewed the home's environment including a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. Residents' bedrooms were personalised with items important to them. Bedrooms were suitably furnished and decorated. Bedroom doors were colour coded and there were memory boxes outside each bedroom containing items/pictures of importance to the resident and acted as an aid in identifying their room. There was good directional signage on communal corridors and signage on doors to communal areas to allow for easier orientation around the home.

Appropriate doors leading to rooms which contained hazards to residents had been locked. The home was warm, clean and comfortable. There were no malodours detected in the home.

It was evident that fire safety was important in the home. Staff had received training in fire safety and fire safety checks, including fire door checks and fire alarm checks, were conducted regularly. Corridors in the home were free from clutter and obstruction as were the fire exits should residents have to be evacuated. Fire extinguishers were easily accessible.

Monthly infection control audits were conducted to monitor the environment and staffs' practices. Where actions for improvement were identified, an action plan was included and identified the actions taken in response to findings. Decontamination records were maintained of mattresses and beds in use and for floor alarm mats. Hand hygiene audits were completed to monitor staffs' practice in this area of care. There were ample supplies of hand hygiene facilities and personal protective equipment. The laundry system had a clear 'dirty entry' and 'clean exit' process. Good compliance on infection control practices were observed during the inspection.

5.2.4 Quality of Life for Residents

Staff knew their residents well and were aware of their individual likes, dislikes, hobbies and interests. It was clear through the daily records that activities were conducted with residents in accordance with their interests and likes. Staff had a good rapport with residents. Residents told us, “Staff are lovely”, “Staff are very good to us”, and, “This is a really good place”.

Each resident had their own activities and family involvement care plan in place. This outlined their previous occupations, interests and individual preferences. It identified who and what was important to them and included a list of people they did not wish to visit them. The care plan was reviewed monthly to monitor engagement with activities and to see if it could be further developed. Individual records of activity engagements were recorded within the residents’ care records.

An activities therapist oversaw the activities in the home. The activities programme was displayed showing planned activities for each morning and afternoon. Activities included arts and crafts, bingo, games, baking and puzzles. There were multiple resources in the home for activities, such as, arts and crafts, watching television or listening to music. Some residents had a daily newspaper delivered to them. Activities were conducted on a group or on a one to one basis where this was preferred.

The activities therapist confirmed regular weekly outings for residents for coffee mornings or café visits. Residents had access to an outdoors seating area where they could go when they wished. Musicians would come into the home to entertain the residents. Residents could avail of the privacy of their own bedroom or join other residents and staff in one of the communal areas.

Seasonal events, such as, Easter and Christmas were celebrated as were residents’ birthdays. Staff, residents and family members had access to a Facebook account where they could see pictures of residents enjoying activities. Residents and/or family members had consented to the use of photographs on the social media platform.

Visiting was open and residents were free to leave the home with family members if they wished. Records of family contacts were maintained.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been no change to the management arrangements. Sharon Troughton has been the Registered Manager of the home since 18 June 2020. Discussion with staff confirmed that there were good working relationships between staff and the manager. Staff described the manager as ‘approachable’ and ‘would listen to any concerns’.

Staff told us that they would have no issue in raising any concerns regarding residents’ safety, care practices or the environment. Staff had a good understanding of the home’s organisational structure should they need to escalate their concern and were aware of the departmental authorities that they could contact should they need to escalate further.

A suite of audits were completed to monitor the quality of care and other services provided to the residents. Staff, including managers, nurses, domestics and administrative staff had their own nominated audit list to complete. Audits were conducted on, for example, residents' care records, medicines management, activities, housekeeping, dining and nutrition, food safety, staff registrations, staff training and the environment.

The home was visited each month by a representative of the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed and completed reports were available for review by residents, their representatives, the Trust and RQIA. Where improvement actions were required, an action plan was included within the report. The action plan would be reviewed at the subsequent monthly monitoring visit to ensure completion.

A system was in place to manage complaints in the home. There were no recent or ongoing complaints relating to the home. A compliment's log was completed and included thank you cards and verbal compliments received. Compliments received were shared with the staff.

7.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Isimeme Agbovi, Nurse in Charge, as part of the inspection process and can be found in the main body of the report.

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