

Inspection Report

Name of Service: Bradley Court

Provider: Healthcare Ireland (Belfast) Limited

Date of Inspection: 21 January 2025

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

1.0 Service information

Organisation:	Healthcare Ireland (Belfast) Limited
Responsible Individual:	Andrea Louise Campbell
Registered Manager:	Paul Williamson – not registered
<p>Service Profile – This home is a registered nursing home which provides nursing care for up to 12 patients who have a learning disability. Bedrooms and living areas are located over two floors. Patients have access to communal lounges, dining areas and an enclosed garden. Bedrooms on the ground floor have access to private enclosed outside patio areas.</p> <p>This home is located on the same site as another nursing and residential care home with separate managerial arrangements.</p>	

2.0 Inspection summary

An unannounced inspection took place on 21 January 2025, from 9.30 am to 3.30 pm by care inspectors.

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 18 April 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

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.

While we found care to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the staff registration checks and record keeping.

As a result of this inspection seven areas for improvement were assessed as having been addressed by the provider. One area for improvement has been stated again. 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.

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 who were able to share their opinions on life in the home said or indicated that they were well looked after and were observed to be at ease in the company of staff and to be content in their surroundings

Relatives and visiting health professionals spoken with were complimentary about the care provided in the home.

Discussions with staff confirmed that they felt positive about their roles and duties, the provision of care and teamwork. Staff said that Bradley Court was a good place to work and that the management team were supportive and approachable.

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.

Staff spoke positively about staffing levels. Staff said that there was enough staff on duty to meet the needs of the patients, teamwork was good and they felt well trained for their roles and responsibilities.

There was a system in place to monitor that staff were appropriately registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC). However; review of the care staff registration with Northern Ireland Social Care Council (NISCC) identified staff who had not paid their yearly fee. This was discussed with the manager for his appropriate action and an area for improvement was identified.

3.3.2 Quality of Life and Care Delivery

Staff said they met for a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff demonstrated their knowledge of individual patients' needs, preferred daily routines, likes and dislikes.

Staff were seen to treat the patients with kindness and understanding. It was observed that staff respected patients' privacy and dignity; they knocked on doors before entering bedrooms and bathrooms and offered personal care to patients discreetly.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress, 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.

At times some patients may require the use of equipment or assessed as requiring continuous supervision; this could be considered restrictive, they may also 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. The staff were knowledgeable about each patients' care needs. Behaviour support care plans included details of identified triggers, what the behaviours might look like and the plan in place to manage and de-escalate behaviours.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly. A review of repositioning records evidenced that patients were not always repositioned as prescribed in their care plan and in addition inconsistencies were observed when care staff recorded the position the patient was repositioned to and from. An area for improvement was stated for a second time and a new area for improvement identified.

Where a patient was at risk of falling, measures to reduce this risk were put in place. The manager confirmed that staff take appropriate action in the event of a fall, for example, the staff observe and monitor the patient post fall and seek medical assistance if required.

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. Patients were offered a choice of meals. Staff supported patients to eat their meals in their preferred location of the home. The activity staff advised that the home is introducing a regular take away evening and encouraging the patients to dine together.

The importance of engaging with patients was well understood by the manager and staff. Staff understood that meaningful activity was not isolated to the planned social events or games. The home has a dedicated activity therapist, both families and visiting health professionals praised this staff member on the activities provided for the patients with positive effects on patients' mood and behaviours. Each patient has their own individualised activity programme.

3.3.3 Management of Care Records

Patient care records were individualised, comprehensive and person centred. The care records also evidenced regular review. Nursing staff recorded regular evaluations about the delivery of care. Care plans were shared with patients' relatives, if this was appropriate.

Patients' needs should be assessed at the time of their admission to the home. Following this initial assessment, care plans and risk assessments should be developed in a timely manner to direct staff on how to meet the patients' needs. Review of an identified patient's care records evidenced that they were not developed in a timely manner. An area for improvement was identified.

Review of care records for an identified patient who had recently spent some time in hospital did not evidence that their care records were reviewed timely upon readmission to the nursing home. An area for improvement was identified.

Patients care records were held confidentially.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy. There was evidence of some wear on paint and wood work mostly in the downstairs unit. This was discussed with the manager who advised of an ongoing refurbishment / painting plan. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Review of records and discussion with the manager confirmed 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. Corridors and fire exits were clear from clutter and obstruction. Records showed that regular fire drills had been undertaken by staff at suitable intervals.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Mr Paul Williamson has been the acting manager of the home since 16 September 2024.

Patients, relatives and staff commented positively about the manager and described him as supportive, approachable and able to provide guidance. Staff confirmed that there were good working relationships.

Review of a sample of records evidenced that the manager had processes in place to monitor the quality of care and other services provided to patients. 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 the quality of services provided by the home. However, it was observed that the care record audits did not evidence that any identified deficits were brought forward to an action plan to be addressed. An area for improvement was identified.

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	2	4*

*the total number of areas for improvement includes one standard that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Paul Williamson, 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	
Area for improvement 1 Ref: Regulation 20 (1) (c) (ii) Stated: First time To be completed by: From the date of the inspection 21 January 2025	The Registered Person shall ensure care staff registration is effectively monitored by the manager to ensure staff are up to date with their yearly fee and are on the live Northern Ireland Social Care Council (NISCC) register. Ref: 3.3.1 Response by registered person detailing the actions taken: All staff were reminded of their personal responsibility and accountability to monitor and check their NISCC registration. Home Management have increased level of checks to twice monthly to ensure compliance in this area.
Area for improvement 2 Ref: Regulation 16 (2) (b) Stated: First time	The Registered Person shall ensure risk assessments and care plans are reviewed and updated following any patient's admission to hospital. Ref: 3.3.3

<p>To be completed by: From the date of the inspection 21 January 2025</p>	<p>Response by registered person detailing the actions taken: All registered nursing staff have completed group supervision and have been reminded of the importance of timely and accurate information. New managerial audit commenced to ensure oversight of new admissions and re-admissions into the home. Ongoing review of compliance in this area during monthly managerial governance and regulatory visits.</p>
<p>Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)</p>	
<p>Area for improvement 1</p> <p>Ref: Standard 23.2</p> <p>Stated: Second time</p> <p>To be completed by: From the date of the inspection 21 January 2025</p>	<p>The Registered Person shall ensure that patients are repositioned as prescribed in their care plans.</p> <p>Ref: 2.0 and 3.3.2</p> <p>Response by registered person detailing the actions taken: New managerial audit in situ to review and provide oversight of repositioning schedule. Staff supervision has been completed to further impress importance of repositioning care plan and adherence to same. Patient Care System reviewed and "Planned care" function reviewed to ensure staff are alerted to identified plan of care in relation to repositioning.</p>
<p>Area for improvement 2</p> <p>Ref: Standard 23.2</p> <p>Stated: First time</p> <p>To be completed by: From the date of the inspection 21 January 2025</p>	<p>The Registered Person shall ensure that repositioning records are accurately maintained to accurately include the position the patient is repositioned to.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: Home manager to ensure audits include that repositioning records note the position the patient is repositioned to. The importance of this will be communicated to nursing and care staff at team meetings.</p>
<p>Area for improvement 3</p> <p>Ref: Standard 4.1</p> <p>Stated: First time</p> <p>To be completed by: From the date of the inspection 21 January 2025</p>	<p>The Registered Person shall ensure that an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. A detailed plan of care for each patient is generated from a comprehensive, holistic assessment and drawn up with each patient. The assessment is commenced on the day of admission and completed within 5 days of admission to the home.</p> <p>Ref: 3.3.3</p>

	<p>Response by registered person detailing the actions taken: All registered nursing staff have completed group supervision and have been reminded of the importance of timely and accurate information post admission to the home. New managerial audit commenced to ensure oversight of new admissions and re-admissions into the home.</p>
<p>Area for improvement 4</p> <p>Ref: Standard 35</p> <p>Stated: First time</p> <p>To be completed by: 28 February 2025</p>	<p>The Registered Person shall ensure that care record audits include a clear action plan when deficits are identified. These action plans should include the person responsible for completing the action and appropriate follow up to ensure any identified actions are addressed.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: A robust action plan document will be developed and implemented to record and identify progress in care audits. Learning will be shared with all staff as part of group supervision.</p>

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