The Regulation and Quality Improvement Authority

Inspection Report

13 June 2022

Brooklands Healthcare Antrim Residential Unit

Type of service: Residential Care Home
Address: 50 Bush Road, Antrim, BT41 2QB
Telephone number: 028 9446 0444

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: Ms Therese Elizabeth Conway.	Registered Manager: Mrs Geraldine Merry - Acting Manager
Person in charge at the time of inspection: Mrs Geraldine Merry	Number of registered places: 19
Categories of care: Residential Care (RC) DE – dementia	Number of residents accommodated in the residential care home on the day of this inspection: 18
Brief description of the accommodation/how the service operates: Brooklands Healthcare Antrim – Residential Unit is a registered residential care home which provides health and social care for up to 19 residents living with dementia. The registered nursing home is located within the same building. The manager has operational responsibility and oversight for both the nursing home and the residential care home. The residential care home is on the ground floor.	

2.0 Inspection summary

An unannounced inspection took place on 13 June 2022, from 10.05am to 2.10pm. It was completed by a pharmacist inspector and focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

Progress with one of the areas for improvement identified at the last inspection was assessed. Following discussion with the aligned care inspector, it was agreed that the remaining two areas for improvement identified at the last care inspection would be followed up at the next care inspection.

Review of medicines management found that largely robust arrangements were in place for the safe management of medicines. Whilst one area for improvement was identified in relation to the management of inhaled medicines, RQIA can conclude that overall, with the exception of a small number of these medicines, the residents were being administered their medicines as prescribed.

Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team with respect to medicines management.

RQIA would like to thank the residents, staff and management for their assistance throughout the inspection.

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, information held by RQIA about this home was reviewed. This included previous inspection findings, incidents and correspondence. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector also spoke to staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with the acting manager, the residential unit manager and two other members of the management team. Staff were warm and friendly and it was evident from discussions that they knew the residents well. Staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and that management were available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA. One staff response was received, which indicated that the staff member was satisfied with the service provided.

5.0 The inspection

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

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 18 January 2022</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005</td><td>Validation of compliance</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13 (7)

Stated: First time</td><td>The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.

This area for improvement relates to the following:

• donning and doffing of personal protective equipment
• appropriate use of personal protective equipment
• staff knowledge and practice regarding hand hygiene.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Observations throughout the inspection evidenced that this area for improvement has been met. There were written records of staff supervision, training and hand hygiene audits to support this.</td></tr>
<tr><td colspan="2">Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)</td><td>Validation of compliance</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 9.3

Stated: First time</td><td>The registered person shall ensure residents are appropriately monitored following a fall and that all such observations/actions taken post fall are appropriately recorded in the resident’s care record.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>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.</td></tr>
</table>

Area for improvement 2 Ref: Standard 6.6 Stated: First time	The registered person shall ensure that resident care plans and risk assessments evidence they are regularly reviewed to ensure they reflect the needs of the resident. This area for improvement is in specific reference to the management of weight loss.	Carried forward to the next 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 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the pharmacist or during a hospital admission.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist and/or the discharging hospital.

Personal medication records were in place for each resident. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had usually verified the personal medication records when they were written and updated, to provide a check that they were accurate. Staff were reminded that this should take place on every occasion. Staff were also reminded that when medicines are discontinued or the dose is changed, the original entry should be cancelled, the date recorded and a new entry made for any changed dose.

Copies of prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All residents should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

Residents will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the resident's distress and if the prescribed medicine is effective for the resident.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed. Directions for use were recorded on the personal medication record and a care plan was in place. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome of each administration.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered as prescribed. Care plans were in place.

Some residents may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the resident should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the resident.

The management of thickening agents was reviewed and found to be satisfactory. A speech and language assessment report and care plan were in place.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the resident's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were available for administration when residents required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were organised so that medicines belonging to each resident could be easily located. The medicine trolley was clean, tidy and organised. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A controlled drugs cabinet and medicines refrigerator were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines.

5.2.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to residents to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of staff for ongoing close monitoring (see below). The records were filed once completed and were readily retrievable for audit/review.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out and any discrepancies were investigated. The date of opening was recorded on medicines so that they could be easily audited. This is good practice. The majority of audits completed at the inspection indicated that medicines were being administered as prescribed. However, significant discrepancies were observed in the administration of two inhaler preparations. These medicines must be administered as prescribed, accurate records maintained and a referral made to the prescriber if necessary. An area for improvement was identified.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. There were satisfactory arrangements in place for the management of controlled drugs.

Occasionally, a resident may have their medicines administered in food/drinks to assist administration. Care plans detailing how residents prefer to take their medicines were in place including agreement from the prescriber for this to take place.

5.2.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new residents or residents returning from hospital. Written confirmation of the resident's medicine regime was obtained and details shared with the GP and/or community pharmacy as necessary. Medicine records had been accurately completed.

5.2.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that these incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence. The type of incidents that should be reported and reporting responsibilities were discussed with staff.

5.2.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and they are supported. Policies and procedures should be up to date and readily available for staff.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes (Northern Ireland) 2005 and Residential Care Homes Minimum Standards August 2011.

	Regulations	Standards
Total number of Areas for Improvement	1	2*

* The total number of areas for improvement includes two that have been carried forward for review at the next inspection.

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

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13 (4)

Stated: First time

To be completed by:
With immediate effect
(13 June 2022)</td><td>The registered person shall ensure that medicines are administered as prescribed and accurate records of administration maintained.

This area for improvement is in specific reference to the management of inhaler preparations.

Ref: 5.2.3</td></tr>
<tr><td>Response by registered person detailing the actions taken:
An inhaler audit is in place to monitor the administration of inhalers. This is reviewed monthly in line with the new medication cycle.</td></tr>
<tr><td colspan="2">Action required to ensure compliance with Residential Care Homes Minimum Standards 2011</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 9.3

Stated: First time

To be completed by:
18 February 2022</td><td>The registered person shall ensure residents are appropriately monitored following a fall and that all such observations/actions taken post fall are appropriately recorded in the resident’s care record.</td></tr>
<tr><td>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.

Ref: 5.1</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 6.6

Stated: First time

To be completed by:
18 February 2022</td><td>The registered person shall ensure that resident care plans and risk assessments evidence they are regularly reviewed to ensure they reflect the needs of the resident.

This area for improvement is in specific reference to the management of weight loss.</td></tr>
<tr><td>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.

Ref: 5.1</td></tr>
</table>

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Assurance, Challenge and Improvement in Health and Social Care