

Announced Post-Registration Medicines Management Inspection Report 22 March 2018



Brooklands Healthcare Antrim

Type of service: Residential Care Home
Address: Residential Unit, 50 Bush Road, Antrim, BT41 2QB
Tel No: 028 9446 0444
Inspector: Rachel Lloyd

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for



2.0 Profile of service

This is a residential care home with 44 beds registered to provide care for residents living with dementia.

3.0 Service details

Organisation/Registered Provider: Brooklands Healthcare Ltd Responsible Individual: Ms Theresa Elizabeth Conway	Registered Manager: See below
Person in charge at the time of inspection: Mrs Claire Coen	Date manager registered: Mrs Claire Coen – acting manager
Categories of care: Residential Care (RC): DE – Dementia	Number of registered places: 44

4.0 Inspection summary

An announced inspection took place on 22 March 2018 from 10.10 to 13.00.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

This was the first medicines management inspection since registration. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, medicine records, medicine storage and the management of controlled drugs.

No areas for improvement were identified.

Observation of the environment throughout the home and the interactions between staff and residents were all very positive.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Claire Coen, Manager and Jane Bell, Regional Manager,

Brooklands Healthcare Ltd, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced post-registration care inspection undertaken on 23 August 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- recent care inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the home registered.

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection the inspector met with three senior care assistants, the community pharmacist, the manager and the regional manager.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

A sample of the following records was examined during the inspection:

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|--|----------------------------------|
| • medicines requested and received | • medicine audits |
| • personal medication records | • policies and procedures |
| • medicine administration records | • care plans |
| • medicines disposed of or transferred | • training records |
| • controlled drug record book | • medicines storage temperatures |

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 23 August 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and was approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection

This was the first medicines management inspection to the home since registration in July 2017.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings and supervision. The manager stated that annual appraisal and competency assessment will take place. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

Robust arrangements were in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. This safe practice was acknowledged.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Robust arrangements for administering medicines in disguised form, where necessary, were in place.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicine refrigerators were checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, the management of medicines on admission, the management of changes to medication, the management of controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

When a resident was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that this change may be associated with pain. The reason for and the outcome of administration were recorded on a separate record sheet. A care plan was in place.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. Staff advised that most of the residents could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the prescribed consistency. Administration was recorded and care plans and speech and language assessment reports were in place.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident’s health were reported to the prescriber.

Medicine records were well maintained and readily facilitated the audit process. Staff were commended on the standard of record keeping and areas of good practice were acknowledged. These included the use of separate colour coded personal medication records for antibiotics and topical preparations and antibiotic administration sheets.

Practices for the management of medicines were audited throughout the month. This included maintaining running stock balances for medicines not supplied in the monitored dosage system. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the needs of the residents.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to residents was completed in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible.

Throughout the inspection, good relationships were observed between the staff and the residents. Staff were noted to be friendly and courteous. Residents who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Ten questionnaires were left in the home to facilitate feedback from residents and relatives. None were returned within the specified timescale (two weeks).

Any comments from residents, their representatives or staff received after the issue of this report will be shared with the manager for their information and action as required.

Areas of good practice

There was evidence that staff listened to residents and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with these.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. One medicine related incident reported since registration was discussed. There was evidence of the action taken and learning implemented following incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion and observation, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with management. They stated that there were good working relationships.

No members of staff shared their views by completing the online questionnaire prior to the issue of this report.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.



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