



Unannounced Post-Registration Medicines Management Inspection Report 14 June 2018



Brooklands Healthcare – Magherafelt

Type of Service: Residential Care Home
**Address: Residential Dementia Unit, 66 Hospital Road,
Magherafelt, BT45 5EG**
Tel No: 028 7963 4490
Inspector: Catherine Glover

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 eight beds that provides care for residents living with dementia. The residential care home is on the same site as a nursing home.

3.0 Service details

Organisation/Registered Provider: Brooklands Healthcare Ltd Responsible Individual: Ms Therese Conway	Registered Manager: Mrs Deirdre Monaghan
Person in charge at the time of inspection: Mrs Deirdre Monaghan	Date manager registered: 11 June 2018
Categories of care: Residential Care (RC) DE – Dementia	Number of registered places: 8

4.0 Inspection summary

An unannounced inspection took place on 14 June 2018 from 11.00 to 14.20.

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 in this newly registered residential care home situated within Brooklands Healthcare - Magherafelt. The inspection was 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 medicine records, care planning, medicine administration, medicine storage and the management of controlled drugs.

No areas for improvement were identified.

The residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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 Deirdre Monaghan, Registered Manager, 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 pre-registration inspection

The most recent inspection of the home was an announced pre-registration care inspection undertaken on 16 April 2018. 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 inspection reports and returned QIPs
- recent correspondence with the home
- the management of incidents: it was ascertained that no incidents involving medicines had been reported to RQIA since the home registered.

During the inspection the inspector observed all of the residents in the lounge, and met with the registered manager and a senior care assistant. We spoke to one visitor to the home.

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

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

- | | |
|--|----------------------------------|
| • 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 16 April 2018

The most recent inspection of the home was an announced care inspection. The completed QIP was returned and 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.

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 are responsible for medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. 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 had been received into the home without delay.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by staff members. This safe practice was acknowledged.

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

The arrangements for the disposal of discontinued or expired medicines were discussed with the registered manager. There have been no medicines disposed of since registration.

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.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	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. The reason for and the outcome of administration were recorded. A care plan had not been completed however the registered manager advised that this would be completed immediately after the inspection.

The management of pain was examined. Although none of the residents were prescribed regular pain relief, there was evidence that pain was regularly assessed and pain relief was considered when a resident was distressed.

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 facilitated the audit process. Areas of good practice were acknowledged. They included additional records for recording the reason for administering analgesics and auditing sheets for antibiotics.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of residents.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping, care planning 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 not observed during this inspection, however staff were knowledgeable regarding the residents’ medicines and requirements.

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were noted to be friendly, courteous and happy in their work; they treated the residents with dignity.

We spoke to one regular visitor to the home who was very complimentary about the home and staff. Comments included:

“The staff are so caring, the home is excellent. The manager is very approachable and caring. The staff are always busy.”

During the inspection residents were observed in the lounge enjoying music and singing. Another visitor to the home was greeted warmly by staff and residents and was encouraging a sing-a-long.

Of the questionnaires that were issued, three were returned from residents and relatives. The responses indicated that they were very satisfied with all aspects of the care. One comment stated “All aspects are brilliant”.

Any comments from residents or their representatives in returned questionnaires received after the return date will be shared with the registered 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. There was a warm and welcoming atmosphere.

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. Management advised that these were reviewed regularly. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report any 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 lead and safeguarding team.

A review of the audit records indicated that largely 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 with the registered manager and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that management were open, approachable and willing to listen.

There were no responses to the online staff questionnaire.

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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