The Regulation and Quality Improvement Authority

Inspection Report

23 January 2024

Brooklands Healthcare - Dunmurry Nursing Unit

Type of service: Nursing Home
Address: 42e Cloona Park, Dunmurry, Belfast, BT17 0HH
Telephone number: 028 9060 1020

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 Limited **Responsible Individual:** Mr Jarlath Conway	**Registered Manager:** Mrs Perla Balmes **Date registered:** 13 April 2023
Person in charge at the time of inspection: Ms April Agagas, Deputy Manager, until 11.15 Mrs Perla Balmes, Registered Manager, from 11.15 onwards	**Number of registered places:** 57 A maximum on 29 patients in category NH-DE on designated unit on the first floor.
Categories of care: Nursing (NH): I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 54
Brief description of the accommodation/how the service operates: Brooklands Healthcare Dunmurry is a nursing home which is registered to provide care for up to 57 patients. The home is divided into two units; the first floor provides care for people living with dementia and the ground floor provides general nursing care.	

2.0 Inspection summary

An unannounced medicines management inspection took place on 23 January 2024 from 9.50am to 2.30pm. This was completed by a pharmacist inspector and focused on medicines management. 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.

The areas for improvements identified at the last care inspection were not examined and will be followed up at the next care inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained

and competent to manage medicines and patients were administered their medicines as prescribed. No new areas for improvement were identified.

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 regarding the management of medicines.

RQIA would like to thank the staff 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, staff training and the auditing systems used to ensure the safe management of medicines. Discussions were held with 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 three nurses, the deputy manager and the manager. In addition, the regional manager also joined by telephone at the point of feedback.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs.

5.0 The inspection

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

Areas for improvement from the last inspection on 7 December 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that accidents and incidents are appropriately reported to RQIA in a timely manner. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that where a patient has been assessed as requiring repositioning: • care plans and repositioning charts are consistent in relation to the recommended frequency of repositioning • the frequency of repositioning recorded within charts is reflective of the recommended frequency within the care plan. **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.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure that a system is in place to ensure that shower chairs are effectively cleaned between each use with particular attention paid to the underside of the seat.	**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?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' 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.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. 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 or 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 checked and signed the personal medication records when they were written and updated to state that they were accurate.

Copies of patients' prescriptions/hospital discharge letters were usually retained in the home so that any entry on the personal medication record could be checked against the prescription. It was agreed that these would be filed in patient and chronological order to facilitate retrieval.

All patients 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.

Patients 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 nurses 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 nurses record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines prescribed on a "when required" basis for distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware of the factors that this change may

be associated with. Nurses were reminded that records should include the outcome of each administration on every occasion, these details were usually recorded.
The management of pain was discussed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place. Two care plans needed to be updated to reflect recent changes in prescribed medicines; this was addressed immediately.

Some patients 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 patient 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 patient.

The management of thickening agents was reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained. One personal medication record needed updating with a recent change in prescribed consistency, this was addressed immediately. There was evidence the patient had received the correct consistency.

Care plans were also in place for example, when patients required insulin to manage their diabetes; including sufficient detail to direct staff if the patient's blood sugar was too low or too high, when patients were prescribed warfarin and for rescue medicines for seizures.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

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

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient'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 patients required them.

The medicines storage areas were observed to be locked to prevent any unauthorised access when not in use. They were tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicines storage areas was monitored and recorded. Medicine refrigerators and controlled drugs cabinets were available for use as needed. Staff were reminded to cover inhaler spacer devices on trolleys for infection prevention and control purposes. This was addressed immediately.

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 patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed and these were found to have been accurately completed. The records were filed once completed. Nurses were reminded that handwritten medicine administration records should always include the start date, as is the expected practice within the home.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Consent was recorded and care plans were in place when this practice occurred.

Management and staff audited medicines administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on medicines so that they could be easily audited which is good practice.

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 patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The 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.

There had been no medicine related incidents reported to RQIA since the last medicines management inspection. This was discussed and management and nurses were familiar with the type of incidents that should be reported.

The audits completed at the inspection indicated that medicines were being administered as prescribed. One discrepancy in the administration of warfarin was identified and shared with staff for investigation. This was completed immediately and reported appropriately to the prescriber and RQIA.

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

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. Competency was assessed following induction and then annually. Policies and procedure documents were in place.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	1*	2*

* The number of areas for improvement includes three which are carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mrs Perla Balmes, Registered Manager, Ms April Agagas, Deputy Manager, and Ms Victoria Humphries, Regional Manager, by telephone, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** 7 December 2023	The registered person shall ensure that accidents and incidents are appropriately reported to RQIA in a timely manner.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 31 December 2023	The registered person shall ensure that where a patient has been assessed as requiring repositioning: • care plans and repositioning charts are consistent in relation to the recommended frequency of repositioning • the frequency of repositioning recorded within charts is reflective of the recommended frequency within the care plan.
	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
Area for improvement 2 **Ref**: Standard 46 **Stated:** First time **To be completed by:** 7 December 2023	The registered person shall ensure that a system is in place to ensure that shower chairs are effectively cleaned between each use with particular attention paid to the underside of the seat.
	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

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