The Regulation and Quality Improvement Authority

Inspection Report

6 December 2022

Brooklands Healthcare Antrim

Type of service: Nursing 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:** Mr Leslie Stephens, Acting Manager
Person in charge at the time of inspection: Mr Leslie Stephens	**Number of registered places:** 49
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years DE – dementia TI – terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 42
Brief description of the accommodation/how the service operates: Brooklands Healthcare Antrim is a nursing home registered to provide nursing care for up to 49 patients. The home is split over two floors. The ground floor of the home provides nursing care for up to 31 patients living with dementia. The first floor provides general nursing care for up to 18 patients. Patients have access to communal lounges, dining rooms and an enclosed garden. There is also a registered residential care home located within the same building; the manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 6 December 2022 from 10.20am to 3.30pm and was completed by a pharmacist inspector. The inspection 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.

Following discussion with the aligned care inspector, it was agreed that the area for improvement carried forward at the last care inspection would 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 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 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 two nurses on duty, the manager and the regional manager. Staff interactions with patients were warm, friendly and supportive. Staff were wearing face masks and other personal protective equipment (PPE) as needed.

The staff spoken with generally 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 for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no responses had been received.

5.0 The inspection

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

The last inspection to the nursing home was undertaken on 19 May 2022 by a care inspector; no new areas for improvement were identified, one area for improvement was carried forward.

Areas for improvement from the last inspection on 19 May 2022		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 21.1 **Stated:** First time	The registered person shall ensure that patients' wound care needs are managed in an effective manner at all times; this includes but is not limited to ensuring that: records are updated in a timely manner to reflect the assessed needs of patients; wound assessments and evaluations are completed after each dressing, daily progress notes include meaningful and patient centred entries regarding patients' skin condition; a robust wound care audit is being used in the home.	**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. Staff were reminded to cancel and promptly archive personal medication records that have been rewritten to prevent them being used in error.

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

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.

Medicine related care plans were in place for example for pain, distressed reactions, modified diets, warfarin and insulin. Other appropriate care plans were in place, for example, the management Parkinson's. Advice was provided on ensuring that patient and medicine specific detail is included as necessary.

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 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. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicine storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed. Two expired eye preparations were observed on the trolley, these were not in use and were removed immediately.

Satisfactory arrangements were in place for the 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 medication administration records was reviewed and were found to have been fully and accurately completed. The records were filed once completed and were easily retrievable for audit.

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 a controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The audits completed at the inspection indicated that medicines were administered as prescribed. The date of opening was recorded on the majority of medicines so that they could be easily audited. Staff were reminded that insulin pen devices, which have a limited shelf life after opening, should always be dated. The majority were and the manager agreed to remind nurses of this expected 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 patients new to the home or returning from hospital. Written confirmation of the medicine regimes was usually obtained at or prior to admission and details shared with the GP/community pharmacy as necessary. The medicine records had been accurately completed. There was evidence that nurses had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

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.

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

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 nurses 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

	Regulations	Standards
Total number of Areas for Improvement	0	1*

* The area for improvement is one which is 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 Mr Leslie Stephens, Manager and Mrs Geraldine Merry, Regional Manager, 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 Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 21.1 **Stated:** First time **To be completed by:** Immediate action required (4 December 2021)	The registered person shall ensure that patients' wound care needs are managed in an effective manner at all times; this includes but is not limited to ensuring that: records are updated in a timely manner to reflect the assessed needs of patients; wound assessments and evaluations are completed after each dressing, daily progress notes include meaningful and patient centred entries regarding patients' skin condition; a robust wound care audit is being used in the home.
	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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