Brooklands
RQIA ID: 11289
50 Bush Road
Antrim
BT41 2QB

Inspectors: Helen Daly
Judith Taylor
Inspection ID: IN022695

Tel: 028 9446 0444
Email: therese.conway.bhl@googlemail.com

Unannounced Medicines Management Inspection of Brooklands

3 November 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced medicines management inspection took place on 3 November 2015 from 10:15 to 16:55.

The management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

This inspection was underpinned by the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

For the purposes of this report, the term "patients" will be used to described those living in Brooklands which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the report there were no further actions required to be taken following the medicines management inspection on 30 January 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	2

The details of the QIP within this report were discussed with Ms Liz Bonello, Manager, and Ms Wendy Megarrell, Regional Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Brooklands Healthcare Ltd Ms Therese Elizabeth Conway (Acting)	**Registered Manager:** Not applicable
Person in Charge of the Home at the Time of Inspection: Ms Liz Bonello (Manager)	**Date Manager Registered:** Not applicable
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI, RC-DE	**Number of Registered Places:** 62
Number of Patients Accommodated on Day of Inspection: 61	**Weekly Tariff at Time of Inspection:** Residential:£520 - £578 Nursing: £643 - £687

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 28: Management of Medicines
Standard 29: Medicines Records
Standard 31: Controlled Drugs

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately.

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to the inspection, we reviewed the management of medication related incidents reported to RQIA, since the last medicines management inspection.

We met with the manager, the regional manager, two registered nurses and one senior carer.

The following records were examined:

- Medicines requested and received
- Personal medication records
- Medicines administration records
- Medicines disposed of or transferred
- Controlled drug record book
- Medicine audits
- Policies and procedures
- Care plans
- Training records
- Medicine storage temperatures

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection on 15 October 2015. The care inspector confirmed that there were no issues to be followed up at this inspection.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

No requirements or recommendations were made.

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

The majority of the audits which were carried out on several randomly selected medicines produced satisfactory outcomes, indicating that the medicines had been administered as prescribed. However, significant audit discrepancies in the administration of a number of medicines which were not contained within the blister pack system, including liquids and eye preparations, were observed in the nursing suite. In addition a number of audits could not be completed because dates of opening had not been recorded. The unsatisfactory audits were discussed in detail with the manager and regional manager.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. All medicines were available for administration on the day of the inspection, apart from paracetamol tablets for one patient. The paracetamol tablets were on order and an alternative analgesic was available for this patient. Medicines were observed to be labelled appropriately.

Written confirmation of current medication regimes had not been obtained for two recently admitted patients. Two registered nurses/senior carers had signed the personal medication records which correlated with the medicines provided by the patients' families.

The management of warfarin was reviewed and found to be satisfactory. However, obsolete dosage directions had not been cancelled and archived.

Medicine records had been maintained in a mostly satisfactory manner. Personal medication records had been verified and signed by two registered nurses/senior carers. A number of plastic dividers were missing between patient records in the nursing suite which could lead to an error being made.

The actual dose administered had not been recorded for medicines which were prescribed to be administered at a variable dose. In addition the unsatisfactory audit outcomes indicated that registered nurses/senior carers may have signed for the administration of medicines which they did not actually administer. Incomplete records for the administration of external preparations were also observed.

The sample of records of medicines ordered, received and disposed of which were reviewed had been maintained in a satisfactory manner.

Records showed that discontinued and expired medicines had been returned to a waste management company. The manager confirmed that two registered nurses/senior carers were involved in the disposal of medicines and both had signed the records of disposal.

The controlled drug record books and records of stock reconciliation checks of Schedule 2 and Schedule 3 controlled drugs were well-maintained. However, one supply of temazepam tablets which was contained in a compliance aid had not been stored in the controlled drugs cabinet; this was addressed at the inspection. Additional monitoring for controlled drugs in Schedule 4 (Part 1) e.g. diazepam tablets, zopiclone tablets was not being carried out.

Is Care Effective? (Quality of Management)

Policies and procedures for the management of medicines, including Standard Operating Procedures for the management of controlled drugs, were available.

There was evidence that medicines were being managed by registered nurses and senior carers who had been trained and deemed competent to do so. Competency assessments were currently being completed with all trained staff.

Registered nurses had also received training on the management of enteral feeding, syringe drivers and diabetes awareness.

Care staff were responsible for the administration of thickening agents and emollient preparations. The manager confirmed that training on the administration of external medicines and thickening agents had been provided as part of their induction and that there was on going refresher training.

There were a number of auditing systems in place. The management team completed a monthly audit and action plans were then developed and implemented. The community pharmacist completed a quarterly audit. In the residential suite running stock balances were being maintained.

There were procedures in place to report and learn from medication related incidents that have occurred in the home. The medicine incidents reported to RQIA since the last medicines management inspection had been managed appropriately.

Is Care Compassionate? (Quality of Care)

There was evidence that registered nurses had requested alternative formulations to assist administration when patients have had difficulty swallowing tablets/capsules.

The records for a number of patients who were prescribed anxiolytic medicines for administration on a “when required” basis for the management of distressed reactions were examined. Records of prescribing and administration were in place. Although staff were knowledgeable regarding when these medicines should be administered to each patient, care plans were not in place. For two patients the medicines were being administered every day. The reason for administrations had been recorded in the daily notes on some occasions. The outcome of administrations had not been recorded.

The management of pain was reviewed. The names of the medicines and the parameters for administration had been recorded on the personal medication records. Pain assessment tools were being used. However, there was evidence that pain management had not been reviewed as part of the admission assessment in the residential suite. In addition care plans for the management of pain were in place for some patients only. These findings were discussed in detail with the manager and regional manager.

Areas for Improvement

The registered person must implement a robust auditing system to ensure that all medicines are being administered as prescribed. A requirement was made.

The registered person must ensure that written confirmation of current medication regimes is obtained for all patients. A requirement was made.

The management of medicines which are prescribed to be administered “when required” for the management of distressed reactions should be reviewed and revised. Detailed care plans, which are reviewed regularly, should be in place. The regular use of these medicines should be referred to the prescribers for review. The reason for and outcome of each administration should be recorded. A recommendation was made.

The systems in place for the management of pain should be reviewed and revised. Pain management should be assessed for all patients with dementia. Care plans, which are reviewed regularly, should be in place when necessary. A recommendation was made.

The manager agreed to ensure that obsolete dosage directions for warfarin are cancelled and archived and that plastic dividers would be made available in the medicines files in the nursing suite.

The manager advised that the standard of maintenance of the medication administration records and records of administration of emollient preparations by care staff would be monitored as part of the audit process.

The manager confirmed that stock counts would be carried out on controlled drugs in Schedule 4 (Part 1).

Number of Requirements:	**2**	**Number of Recommendations**:	**2**

5.4 Additional Areas Examined

Storage was observed to be tidy and organised.

The temperatures of the treatment rooms and medicines refrigerators were monitored and recorded each day. There was evidence that corrective action was taken when temperatures outside the accepted range were observed. The medicines refrigerator in the nursing suite had been reported to the maintenance team; it was agreed that the medicines would be moved to an alternative medicines refrigerator until the repair work had been completed.

Dates of opening had not been recorded on all medicines, including limited shelf-life medicines, and a small number of out of date and discontinued medicines were observed on the medicines trolleys. This was discussed with the manager who advised that it would be monitored as part of the audit process.

It was also agreed that the storage of oxygen would be reviewed and that inhaler spacer devices would be replaced. There were several oxygen cylinders in place and a chain for their secure storage was not in use.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Liz Bonello, Manager, and Ms Wendy Megarrell, Regional Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Person/Registered Manager

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to **pharmacists@rqia.org.uk** and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be Completed by:** 3 December 2015	The registered person must implement a robust auditing system to ensure that all medicines are being administered as prescribed.
	Response by Registered Person(s) Detailing the Actions Taken: A robust medication management auditing system is in place which is overseen by the registered manager and monitored at the monthly regulation 29 visits by the Clinical Governance Manager.
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be Completed by:** 3 December 2015	The registered person must ensure that written confirmation of current medication regimes is obtained for all patients prior to or on admission.
	Response by Registered Person(s) Detailing the Actions Taken: Registered nurses have been updated on admission protocols and procedures. This is monitored through medication management audits.
Recommendations	
Recommendation 1 **Ref:** Standard 18 **Stated:** First time **To be Completed by:** 3 December 2015	The management of medicines which are prescribed to be administered "when required" for the management of distressed reactions should be reviewed and revised as detailed in the report.
	Response by Registered Person(s) Detailing the Actions Taken: A system is in place for the administration of 'when required' anxiolytic medicines for the management of resident distressed reactions. This includes reasons for each administration and detailed care plans.
Recommendation 2 **Ref:** Standard 4 **Stated:** First time **To be Completed by:** 3 December 2015	The systems in place for the management of pain should be reviewed and revised as detailed in the report.
	Response by Registered Person(s) Detailing the Actions Taken: A system is in place for the assessment and management of resident's pain on admission to the home. This is regularly monitored by the registered manager.

Registered Manager Completing QIP	Liz Bonello	**Date Completed**	7.12.15
Registered Person Approving QIP	Therese Conway	**Date Approved**	7.12.15
RQIA Inspector Assessing Response	Helen Daly	**Date Approved**	10.12.15

Please ensure the QIP is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address