The Regulation and Quality Improvement Authority

Inspection Report

20 & 21 September 2023

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: Brooklands Healthcare Ltd **Responsible Individual:** Mrs Therese Elizabeth Conway	**Registered Manager:** Mr Leslie Stephens – not registered
Person in charge at the time of inspection: Mr Leslie Stephens – acting manager	**Number of registered places:** 49 There will be a maximum of 31 patients in the category NH-DE to be accommodated on the ground floor. 18 patients in the categories NH-I, NH-PH, NH-PH(E), NH-TI to be accommodated on the first floor.
Categories of care: Nursing Home (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. TI – Terminally ill. DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 46
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 dementia. The first floor provides general nursing care for up to 18 patients. Ensuite bedrooms, lounges and dining rooms are located on both floors of the home. 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 20 September 2023 from 9.15am to 5.00pm and 21 September 2023 from 9.00am to 3.45pm and was completed by a care inspector; an inspection of medicines management took place on 20 September 2023, from 9.15am to 2.30pm and was completed by a pharmacist inspector.

Prior to the inspection RQIA received information from the Northern Health and Social Care Trust (NHSCT) with regard to care provision and medicines management. In response to this information RQIA decided to undertake a combined care and medicines management inspection.

From a care perspective, the inspection also sought to assess progress with all areas for improvement identified since the last care inspections and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

From a medicines management perspective this inspection focussed on reviewing a range of medicine records and care planning regarding the use of medicines prescribed and administered on a 'when required' basis for the management of distressed reactions. Most medicine records and medicine related care plans were well maintained. There were auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed.

In total five new areas for improvement were identified. Please see the Quality Improvement Plan (QIP) in section 6 for further details.

Addressing the areas for improvement will further enhance the quality of the care and services in Brooklands Healthcare Antrim.

RQIA would like to thank the patients, 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 the home was 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 the care inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, and a range of information about the service was reviewed to help us plan the inspection.

To prepare for the medicines management inspection, information held by RQIA about this home was reviewed. This included previous inspection findings, incidents and correspondence. To complete the inspection, the following were reviewed, a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

A poster was provided to the manager detailing how staff could provide their views and opinions by completing an online questionnaire. Questionnaire leaflets were also provided, to allow patients and those who visit them, the opportunity to provide feedback after the inspection with their views of the home.

The daily life within the home was observed and how staff went about their work. A range of documents and records were examined to determine that effective systems were in place to manage the home.

4.0 What people told us about the service

During the inspection the inspectors met with six patients, twelve staff and one relative.

Due to the nature of dementia not all patients were able to tell us how they found life in the home. Patients who were less able to communicate were seen to be content in their surroundings and in their interactions with staff. Patients who could express their views spoke positively about life in the home. Comments made by patients included “it’s very good” and “the food is good”.

Staff reported that they enjoyed working in the home and that teamwork was good.

Relatives reported that they were content with the care provided to their loved one and were kept well updated by staff.

As stated in section 3.0, questionnaires and a poster with a link to an online survey were left with the management to allow patients, relatives, visitors and staff unable to meet with the inspector the opportunity to provide feedback on the home. Two responses were received from relatives, indicating varying degrees of satisfaction ranging from satisfied to very satisfied with the care and services provided in Brooklands Healthcare Antrim. The questionnaires also included comments that were shared with the manager for review and action as appropriate. There were no responses received from the staff online survey within the allocated timeframe.

5.0 The inspection

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

The last medicines management inspection was undertaken 6 December 2022, no areas for improvement were identified. The last care inspection was undertaken 8 March 2023, see below.

Areas for improvement from the last care inspection on 8 March 2023		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that patients are repositioned in accordance to their assessed needs as detailed within their care plan and that repositioning charts are signed by two staff where assistance of two is required.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect patients. Discussion with staff and a review of relevant records confirmed that staff completed an induction prior to working with patients.

There was a system in place to monitor that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC).

A system was in place to ensure staff completed their mandatory training; bespoke training, to enhance staff awareness for dementia care, was scheduled for staff to attend. Staff were satisfied with the range of training offered.

The staff duty rota accurately reflected the staff working in the home on a daily basis and identified the person in charge when the manager was not on duty. Staff allocated to provide one to one care for patients, were clearly identified with records maintained.

Staff who take charge in the home in the absence of the manager had completed relevant competency and capability assessments.

Staff should have the opportunity to attend supervision and appraisal sessions to review their role and enhance their professional development. A review of records provided assurance that a system was in place to ensure staff had undertaken supervision and appraisal.

During the inspection, it was noted that staff were busy, but were seen to respond to patients' requests for assistance in a timely manner. Staff spoken with told us there was good teamwork in the home.

The majority of staff consulted, commented positively on recent changes to the staffing skill mix, however, some nursing staff reported that their day can be very busy due to the reduction in nursing staff hours. The manager explained that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. As the staff skill mix had recently been changed, discussion took place with management to ensure that dependency levels were regularly reviewed and detailed records maintained.

We reviewed how staff were deployed and noted that whilst there were systems in place for staff allocation throughout the day, the supervision of communal spaces, for example lounges were not included. This resulted in a lack of supervision and presence of staff to support patients in some areas of the home. This deployment of staff was discussed with the management for review and action: an area for improvement was identified.

5.2.2 Care Delivery and Record Keeping

Staff confirmed they attended a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine, wishes and preferences.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans were developed to direct staff on how to meet patients' needs. A sample of care records were reviewed and evidenced that generally care plans were regularly reviewed and updated; and included any advice or recommendations made by other healthcare professionals. Discussion with the management confirmed that a care file audit was undertaken on a regular basis to ensure that care records were suitably maintained.

Patients' individual likes and preferences were reflected throughout the records. Care plans contained information on what or who was important to them; and daily records were maintained on how each patient spent their day and the care and support provided by staff.

Staff were observed to be prompt in recognising patients' needs, including those patients who had difficulty in making their wishes or feelings known.

Some patients were observed to be availing of one to one enhanced supervision. Discussion with staff confirmed that they were provided with information pertaining to the needs of the patients with a care plan in place to direct care.

Patients who are less able to mobilise were assisted by staff to mobilise or change their position as required, and care plans were in place to direct care for the prevention of pressure ulcers. Patients were being assisted by staff to change their position regularly.

Care records for patients who experience a fall evidenced that care plans and risk assessments were reviewed and updated appropriately. There was evidence that the detail of the fall was recorded and audited for trends and patterns.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The meal time experience was reviewed in two identified units and inconsistencies were observed in the mealtime experience, and are detailed below.

The dining experience in one unit was well organised, unhurried and with good support provided to the patients. The food served was attractively presented, smelled appetising and a variety of drinks were served with the meal. Staff attended to patients' dining needs in a caring and compassionate manner and where required, staff engaged with patients' on a one to one basis to assist them with their meal. A menu was clearly displayed with the food options for the meal times; and meal choices were offered to patients including those who required to have their food modified. Staff were knowledgeable in regards to patient's nutritional requirements, however identification of the meal time co-ordinator role should be reviewed.

In the second unit, the majority of patients required their meals to be brought to their room; with a small number of patients having their meal served in the dining room.

Due to a significant number of patients requiring their meal to be brought to their room, staff were not always present in the dining room to supervise and support the patients. It was further noted that a patient who required specified feeding utensils as prescribed by Speech and Language Therapy (SALT) were not provided with these.

The issues observed during the meal time experience, were brought to the immediate attention of management. Patient supervision has been identified as an area for improvement in section 5.2.1. The adherence to SALT recommendations at mealtimes was identified as an area for improvement.

Discussion with staff confirmed that there was a system in place to ensure patients were provided with their meals as prescribed. Meals were transferred from the kitchen to this dining room and placed in a heated trolley for serving. Plates were labelled to identify which modified meal was for which patient, however, it was noted that the labels were not secure; this was discussed with the manager and was identified as an area for improvement.

Discussion took place with the manager regarding the importance of ensuring that "Mealtimes Matter"; the regionally agreed Health and Social Care (HSC) framework was enhanced in the home, to maximise service user safety during mealtimes.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain, if required, records were kept of what patients had to drink and eat daily.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. The home was warm, clean and comfortable. Patients bedrooms were clean, tidy and personalised with items of importance to each patient, such as family photos and sentimental items from home. Patients had access to televisions and/or music in their own rooms and also in communal sitting rooms.

Corridors and fire exits were observed to free of clutter and obstruction, however corridors lacked clear signage and points of interest to assist the orientation of patients in the dementia unit. This was discussed with management who advised that plans were in place to undertake a review of the environment to enhance the patient experience in the dementia unit. Given this assurance, an area for improvement was not identified at this time, however this will be reviewed at a future inspection.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of Personal Protective Equipment had been provided. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

Environmental infection prevention and control audits had been conducted and the manager confirmed they undertake regular workaround's and spot checks

5.2.4 Quality of Life for Patients

Staff took time to chat to patients as they were going about the daily routine; they asked patients how they were, if they would like a drink and if they needed anything. The atmosphere throughout the home was warm, welcoming and friendly.

Discussion with management and staff confirmed that an activity co-ordinator was available to provide activities for patients and they were actively recruiting for another member of the activity team, to further enhance the activity provision. A monthly activity planner was available and detailed the range of activities offered, for example, music and pamper sessions. A record of each patient's activity engagements was recorded within their care records.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mr Leslie Stephens has been the Acting Manager since 8 November 2022. Discussion with the management confirmed that an application to register will be submitted to RQIA.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

A review of records evidenced that a system of auditing was in place to monitor the quality of care and other services provided to patients. Areas audited included, for example, patients care records, restrictive practice, patient's weights infection management, staff training and the environment.

Observation and discussion with staff confirmed that walk rounds were undertaken by the manager, however recorded evidence was not available for review. This was discussed with the management and assurance was provided that an evidence record would be immediately implemented.

A system was in place to monitor accidents and incidents that happened in the home. A review of a sample of these records found, generally they were reported to RQIA in accordance with regulation and standards, however, there were a small number of occasions where notifications were not submitted to RQIA. It was positive to note that the home's governance processes identified the omissions and retrospective notifications were submitted. Given the assurances that the management audit had identified this issue an area for improvement was not identified on this occasion.

A review of records evidenced that a system was in place to manage complaints.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. A sample of reports were reviewed and identified that where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. The reports were available for review by patients, their representatives, the Trust and RQIA.

5.2.6 Medicines Management

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 mostly 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. Records no longer in use were often stored behind the current record. These must be cancelled immediately and archived to ensure they ae not referred to in error. This had been highlighted for attention at the last medicines management inspection. An area for improvement was identified.

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. This is good practice.

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 recorded on personal medication records. 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. However, care plans did not always include patient and/or medicine specific information to direct staff. Records of administration did not always include the reason for and outcome of administration. An area for improvement was identified.

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 and reviewed regularly.

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. A small number of minor discrepancies were brought to the attention of nurses and immediately addressed. The records were filed once completed.

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 within the home. A range of audits were carried out. The date of opening was recorded on the majority of medicines so that they could be easily audited. A review of management audits indicated that the issues raised in this report had not been identified. It was agreed that the areas for improvement and those highlighted for discussion in this report, would be included in audit procedures.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes, December 2022**

	Regulations	Standards
Total number of Areas for Improvement	2	3

Areas for improvement and details of the Quality Improvement Plan were discussed with the management as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 20 (2) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review the deployment of staff, taking account of the daily routine, to ensure that patients are appropriately supervised. This refers to, but not limited to: • Communal lounges • Dining rooms Ref: 5.2.1 & 5.2.2
	Response by registered person detailing the actions taken: The daily allocation sheet has been reviewed and adapted to ensure the dining rooms have mealtime co ordinators allocated to each dining room and appropriate staff supervision in the communial lounges.
Area for improvement 2 **Ref:** Regulation 14 (2) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that, were applicable, patients are provided with the correct utensil as detailed in the recommendations of the speech and language therapist. Ref: 5.2.2
	Response by registered person detailing the actions taken: Each dining room has a SALT folder in place detailing the recommendations from the Speech and Language therapist to ensure the correct utensils are provided. This information is also available on the handover sheet for all staff knowledge.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 12.1 **Stated:** First time	The registered person shall ensure there is a robust system in place for the management of modified diets and the clear labelling of modified diets. Ref: 5.2.2

To be completed by: With immediate effect	**Response by registered person detailing the actions taken:** The system for the management of modified diets and clear labelling has been reviewed and enhanced.
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** With immediate effect (20 September 2023)	The registered person shall ensure that obsolete personal medication records are cancelled immediately and archived to ensure they are not referred to in error. Ref: 5.2.6 **Response by registered person detailing the actions taken:** The medicines audit schedule has been updated to include review of personal medication records to ensure cancelled Kardex's have been archived.
Area for improvement 3 **Ref:** Standard 18 **Stated:** First time **To be completed by:** With immediate effect (20 September 2023)	The registered person shall ensure that a patient specific care plan is in place and that the reason for and the outcome of administration is recorded on every occasion when medication is prescribed/administered on a 'when required' basis for the management of distressed reactions. Ref: 5.2.6 **Response by registered person detailing the actions taken:** Annual Medicines Management training is scheduled for all nursing staff on 29.11.2023. The medicines audit schedule has been updated to include the review of careplans for residents prescribed "when required" distressed reaction medications.

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care