The Regulation and Quality Improvement Authority

Inspection Report

30 January 2024

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:** Mr Jarlath Conway	**Registered Manager:** Mrs Perla Balmes, not registered
Person in charge at the time of inspection: Mrs Perla Balmes	**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:** 45
Brief description of the accommodation/how the service operates: Brooklands Healthcare Antrim, Nursing Unit, 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. En-suite bedrooms, lounges and dining rooms are located on both floors of the home. There is a 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 30 January 2024, from 9.20 am to 6.30 pm by a care inspector and from 9.15 am to 4.10 pm by a pharmacist inspector.

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

From a medicines management perspective this inspection focussed on reviewing a range of medicine records and care plans regarding the use of medicines prescribed and administered on a 'when required' basis for the management of distressed reactions and for those medicines administered covertly.

Two new areas for improvement were identified in relation to medicine records and care plans for the covert administration of medicines and one area for improvement was stated for a second time regarding medicine records for the management of distressed reactions.

From a care perspective five new areas for improvement were identified, please see section 6 for further information.

The inspection resulted in a total of eight areas for improvement, one of which was stated for the second time.

Addressing the areas for improvement will further enhance the quality of 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 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 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.

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

The inspectors spoke with a number of staff, patients and the management team during the inspection.

Patients spoke positively about the care that they received, and patients who were less able to tell us about how they found life in the home were seen to be relaxed in their surroundings.

Discussions with staff confirmed that they felt generally positive about their roles and duties, the provision of care, staffing, teamwork, and managerial support, where comments were made, these were shared with management for review and action as appropriate.

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 inspectors, the opportunity to provide feedback on the home. The responses and comments were shared with the management of Brooklands, Antrim. Assurance was provided by the management that this information would be reviewed and actioned as appropriate.

5.0 The inspection

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

Areas for improvement from the last inspection on 20 and 21 September 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 20 (2) **Stated:** First time	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	**Met**

	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met.	
Area for improvement 2 **Ref:** Regulation 14 (2) (b) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met.	
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time	The registered person shall ensure that obsolete personal medication records are cancelled immediately and archived to ensure they are not referred to in error.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met (see section 5.2.6).	
Area for improvement 3 **Ref:** Standard 18 **Stated:** First time	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.	**Partially met**
	Action taken as confirmed during the inspection:	

	There was evidence that this area for improvement has been partially met (see section 5.2.6). **This area for improvement has been stated for a second time**.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

The duty rotas accurately reflected the staff working in the home over a 24-hour period and identified the person in charge when the manager was not on duty.

Registered nurses taking charge of the home in the absence of the manager are required to have undertaken a competency and capability assessment; discussion with staff and review of a sample of these records confirmed these had been completed as required.

Discussion with management confirmed that a system was in place to monitor the dependency levels of patients and ensure the number of staff on duty was regularly reviewed to assist meet the needs of patients. Observation during the inspection, evidenced that staff attended to patients' needs in a timely manner; and where patients required support on a 1:1 basis, care staff assisted them consistently with their assessed care needs.

There were systems in place to ensure staff were trained and supported to do their job. Mandatory training was progressing for staff and the management confirmed that training compliance was kept under review. Discussion with staff confirmed they were provided with an induction programme to support them in the tasks associated with their role and duties, however, it was identified that a member of staff had not been provided with the necessary full complement of training prior to commencing their role. This was discussed with the management for immediate review and action; an area for improvement was identified.

Discussion with management confirmed that the home had engaged with the Northern Health and Social Care Trust (NHSCT) to further complement training for staff in dementia care. Some staff had undertaken the training sessions provided by the NHSCT and further sessions were planned for the remainder of the staff. This will be reviewed at a future inspection.

Staff should have the opportunity to attend supervision and appraisal sessions to review their role and enhance their professional development. Discussion with the management confirmed that a schedule was available and was ongoing. The management confirmed that staff who did not have English as their first language could be provided with further support where necessary.

During the inspection, an emergency alarm sounded and observation noted inconsistencies in the response. This was brought to management attention for review and action; an area for improvement was identified.

Staff were observed to work well with one another during the inspection.

5.2.2 Care Delivery and Record Keeping

Staff said they met for a handover at the beginning of each shift to discuss any changes in the needs of the patients, and a handover record was available and included detailed meaningful information pertaining to patients' individual needs. Discussion with staff confirmed that an allocation sheet directed staff to their daily duties. Where patients required bespoke one to one care, a separate allocation record was maintained.

Discussion with management confirmed that where the needs of patients required bespoke 1:1 care, a system was in place to ensure this was progressed and reviewed with the care manager and Health and Social Care Trust.

Discussion with care staff providing 1:1 support confirmed they were provided with a handover to ensure they were aware of the patient's specific individual needs; a record was maintained to evidence the patient's daily routine. Staff were knowledgeable regarding individual patients' needs, preferred daily routines, likes and dislikes, for example, where patients preferred to sit and what they liked to eat.

Care records evidenced that patients' needs were assessed at the time of admission to the home. Following this initial assessment, care plans were developed to direct staff how to meet the patient's needs, however the system in place for reviewing care records was difficult to navigate which resulted in some care plans not being updated to reflect changes in the patient's assessed needs. This was identified as an area for improvement. Care plans for patients who required 1:1 care lacked personalised details; this was discussed with the management for review and action; an area for improvement was identified.

It was further identified that one patient's assessed Speech and Language Therapist (SALT) requirements were incorrectly recorded on the daily handover record. This was discussed with the management for immediate review and action; an area for improvement was identified.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients' needs determine that they may require a range of support with eating and drinking; this may include simple encouragement through to full assistance from staff. Some patients may require their food to be modified and /or may require specific utensils to aid eating and drinking following assessment by the Speech and Language Therapist.

Staff told us how they were made aware of patients' nutritional needs to ensure they were provided with the right consistency of diet; and where patients preferred to have their meal in their own room, this was readily accommodated with support provided as required. A menu was available to inform patients of the meal and choice available.

The serving of lunch was observed in one unit; 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. Observation noted the food served was attractively presented, smelled appetising and a variety of drinks were served with the meal. Patients were observed to receive their meals as prescribed.

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 eat or drink daily.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was divided into two units and it was observed, that patient bedrooms had varying degrees of personalisation. Corridors and fire exits were observed to be clear of clutter and obstruction. The previous inspection had noted corridors and communal areas in an identified unit lacked clear signage and points of interest to assist the orientation of patients living with dementia. This was discussed again with management for review and action. Management provided assurance that this would be addressed and given the short timeframe from the previous inspection, this assurance was accepted and will be reviewed at a future inspection.

The home was observed to be clean and tidy, however a malodour was noted in an identified area. This was brought to the attention of the management and addressed. Discussion with staff confirmed that a system was in place to ensure deep cleans of areas were undertaken with records maintained.

Review of records and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of personal protective equipment (PPE) 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.

5.2.4 Quality of Life for Patients

Patients were able to choose how they spent their day. For example, some patients chose to stay in their room, whilst others were observed attending the communal spaces. The atmosphere of the home was relaxed and friendly with staff seen to be interacting with patients and asking them how they were and if they needed anything.

Discussion with care staff confirmed that activities were provided for patients, for example, music sessions; during the inspection it was noted that patients were enjoying a music session provided by an external entertainer. Discussion with management acknowledged that activities were an integral part of patient care and advised that activity provision was under review as they were actively recruiting activity staff. Progress in this area will be reviewed at a future inspection.

5.2.5 Management and Governance Arrangements

There has been a change in the manager since the last inspection; Mrs Perla Balmes has been the Manager since 25 January 2024. RQIA were notified appropriately.

Staff members 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.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Discussion with management confirmed that the audit process was being reviewed, with a view to being further developed; this will be followed up at a future inspection.

Discussion with the manager confirmed that complaints were seen as an opportunity for the team to learn and improve and confirmed a system was in place to manage complaints. Review of available records evidenced that details of dissatisfaction were recorded and reviewed.

The manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

The home was visited each month by a representative of the responsible individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. These reports were available in the home for review by patients, their representatives, the Trust and RQIA.

5.2.6 Medicines Management

Medicine records and care plans

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. 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. However, some entries on these records and medicine administration records had been amended when a dose had changed, which may lead to confusion and an incorrect dose being administered. These entries should be cancelled and a new entry made. 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 factors that this change may be associated with. Records of administration usually included the reason for and outcome of administration. However, care plans did not always include patient and/or medicine specific information to direct staff. Some new entries on care plans were contradictory to previous entries which had not been cancelled. An area for improvement was stated for a second time.

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 satisfactorily completed. A small number of missing entries were brought to the attention of nurses. 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. However, care plans did not always include patient and/or medicine specific information to direct staff. An area for improvement was identified.

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 the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	3	5*

* The total number of areas for improvement includes one that has been stated for a second time.

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(1)(c)(i) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that newly appointed staff complete mandatory training in a timely manner. Ref: 5.2.1
	Response by registered person detailing the actions taken: All newly appointed staff to complete mandatory training before commencing their induction. Mandatory training statistics are reviewed on a weekly basis by the Home Manager and an action plan identifying any deficits is created. Practical mandatory training sessions have been facilitated in the Home in February and March and future sessions are booked for April.
Area for improvement 2 **Ref:** Regulation 16 (1) (2) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that care plans are updated to reflect any changes in the patients' needs. Ref: 5.2.2
	Response by registered person detailing the actions taken: A guide to Person Centred Care Planning has been created and shared with all nursing staff. Care planning supervisions were undertaken with all nursing staff. All residents are allocated a named nurse to ensure sufficient oversight of care plans and that they are all reviewed and updated in accordance with resident needs. The Home Manager completes a monthly care plan audit to ensure evaluations are completed in a timely manner. Furthermore individual resident care file audits are completed monthly by the Home Manager.
Area for improvement 3 **Ref:** Regulation 16(1)	The registered person shall ensure care plans for patients receiving 1:1 care are personalised to clearly identified the assessed needs of the patient.

Stated: First time **To be completed by:** Immediate and ongoing	Ref: 5.2.2
	Response by registered person detailing the actions taken: Person centred care plans are available for residents with bespoke care packages in place, appropriately reflecting their individual needs.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 18 **Stated:** Second time **To be completed by:** From the date of the inspection (30 January 2024)	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: 5.1 & 5.2.6
	Response by registered person detailing the actions taken: Detailed and person centred care plans have been formulated reflecting administration of medications for distressed reactions. Distressed Reactions Monitoring paperwork is in use for all residents prescribed 'when required' medication for the management of distressed reactions. Nursing staff record on every occasion when such medication is administered, the rationale for administration and the outcome of administration. The Home Manager completes a monthly distressed reaction audit.
Area for improvement 2 **Ref:** Standard 39 **Stated:** First time **To be completed by:** From the date of the inspection (30 January 2024)	The registered person shall ensure that staff are knowledgable and demonstrate competency in response to emergency alarms. Ref: 5.2.1
	Response by registered person detailing the actions taken: Call bell auditing processes have been updated to include emergency call bell response time. Responding to emergency alarms is also sufficiently covered through the induction process.

Area for improvement 3 **Ref:** Standard 37.4 **Stated:** First time **To be completed by:** From the date of the inspection (30 January 2024)	The registered person shall ensure that the handover record is routinely reviewed and updated to ensure it is reflective of the patients' current needs. Ref: 5.2.2
	Response by registered person detailing the actions taken: Handover documentation is reviewed daily by nursing staff and dated accordingly.
Area for improvement 4 **Ref:** Standard 29 **Stated:** First time **To be completed by:** From the date of the inspection (30 January 2024)	The registered person shall ensure that medicine records are maintained to ensure a clear audit trail. This is stated with reference to entries on personal medication records and medicine administration records which must not be amended when there is a prescribed dosage change. Ref: 5.2.6
	Response by registered person detailing the actions taken: Staff supervisions have been completed with all nursing staff in relation to their obligations for maintaining clear and accurate medicine records. Medication administration records are not amended and when there is a prescribed dosage change, a new entry is created and all obsolete entries discontinued. Spot checks are completed by the Home Manager as part of their monthly medication audits and issues promptly rectified.
Area for improvement 5 **Ref:** Standard 28 **Stated:** First time **To be completed by:** From the date of the inspection (30 January 2024)	The registered person shall ensure that care plans for the covert administration of medicines include current patient and medicine specific detail to direct staff as to how each medicine should be administered. Ref: 5.2.6
	Response by registered person detailing the actions taken: Detailed and person centred care plans have been formulated reflecting covert administration of medications and include the date consent was obtained from GP prescriber. The administration of covert medications is also included in nursing staff medication competencies which are renewed annually. Furthermore the Home Manager completes a monthly covert medication audit.

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

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