Enforcement Monitoring Inspection Report
18 January 2021

Brooklands Healthcare Londonderry

Type of Home: Nursing Home
Address: 25 Northland Road, Londonderry, BT48 7NF
Tel No: 028 7126 3987
Inspectors: Judith Taylor & Sharon McKnight

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home which is registered to provide care for up to 45 patients.

2.0 Service details

Organisation/Registered Provider: Brooklands Healthcare Ltd **Responsible Individual (RI):** Ms Therese Elizabeth Conway	**Registered Manager and date registered:** Ms Geraldine Merry – Acting Manager
Person in charge at the time of inspection: Ms Geraldine Merry	**Number of registered places:** 45
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment	**Total number of patients in the nursing home on the day of this inspection:** 38

4.0 Inspection summary

An inspection took place on 18 January 2021 from 10.00 to 18.10. The inspection was undertaken by a care inspector and a pharmacist inspector.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

The inspection sought to assess the level of compliance achieved in relation to three Failure to Comply (FTC) Notices which were issued on 17 November 2020. The areas identified for improvement and compliance with regulations were in relation to management and governance arrangements, medicines management, and the systems in place to ensure that patients were not placed at risk of harm. The date of compliance with the notices was 18 January 2021.

The following FTC Notices were issued by RQIA:

FTC Ref: FTC000135 Regulation 10(1) Registered person: general requirements
FTC000136 Regulation 13(4) Health and Welfare of patients
FTC000137 Regulation 14(4) Further requirements as to health and welfare

During this inspection we were able to evidence compliance with the three Failure to Comply Notices. Significant improvement had been made in the management of medicines and record keeping, the oversight of the day to day operation of the home by the manager, provision of staffing, IPC practices, the management of nutrition, and deprivation of liberty safeguards.

Three new areas for improvement were identified in relation to the recording of enteral fluids, staff training and the auditing of restraint.

We saw patients relaxed and comfortable in their surroundings and in their interactions with other patients and with staff.

We spoke with staff on duty who commented positively in respect of the training and support they were receiving from the management team.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Geraldine Merry, Manager at the end of the inspection, and also Ms Therese Conway, by telephone on 19 January 2021. Timescales for completion commence from the date of inspection. Enforcement action did not result from the findings of this inspection.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

Before the inspection, we reviewed a range of information relevant to the home. This included the following:

- recent inspection reports and returned QIPs
- enforcement information and associated correspondence
- recent correspondence regarding the home
- the management of incidents reported to RQIA since the last inspection

We met with patients, three nurses, the chef, seven care assistants, two members of housekeeping staff and the manager.

A sample of the following records was examined and/or discussed during the inspection:

- audit records and action plans
- care plans relating to medicines, nutrition and the management of restraint
- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred

- fluid intake records
- duty rota from the period 11 December 2020 to 21January 2021
- staff training records
- staff supervision records
- cleaning schedules
- monthly monitoring reports undertaken on behalf of the RI

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection

The most recent inspection of the home was an unannounced care and medicines management inspection. It was undertaken on 3 and 5 November 2020 and resulted in the issue of three FTC Notices and a QIP. The completed QIP was returned and approved by the inspectors.

6.2 Review of areas for improvement from the last inspection

Areas for improvement from the last inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	The registered person shall review the care planning in relation to medicines to ensure the necessary information is recorded.	**Met**
	Action taken as confirmed during the inspection: The sample of care plans selected indicated that medicines were referenced and included the management of pain, distressed reactions, diabetes, swallowing difficulty and anticoagulants. A specific audit of medicine related care plans had also been completed.	

Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that written confirmation of the patient's medicine regime is obtained for all admissions to the home.	**Met**
	Action taken as confirmed during the inspection: There had been no new admissions to the home since the last inspection. The relevant policy had been updated and supervision sessions and meetings had been held with staff. Given these findings and the assurances provided, this area for improvement has been assessed as met.	

6.3 Inspection findings

FTC Ref: FTC000135

Notice of failure to comply with Regulation 10(1) of The Nursing Homes Regulations (Northern Ireland) 2005

Registered person: general requirements

Regulation 10.-
(1)The registered provider and the registered manager shall, having regard to the size of the nursing home, the statement of purpose, and the number and needs of the patients, carry on or manage the nursing home (as the case may be) with sufficient care, competence and skill.

In relation to this notice the following nine actions were required to comply with this regulation.

1. Robust auditing systems are developed and implemented which cover all aspects of medicines management; these must be effective in identifying any deficits to be addressed and monitored through an action plan.
2. There is oversight of the medicines management audit from senior management in Brooklands Healthcare Ltd.
3. Systems are in place to ensure that RQIA and other relevant persons are notified when prescribed medicines are not available for administration.
4. A policy is in place to ensure that the self-isolation of patients is managed in accordance with DOH guidance.
5. The manager must demonstrate knowledge of the policy and procedure for the self-isolation of patients.
6. The planned staffing for registered nurses and care staff must be consistently provided to ensure there are sufficient staff on duty to meet the needs of the patients.
7. The manager must escalate deficits in staffing to the responsible individual.
8. An audit of the incidence of restraint and/or restrictive practices is undertaken to monitor progress in reducing the use of such practices to a minimum.
9. Reports under Regulation 29 must be submitted to RQIA fortnightly within five working days of completion.

There was significant improvement in the auditing arrangements for medicines management. New systems had been implemented and were completed by management, staff and the community and trust pharmacists. It was evident that they were effective in identifying areas for improvement as they covered high risk medicines, all formulations of medicines, medicine storage and record keeping, including care plans. In addition to the action plans from audits, an overarching governance audit is now maintained to incorporate the improvements that were required in the FTC Notices. This is monitored by management each week.

The stock control of medicines had been reviewed with staff, the patient's doctor and the community pharmacist. Examination of records showed that the out of stock issues noted at the last inspection had been resolved; there had been no missed doses due to supply issues.

Meetings had been held with staff to discuss the last inspection outcomes. It was evident from the records and discussion with staff that they were aware that any out of stock situations were notifiable events, and recognised the potential impact to patient's health and well-being.

A policy was in place to direct staff in the management of patients who are required to self-isolate in the home. The policy was reflective of Department Of Health (DOH) guidance. The manager and staff were knowledgeable of the correct procedure to follow. We saw that patients who were required to self-isolate were being managed in accordance with best practice; self-isolating notices were displayed and PPE and clinical waste bins were located appropriately.

A review of six weeks of staff rotas evidenced that staffing was consistently provided. We saw that where staff had reported unfit for duty, reasonable steps were taken to provide additional staff, often at short notice and that the rota was updated to reflect the change in staffing. We could see that there were sufficient staff in the home to quickly respond to the needs of the patients and provide support. Staff confirmed that the provision of staffing had improved since the last inspection and that they were satisfied with the staffing arrangements.

We discussed the arrangements to ensure that deficits in staffing are escalated to the RI. There had been a change in the manager since the last inspection; the current manager was knowledgeable of the importance of ensuring the RI is kept informed of deficits in staffing. To support all staff in the escalation of staffing issues, the telephone details of the senior management team, including the RI were available for staff reference.

An audit of the care records in place for the management of restrictive practice, specifically the use of bedrails and alarm mats was completed on 30 December 2020. The audit identified some deficits; there was no evidence of an action plan or arrangements for a re-audit to ensure the required improvements were made. This was identified as an area for improvement.

An audit of the incidence of restraint was completed on 13 January 2021 and detailed the type of restraint in use in the home. Records reflected the use of bedrails, alarm mats and lapbelts on wheelchairs. The manager confirmed that the use of restraint would be audited monthly to ensure it was still required.

We examined the monitoring reports completed on behalf of the RI for November and December 2020. If any issues were identified, an action plan was developed which included timescales and the person responsible for completing the action. The action plan was reviewed and commented on at each subsequent visit. A copy of the reports had been received by RQIA.

Based on the evidence, the decision was made by RQIA that compliance with FTC000135 had been achieved.

FTC Ref: FTC000136

Notice of failure to comply with Regulation 13(4) of The Nursing Homes Regulations (Northern Ireland) 2005

Health and welfare of patients

Regulation 13.-
(4) Subject to paragraph (5), the registered person shall make suitable arrangements for the ordering, storage, recording, handling, safe keeping, safe administration and disposal of medicines used in or for the purposes of the home to ensure that –
(b) medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed, and to no other patient; and
(c) a written record is kept of the administration of any medicine to a patient.

In relation to this notice the following four actions were required to comply with this regulation:

1. Systems are in place so that patients have a continuous supply of their prescribed medicines.
2. Medicines are stored in accordance with the manufacturers' instructions, all medicines are labelled appropriately and the date of opening is recorded on all limited shelf life medicines.
3. Records of administered medicines are accurately completed.
4. Staff receive training in the management of medicines, their roles and responsibilities and professional accountability.

There was no evidence of any patient missing doses of medicines due to them being unavailable. Low stocks of medicines were being closely monitored by the registered nurses to ensure all medicines were available for administration. As part of the improvements, a new system had been implemented to ensure that a nurse is given protected time to oversee the stock control of medicines. The community and trust pharmacists were also providing medicines management support to the staff in the home.

Medicines were stored safely and securely and the correct temperature. All medicines selected for audit were labelled appropriately. The date of opening was routinely recorded on limited shelf medicines for example, insulin and eye drops and also on other medicines, which assists with the audit process.

Examination of several records indicated that patients had been administered their medicines as prescribed. The records clearly indicated when a medicine was not given and the reason why. The correct medicine codes were recorded.

Training and supervision sessions regarding the deficits noted during the last inspection were completed with the registered nurses. This included reference to the professional nursing standards, record keeping and medicines management.

Based on the evidence, the decision was made by RQIA that compliance with FTC000136 had been achieved.

FTC Ref: FTC000137

Notice of failure to comply with Regulation 14(4) of The Nursing Homes Regulations (Northern Ireland) 2005

Further requirements as to health and welfare

Regulation 14.-
(4) The registered person shall make arrangements, by training staff or by other measures, to prevent patients being harmed or suffering abuse or being placed at risk of harm or abuse.

In relation to this notice the following 12 actions were required to comply with this regulation.

1. Staff adhere to the policy in place to ensure that the self-isolation of patients is managed in accordance with DOH guidance.
2. Any room used by patients during their period of self-isolation must be effectively cleaned and records maintained to evidence cleaning.
3. The manager and staff must receive training in accordance with their roles and responsibilities in the The Mental Capacity Act (Northern Ireland) 2016 and the Deprivation of Liberty (DOL) Safeguards emphasising attitudinal and cultural change among staff in relation to restrictive practices used in the home.
4. The manager and staff can demonstrate their knowledge in relation to potentially restrictive practices and the deprivation of liberty safeguards.
5. Where restrictive practices are used there is evidence that these are proportionate, necessary and the minimum required to reduce the identified risks.
6. Any patients assessed as requiring one to one supervision must be provided with this level of supervision in accordance with their care plan.
7. Records must clearly evidence how the one to one supervision is managed on a day by day basis.
8. The relevant health and social care trust must be informed of any incidence when one to one supervision has not been provided.
9. The management of the hand over report at the beginning of each shift must be reviewed to ensure that staff are fully informed of patient need at the time of their admission to the home.
10. Care records of patients assessed as requiring a modified textured diet must be reviewed and the International Dysphagia Diet Standardisation Initiative (IDDSI) terminology used to identify the texture required.
11. Patients must be provided with the correct texture of diet in accordance with their individual assessed need.
12. When a total daily fluid volume has been prescribed, systems must be in place to ensure the records are accurately maintained and checked to ensure this target volume has been achieved.

Observations made throughout the inspection confirmed that staff were adhering to the policy for patients who were self-isolating. A review of cleaning schedules evidenced that any rooms used for the self-isolation of patients were effectively cleaned. We spoke with two members of housekeeping staff; both spoke confidently of the cleaning routine in the home and were knowledgeable of good infection prevention and control practices.

Records confirmed that the manager had completed online training in The Mental Capacity Act (Northern Ireland) 2016 and Deprivation of Liberty (DOL). We saw that information on DOLS safeguards and the Mental Capacity Act (Northern Ireland) was available in the home for staff to read; they were then required to sign to confirm that they had read and understood the information provided. At the time of the inspection only a small proportion of staff had signed the record. The manager must ensure that all staff complete this exercise; this was identified as an area for improvement.

During the previous inspection it was identified that a keypad had been placed on the door into an area of the home where five patients resided without the required DOL safeguards in place. We saw that this keypad had been removed. Following the removal of the keypad one patient had an alarm mat put in place; a best interest discussion had been held with the patient, staff and the relevant health and social care trust, the decisions clearly documented and care plans created. Records also evidenced that capacity assessments and DOL safeguards were being completed by the relevant health and social care trusts as required.

We reviewed the care of patients who are assessed as requiring one to one supervision. A care plan was in place identifying the reason for this level of supervision and staff allocation records for the period 1-18 January 2021 evidenced that supervision was provided in accordance with the care plan. The manager was knowledgeable of the need to inform the relevant health and social care trust of any occasion when one to one supervision was not provided.

The manager explained that the record used to inform the handover report had been reviewed and amended following the previous inspection. It now included details of patients' daily needs, for example allergies, diet requirements, alongside details of any daily changes. Staff spoken with told us that the handover report was effective in keeping them informed of patient need and any changes to their daily needs.

Examination of care records regarding modified textured diet, indicated that the correct IDDSI terminology was being used. As previously discussed this was referenced in the daily handover report. Information and guidance regarding IDDSI was readily available for staff. During the serving of lunch we saw that patients were provided with the correct texture in accordance with their assessed need.

In relation to administration of thickened fluids to assist with swallowing and fluid intake, the prescribed consistency was recorded on the personal medication records, but was not recorded on the administration records. It was agreed that this would be addressed immediately after the inspection.

We identified inconsistencies in the recording of enteral fluids and flushes. Some staff had totalled the 24 hour intake, but this was not routinely recorded; and where there was a deficit in target volume, there was no evidence that this had been evaluated. Following discussion with staff and the manager, we were advised that staff do administer the fluids, but may not always sign the record. There was evidence that this area of improvement was included in the organisation's overarching audit process. The need to develop a meaningful evaluation each day was emphasised, and was identified as an area for improvement.

Based on the evidence, the decision was made by RQIA that compliance with FTC000137 had been achieved.

Areas for improvement

Three areas for improvements were identified in relation to the recording of enteral fluids, staff training and the auditing of restraint.

	Regulations	Standards
Number of areas for improvement	0	3

6.4 Conclusion

Evidence was available to validate compliance with the Failure to Comply Notices. The progress made was acknowledged and we saw that systems were in place to continue to monitor and sustain progress. No patient safety concerns were noted and staff were knowledgeable of their roles and responsibilities.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Geraldine Merry, Manager and Ms Therese Conway, Responsible Individual, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 the nursing home. 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April (2014).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspectors.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 15 February 2021	The registered person shall implement robust systems to oversee the completion of fluid intake records to ensure that these clearly indicate the quantity of oral and enteral fluids taken, and are evaluated in line with the patient's care plan. Ref: 6.3
	Response by registered person detailing the actions taken: The Fluid balance chart has been reviewed and updated to ensure clear recording of oral and enteral fluids. The fluid balance chart is supported by a standard opeating procedure which has been shared with all staff as part of a supervision. Residents fluid balances are totalled and discussed at each shift hand over. These records are also maintained for the manager to review on a weekly basis.
Area for improvement 2 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 15 February 2021	The registered person shall ensure that where deficits are identified as a result of auditing, actions are taken to address the deficits and areas are re-audited to ensure the required improvements are made. Ref: 6.3
	Response by registered person detailing the actions taken: A monthly auditing summary is in place to ensure any actions from audits are captured and reaudited to ensure the required improvements are made.
Area for improvement 3 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 15 February 2021	The registered person shall ensure that all staff receive training on the Deprivation of Liberty and The Mental Capacity Act (Northern Ireland) 2016. Ref: 6.3
	Response by registered person detailing the actions taken: I can confirm that all staff have completed awareness training on Deprivation of Liberty and the Mental Capacity Act (Northern Ireland)

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

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