

Inspection Report

21 March 2022



Brooklands Healthcare Magherafelt

Type of service: Nursing Home
Address: Nursing Unit, 66 Hospital Road,
Magherafelt, BT45 5EG
Telephone number: 028 7963 4490

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Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

1.0 Service information

Organisation/Registered Provider: Brooklands Healthcare Ltd	Registered Manager: Mrs Deirdre Mary Monaghan
Registered Person/s OR Responsible Individual Ms Therese Elizabeth Conway	Date registered: 30/09/2014
Person in charge at the time of inspection: Mrs Deirdre Mary Monaghan	Number of registered places: 47 There shall be a maximum of 1 named resident receiving residential care in category RC-PH(E).
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	Number of patients accommodated in the nursing home on the day of this inspection: 43
Brief description of the accommodation/how the service operates: This home provides nursing care for up to 47 patients. The home is divided over two floors with bedrooms, communal lounges and dining rooms on both. There is a separate residential care home which occupies part of the ground floor of the building and the registered manager manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 21 March 2022, from 10.15am to 1.30pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed.

Based on the inspection findings with regards to medicines management, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team. No new areas for improvement were identified.

RQIA would like to thank the staff and patients for their assistance throughout the inspection.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection, information held by RQIA about this home was reviewed. This included previous inspection findings, incidents and correspondence. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. Staff views were also obtained.

4.0 What people told us about the service

Patients were observed to be relaxing in bedrooms and communal lounges of the home.

The inspector met with care staff, nursing staff and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA.

5.0 The inspection

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

Areas for improvement from the last inspection on 10 February 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for Improvement 1 Ref: Regulation 27 (4) (a) Stated: First time	The Responsible Individual shall have in place a current risk written assessment and fire management plan and addresses all recommendations in the fire risk assessment within the recommended timeframes.	Carried forward to the next inspection
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for Improvement 1 Ref: Standard 38 Stated: First time	The Responsible Individual shall ensure staff are recruited and employed in accordance with relevant statutory employment legislation.	Carried forward to the next inspection
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	

5.2 Inspection findings

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate.

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.

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 on 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 the management of distressed reactions was reviewed for two patients. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. The reason for and outcome of each administration were recorded in supplementary medicine administration records.

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.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents was reviewed for three patients. A speech and language assessment report and care plan was in place for each patient. Records of prescribing and administration which included the recommended consistency level were maintained.

The management of warfarin was reviewed. Safe systems were in place to ensure the latest dosage regime was transcribed accurately by two members of staff. Separate administration records which included running stock balances were maintained. The date of opening was recorded on warfarin medicine boxes to facilitate audit.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines.

5.2.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. The records reviewed were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs were recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

5.2.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. Medicines had been accurately received into the home and administered in accordance with the most recent directions. The medicine records had been accurately completed.

5.2.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

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

The audits completed at the inspection indicated that medicines were being administered as prescribed.

5.2.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that their staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	1*	1*

* The total number of areas for improvement includes two which are carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mrs Deirdre Monaghan, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for Improvement 1 Ref: Regulation 27 (4) (a) Stated: First time To be completed by: 30 June 2022	The Responsible Individual shall have in place a current risk written assessment and fire management plan and addresses all recommendations in the fire risk assessment within the recommended timeframes. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for Improvement 1 Ref: Standard 38 Stated: First time To be completed by: Immediately from the date of inspection (10 February 2022)	The Responsible Individual shall ensure staff are recruited and employed in accordance with relevant statutory employment legislation. Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1



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