The Regulation and Quality Improvement Authority

Inspection Report

16 September 2021

Brooklands Healthcare Kilkeel

Type of Service: Nursing Home (NH)
Address: 10 Newry Road, Kilkeel, BT34 4DT
Tel No: 028 4176 4968

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 **Responsible Individual:** Ms Therese Elizabeth Conway	**Registered Manager:** Miss Sharon Troughton **Date Registered:** 18 June 2020
Person in charge at the time of inspection: Ms Marina Burns (Registered Nurse)	**Number of registered places:** 48 Maximum number of persons in each category as follows: Ground Floor: NH-DE - 13, NH-MP(E) - 1. First Floor: NH-I - 27, NH-LD - 2, NH-LD(E) - 1, NH-PH - 1, NH-PH(E) - 2. There shall be a maximum of 1 named resident receiving residential care in category RC-I.
Categories of care: Nursing Home (NH): I – Old age not falling within any other category. DE – Dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. LD – Learning disability. LD(E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 45
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for up to 48 patients.	

2.0 Inspection summary

An unannounced inspection took place on 16 September 2021, from 9.30 am to 1.55 pm by a pharmacist inspector. This inspection focused on medicines management within the home.

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 patients were being administered their medicines as prescribed. There were robust arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management.

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. 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.

4.0 What people told us about the service

We met with four members of staff.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff members spoken with expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after patients and meet their needs. They said that the manager was very supportive of staff and readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the nurse-in-charge for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. One questionnaire was returned. The respondent indicated that they were very satisfied with all aspects of care and that the home was well led.

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 12 November 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 21 **Stated:** First time	The registered person shall ensure that staff are recruited in accordance with relevant statutory employment legislation and mandatory requirements and that registration with an appropriate professional body is checked and documented prior to commencement of employment. **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.**	**Carried forward to the next inspection**
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that care records in relation to patient fluid intake charts, are completed accurately and contemporaneously at all times. **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.**	**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 medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will 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 and 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 are written and updated to provide a double check 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.

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, self-administration 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 staff 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 staff 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 four patients. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on the personal medication records. Care plans directing the use of these medicines were available for three of the four patients; the registered nurse gave an assurance that a care plan would be written for the other patient without delay (this patient had not needed the medicine administered for a significant period of time). Records of administration were clearly recorded. The reason for and outcome of administration were generally recorded in the daily progress notes.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Four patients' records were reviewed; each patient had a pain management care plan and regular pain assessments were carried out by the nursing staff.

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. Records of prescribing and administration which included the recommended consistency level were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. The management of medicines and nutrition via the enteral route was reviewed for one patient. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Appropriate arrangements were in place for the 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The records had been completed in a satisfactory manner.

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 are recorded in a controlled drug record book. Robust arrangements were 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 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.

The management of medicines for one patient who had been admitted to this home was reviewed. The medicines prescribed had been confirmed with the GP practice. The personal medication record had been accurately written. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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.

The audit system in place helps staff to identify medicine related incidents. The nursing staff were familiar with the type of incidents that should be reported.

The audits completed at the inspection indicated that the 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 staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff use.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

Records of staff training in relation to medicines management were available for inspection.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to the management of medicines.

Based on the inspection findings and discussions held, RQIA was assured that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager with respect to the management of medicines. Patients were being administered their medicines as prescribed.

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

7.0 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 Ms. Marina Burns, Registered Nurse and Ms. Geraldine Merry, Regional Manager (via telephone), 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 21 **Stated:** First time **To be completed by:** 12 November 2020	The registered person shall ensure that staff are recruited in accordance with relevant statutory employment legislation and mandatory requirements and that registration with an appropriate professional body is checked and documented prior to commencement of employment.
	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 4 **Stated:** First time **To be completed by:** 12 November 2020	The registered person shall ensure that care records in relation to patient fluid intake charts, are completed accurately and contemporaneously at all times.
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