The Regulation and Quality Improvement Authority

Inspection Report

15 August 2024

Brooklands Healthcare Londonderry

Type of Service: Nursing Home
Address: 25 Northland Road, Londonderry, BT48 7NF
Tel no: 028 7126 3987

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:** Mr Jarlath Conway	**Registered Manager:** Miss Shauna Rooney **Date registered:** 22 July 2021
Person in charge at the time of inspection: Miss Shauna Rooney, Manager	**Number of registered places:** 45 This number includes a maximum of ten persons in category NH-PH.
Categories of care: Nursing Home (NH) I – old age not falling within any other category PH – physical disability other than sensory impairment	**Number of patients accommodated in the nursing home on the day of this inspection:** 38
Brief description of the accommodation/how the service operates: Brooklands Healthcare Londonderry is a registered nursing home which provides nursing care for up to 45 patients. The home has four floors with patients' bedrooms located on each floor. Patients have access to lounges, dining rooms and outdoor spaces.	

2.0 Inspection summary

An unannounced inspection took place on 15 August 2024, from 10.00am to 2.45pm. This 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.

The areas for improvement identified at the last care inspection have been carried forward for review at the next care inspection.

The outcome of this inspection concluded that robust arrangements were not in place for some aspects of medicines management. Four new areas for improvement were identified. Details of the areas for improvement can be found in the quality improvement plan and include the management of insulin, completion of medicine administration records, medicines audit and staff training with respect to medicines management.

Following the inspection, the findings were discussed with the Senior Pharmacist Inspector in RQIA and with Lorraine Kirkpatrick, Regional Manager and Jarlath Conway, Responsible Individual. RQIA requested that an action plan to address the deficits identified during the inspection be submitted by 30 August 2024. It was decided that a period of time would be given to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

RQIA would like to thank the staff 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. Discussions were held with staff and management about how they plan, deliver and monitor the management of medicines.

4.0 What people told us about the service

The inspector met with care staff, nursing staff and the manager. Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

The manager stated there had been a recent increase in turnover of nursing staff and despite having completed an induction, staff were still becoming familiar with the homes processes for medicines management.

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 5 June 2024		
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time	The registered person shall ensure that for any patient at risk of dehydration the recommended daily fluid intake is recorded within their supplementary recording chart and care plan, with the action to take and at what stage if the target is not met. **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**
Area for improvement 2 **Ref:** Standard 4 **Stated:** Second time	The registered person shall ensure that care plans are reflective of the patients' needs and relevant medical conditions. **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**
Area for improvement 3 **Ref:** Standard 44 **Stated:** First time	The registered person shall ensure that the identified bath is replaced. **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**
Area for improvement 4 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure that entries within patients' daily progress records are meaningful and provide a reflective evaluation of the patient's day/night. **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 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 largely accurate and up to date. A small number of discrepancies were highlighted to the manager for review and amendment. 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.

A number of obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient. Assurances were provided that the medicines files would be reviewed immediately following the inspection to ensure obsolete records were removed and suitably archived.

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 distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. One instance of regular use was highlighted to the manager for onward referral to the prescriber for review. These medicines were otherwise administered infrequently.

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. 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. A speech and language assessment report and care plan were in place. Records of prescribing and administration which included the recommended consistency level were maintained. One discrepancy in the recommended consistency stated in the care plan was highlighted to the manager for immediate review and amendment.

Review of the management of insulin, a high risk medicine, identified safe systems were not in place. For one patient, the dosage directions on their personal medication record differed from recent directions provided by the diabetes specialist nurse. This was investigated during the inspection and assurances were provided that the correct dose was being administered. Some of the in-use insulin pens were not individually labelled to denote ownership. In addition, the date of opening had not been recorded on in-use insulin pens. This is necessary to facilitate audit and disposal at expiry. Therefore, a number of audits could not be completed. Safe systems must be in place to ensure patients are administered the correct insulin dose i.e. clear records of prescribing, administration, disposal at expiry and audit. An area for improvement was identified.

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

Medicine 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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. Appropriate storage arrangements were in place for medicines which required cold storage and controlled drugs.

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.

Within the home, a record of the administration of medicines is completed on handwritten medicine administration records (MARs). Unexplained gaps were observed in the administration records, including the administration of two antibiotics. There was evidence that medicines had been omitted but signed as administered by nursing staff. Complete and accurate records of the administration of medicines is necessary to provide evidence that patients are administered their medicines as prescribed. An area for improvement was identified.

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 should be 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. However, the audits completed by the inspector identified a significant number of discrepancies including the administration of antiepileptic medicines, antibiotics and one anticoagulant medicine.

While daily running stock balances were in place for all medicines not supplied in the monitored dosage system to monitor administration, corrective action had not been taken when discrepancies were noted and it had not been escalated to the manager. The date of opening was not consistently recorded on all medicines to facilitate audit.

A robust audit system encompassing all aspects of medicines management is necessary to ensure safe systems are in place and that patients are administered their medicines as prescribed. Any deficits identified through the home's audit process should be detailed in an action plan and steps taken to prevent a recurrence. Statutory notifications submitted to RQIA must contain sufficient detail to provide assurance that they have been robustly managed in keeping with best practice. An area for improvement was identified.

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.

Review of medicines for a patient recently admitted from hospital showed that a hospital discharge letter had been received and a copy had been forwarded to the patient's GP. However, discrepancies in the administration of medicines since admission were identified. These were highlighted to the manager for immediate review and investigation. An incident report detailing the actions taken to prevent a recurrence was submitted to RQIA on 16 August 2024.

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.

Although auditing systems were in place, the findings of this inspection indicate they were not effective. Nurses had not escalated errors to the manager and corrective action had not been taken to prevent incidents recurring. Nurses should receive guidance on the action to be taken when an error is identified. See Section 5.2.6

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 they 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.

The findings of this inspection and the practices observed indicate that medicines management training had not been effective in improving practice. As stated in Section 5.2.5, nurses should receive further training and guidance on the action to be taken when a medication error is identified. New staff should receive a robust induction which includes medicines management. An area for improvement was identified.

6.0 Quality Improvement Plan/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 Care Standards for Nursing Homes, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	2*	6*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Shauna Rooney, Registered Manager, 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection (15 August 2024)	The registered person shall ensure safe systems are in place for the management of insulin. Ref: 5.2.1
	Response by registered person detailing the actions taken: nimAll insulin administration records are written up as per diabetes nurse instructions. A copy of the insulin management plan from the diabetes nurse is kept in the patients kardex.All insulin pens are labelled with an opening date.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection (15 August 2024)	The registered person shall implement a robust audit system which covers all aspects of the management of medicines. Any shortfalls identified should be detailed in an action plan and addressed. Ref: 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: All boxed medicines continue to be tallied, this continues to be checked weekly by the Home Manager and Deputy Manager.Meeting held with pharmacy who will support with audit and support labelling system for boxed medicines.
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** From the date of inspection (15 August 2024)	The registered person shall ensure that fully complete and accurate records of the administration of medicines are maintained. Ref: 5.2.3
	Response by registered person detailing the actions taken: All medicine kardexes have been rewritten, all old medicine kardexes have been archived and are not kept within the medicine kardex file.
Area for improvement 2 **Ref:** Standard 39	The registered person ensure that nurses receive robust training and competency assessment in relation to medicines management. This should include guidance on the action to

Stated: First time **To be completed by:** 26 September 2024	be taken when they identify a shortfall in the management or administration of medicines. Ref: 5.2.5 and 5.2.6
	Response by registered person detailing the actions taken: All Nursing staff have had medicine competencies reviewed on a one to one basis. Supervisions have also been completed with all staff regarding action to be taken when a shortfall has been identified. Training has been scheduled with Pharmacy 1st/2nd October.
Area for improvement 3 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 12 June 2024	The registered person shall ensure that for any patient at risk of dehydration the recommended daily fluid intake is recorded within their supplementary recording chart and care plan, with the action to take and at what stage if the target is not met.
	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
Area for improvement 4 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 12 June 2024	The registered person shall ensure that care plans are reflective of the patients' needs and relevant medical conditions.
	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
Area for improvement 5 **Ref:** Standard 44 **Stated:** First time **To be completed by:** 14 January 2024	The registered person shall ensure that the identified bath is replaced.
	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
Area for improvement 6 **Ref:** Standard 4.9	The registered person shall ensure that entries within patients' daily progress records are meaningful and provide a reflective evaluation of the patient's day/night.

Stated: First time **To be completed by:** 12 June 2024	**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

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

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

Assurance, Challenge and Improvement in Health and Social Care