

Inspection Report

Name of Service: Willowbrook Care Centre

Provider: Carswood Limited

Date of Inspection: 24 and 30 October 2024

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:	Carswood Limited
Responsible Individual:	Mr Jarlath Conway
Registered Manager:	Ms Lavina Ann Harris
Service Profile: This home is a registered nursing home which provides nursing care for up to 31 patients living with a mental disorder and/or past or present alcohol or drug dependence. Patient accommodation is spread over three floors. There are a range of communal areas and patients have access to an enclosed garden.	

2.0 Inspection summary

An unannounced inspection took place on 24 October 2024, from 10.45 am to 3.40 pm by a care inspector, and on 30 October 2024, from 10.15 am to 2.30 pm by a pharmacy inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

While we found care to be delivered in a compassionate manner, improvements were required to ensure the effectiveness and oversight of medicines management.

As a result of this inspection three areas for improvement were identified in relation to medicines management. Please refer to sections 3.3.5 and 4.0 for more details.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the 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, registration information, and any other written or verbal information received from patient's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoken with said that they were satisfied with the care and services provided in the home. Patients spoke highly of staff, telling us that staff were available to them when they needed assistance and that staff were always polite and professional in manner. Comments included, "they are nice...someone is always around", "staff are great...couldn't speak highly enough of them", and "staff are polite and well trained...they are patient and give extra care to those who need it."

Patients told us that they get a choice of food and drinks and described the meals as "excellent." Patients said that visiting arrangements worked well and that there was flexibility for visiting during the day.

Some patients told us that they enjoyed the complementary therapies on offer and other patients said that they enjoyed being able to go out for walks, visit the local shops, or listen to music in their bedrooms. Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

Patients told us that they were happy with the home's environment and that the home was kept clean.

Relatives spoken with told us that they were "impressed" with the home, and described the home as "a great place...top notch." Relatives said that staff were "great" and that they had no concerns.

No relative or patient questionnaires were received following the inspection.

Staff told us that they were happy working in the home and that they were supported in doing their job through training, supervisions, and regular meetings. Further staff views are detailed in section 3.3.1 of this report.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Discussion with staff confirmed that they felt supported in their roles. For example, staff described their inductions as good and thorough, and said that they benefited from training on specialist topics such as acquired brain injury and mental disorders.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff confirmed that they also had daily flash meetings to ensure all staff were aware of any directives from management. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

Observation confirmed that staff attended flash meetings and conducted 'safety pauses' prior to mealtimes to ensure good communication across the team about changes in patients' needs.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs. For example, staff were seen to acknowledge a patient's feelings of distress and to use distraction techniques. Staff were seen to use appropriate humour with patients, adding to a relaxed atmosphere.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

Patients were observed to move freely around the communal areas of the home and staff were heard to offer choices to patients, such as where they wished to dine, or what food they wanted. Some patients were seen to lie on in bed or return to bed after their meals. One patient told us that if they didn't want to eat at the main meal times, staff could provide food outside of those times.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, environmental hazards were reduced, and patients were encouraged to use mobility aids where recommended by physiotherapy.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Observation of the lunch time meal, review of records and discussion with patients and staff indicated that there were robust systems in place to manage patients' nutrition and mealtime experience. Patients told us that the chef made daily rounds to discuss the menus and that patients had opportunities to make suggestions about the meals.

The importance of engaging with patients was well understood by the manager and staff. Staff were observed to play games with patients in the morning before lunch. Staff demonstrated that they knew and understood patients' preferences and wishes and helped patients to participate in planned activities or to remain in their bedroom with their chosen activity such as reading, listening to music or waiting for their visitors to come. Staff understood that meaningful activity was not isolated to the planned social events or games.

Patients could avail of a range of individual complementary therapies.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals.

Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

3.3.4 Quality and Management of Patients' Environment Control

The home was clean, tidy and well maintained. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. There were homely touches such as flowers and reading materials. The home was decorated in celebration of Halloween.

Review of records and discussion with staff and maintenance personnel, confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home was safe to live in, work in and visit. For example, fire safety checks, nurse call system checks, electrical installation checks and water temperature checks.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Medicines Management

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 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.

All patients should have care records 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.

The management of distressed reactions, pain, and thickening agents was reviewed. Care records contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed at the inspection indicated that these medicines were administered as prescribed.

The management of clozapine was reviewed. Clozapine is a high risk medicine which requires regular blood testing. The dose of clozapine prescribed depends on the blood test result. Audits completed at the inspection identified discrepancies in the administration of clozapine. Unexplained gaps were observed in the administration records. There was evidence that on occasions when the administration records were accurately completed, the correct dose had not been administered. RQIA requested an immediate investigation into the discrepancy be completed. The findings of the investigation and actions taken to prevent a recurrence was sent to RQIA on 1 November 2024. An area for improvement was identified.

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.

Records reviewed showed that the large majority of medicines were available for administration when patients required them. However, it was observed that two patients recently admitted to the home from hospital did not have stock of their prescribed medication to be administered in the event of a seizure. This was escalated to the manager and deputy manager on the day of the inspection who provided assurances the necessary actions would be taken to obtain supply of the medicines. An area for improvement was identified.

The medicine 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. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

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

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. Most of the records were found to have been fully and accurately completed. As detailed above, gaps were identified in the clozapine administration records. A small number of other discrepancies were highlighted to management for ongoing monitoring. Records were filed once completed and were readily retrievable for audit/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 should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

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 patients recently admitted to the home from hospital was reviewed. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed. However, as stated above, two medicines prescribed to be administered in the event of a seizure were not in stock. Staff had not taken appropriate action to ensure that the correct medicines were available for administration.

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 discrepancies in the administration of clozapine and other medicines not supplied in the monitored dosage system. While running stock balances were in place to monitor the

administration of medicines, corrective action had not been taken when discrepancies were noted and it had not been escalated to the manager. The issues identified at this inspection had not been identified through the homes internal audit process.

A robust audit system which covers all aspects of the management of medicines including those identified at this inspection is necessary to ensure safe systems are in place and that patients are administered their medicines as prescribed. Any shortfalls identified should be detailed in an action plan and addressed. An area for improvement was identified.

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.

No medicine related incidents have been reported to RQIA since the home was registered in June 2024. As stated above, the findings of this inspection indicate that the auditing system is not robust and incidents may not be identified. A robust audit system, which covers all aspects of medicines is necessary, to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.

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 the 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 indicate that medicines management training had not been effective in improving practice. Nurses should receive further guidance on the action to be taken when a medication error is identified.

3.3.6 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Lavina Ann Harris has been the manager in this home since 3 June 2024.

Staff commented positively about the management team, “they are good...we feel listened to”, “go to the manager with anything”, “the manager and deputy come to the flash meetings”, “well led.”

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the management team responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

Patients and their relatives said that they knew who to approach if they had a complaint / had confidence that any complaint would be managed well.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	3	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Lavina Ann Harris, 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 Homes Regulations (Northern Ireland) 2005	
<p>Area for improvement 1</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: Ongoing from the date of inspection (30 October 2024)</p>	<p>The registered person shall ensure safe systems for the management of clozapine are in place.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: This has been addressed. Twice daily monitoring is in place to ensure stock does not run out. All clozapine is now in pill pack except one new service user out on Article 15 from hospital.</p>
<p>Area for improvement 2</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: Ongoing from the date of inspection (30 October 2024)</p>	<p>The registered person shall implement a robust audit system which covers all aspects of medicines management. Any shortfalls identified should be detailed in an action plan and addressed.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: This has been addressed. RQIA Medicines Management Audit sheet is being completed for all boxed medication. Any shortfalls identified are being addressed immediately.</p>

<p>Area for improvement 3</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p>	<p>The registered person shall ensure patients have supply of their prescribed medicines. This is in particular reference to patients recently admitted to the home.</p> <p>Ref: 3.3.5</p>
<p>To be completed by: Ongoing from the date of inspection (30 October 2024)</p>	<p>Response by registered person detailing the actions taken: This has been addressed. Willowbrook is currently full with no new service users admitted. This will continue to be monitored on an ongoing basis by the three Unit Managers and will be spot checked periodically by the Deputy and Home Managers.</p>

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