The Regulation and Quality Improvement Authority

Inspection Report

10 January 2022

Bradley Court

Type of service: Nursing Home
Address: 420 Crumlin Road, Belfast, BT14 7GP
Telephone number: 028 9622 5292

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: Healthcare Ireland (Belfast) Limited **Responsible Individual:** Ms Andrea Louise Campbell	**Registered Manager:** Miss Daniella Curran, registration pending
Person in charge at the time of inspection: Miss Daniella Curran	**Number of registered places:** 11
Categories of care: Nursing (NH): LD – learning disability LD(E) – learning disability – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 8
Brief description of the accommodation/how the service operates: Bradley Court is a registered nursing home which provides nursing care for up to 11 patients. Bedrooms and living areas are located over two floors. Patients have access to communal lounges, dining areas and an enclosed garden. Bedrooms on the ground floor have access to private enclosed outside patio areas. This home is located on the same site as another nursing home and a residential care home.	

2.0 Inspection summary

An unannounced inspection took place on 10 January 2022, between 10.20am and 1.30pm. The inspection was completed by a pharmacist inspector.

This inspection focused on medicines management within the home and also assessed progress with the area for improvement identified at the last inspection. 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.

Review of medicines management highlighted areas of good practice in the admission process, the management of thickened fluids and antibiotics. However, the findings of the inspection indicated that robust arrangements were not in place for all aspects of medicines management. Areas for improvement were identified in relation to the completion of medicine records, care plans, the storage of medicines and auditing systems for medicines management.

This inspection resulted in five areas for improvement being identified.

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 reviewing: 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 in the home.

4.0 What people told us about the service

To reduce footfall throughout the home, the inspector did not meet any patients. The patients were observed to be comfortable and relaxed in their surroundings.

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

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. Staff were warm and friendly and it was evident from discussion that they knew the patients well.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered 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 last inspection?

Areas for improvement from the last inspection on 15 June 2021		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for improvement 1 **Ref:** Standard 12 **Stated:** First time	The responsible person shall ensure that the mealtime is a positive experience for patients. Meals should be kept warm, served in an appealing and appropriate manner and patients should be provided with cutlery, drinks and cups at the time of the serving of their meal.	**Met**
	Action taken as confirmed during the inspection: Meals were observed being brought to each floor of the home in a heated trolley. Plates were covered and meals were served on trays with drinks and cutlery.	

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 records are 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, during medication reviews or hospital appointments.

A review of a sample of the personal medication records identified that they were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. 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. It was evident that staff did not use these records as part of the administration of medicines process. An area for improvement was identified.

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 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 these medicines were discussed with staff. They 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. Care plans directing the use of these medicines were available in the medicines file. The reason for and outcome of administration were usually recorded on the back of the medicine administration records (MARs).

Occasionally a patient may be prescribed two medicines to manage their distress; therefore it is necessary for staff to know which medicine should be considered first. This should be clearly referenced on the personal medication records and MARs. A review of the records indicated that they had not been fully and accurately completed, they were difficult to read and the running stock balances were not accurate. An area for improvement was identified.

The management of pain was discussed. Some patients cannot verbalise pain and therefore a method for assessing pain must be used. Whilst the nurses advised they were familiar with how each patient expressed pain, there was no evidence of the use of pain assessment tools or a care plan to direct the management of pain. An area for improvement was identified.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing. The management of thickening agents was reviewed. 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.

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.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and are safe for administration. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. Medicines requiring cold storage were stored in medicines refrigerators in each treatment room. Only the current temperature of the refrigerators was being monitored and recorded. An area for improvement was identified.

The disposal arrangements for medicines were reviewed. Discontinued medicines were appropriately disposed of. The manager was reminded that each entry in the disposal records should be witnessed and signed by two staff members.

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.

The administration of medicines is completed on pre-printed MARs or occasionally handwritten MARs. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. A number of missed signatures were noted in the MARs sheets; these medicines had been administered but the record had not been completed. A record of all administered medicines must be maintained. See also Section 5.2.1.

A small number of discrepancies in the stock balances of medicines were also brought to the attention of the manager for close monitoring.

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 admission process for patients new to the home or returning to the home after receiving hospital care was reviewed. Written confirmation of the medicine regime had been obtained and all 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.

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 learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, as mentioned, audit discrepancies were observed in the administration of a small number of medicines which should be kept under review.

A review of the monthly management audits showed that the areas for improvement noted during this inspection were not being identified. This shows that the audit process is not robust and must be reviewed. An area for improvement was identified.

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 staff are supported.

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 and at annual appraisal.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, April 2015.

	Regulations	Standards
Total number of Areas for Improvement	3	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Daniella Curran, Manager, and the Service Development and Quality 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:** 10 February 2022	The registered person shall ensure that personal medication records and medicine administration records are fully and accurately completed. Ref: 5.2.1 and 5.2.3
	Response by registered person detailing the actions taken: All kardex's and MAR sheets have been checked to ensure there are no discrepancies.
Area for improvement 2 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 10 February 2022	The registered person shall ensure that the maximum and minimum refrigerator temperatures are monitored and recorded, they are maintained between 2^{o}C and 8^{o}C and the thermometer is reset each day. Ref 5.2.2
	Response by registered person detailing the actions taken: Regular checkes are in place to ensure the temperature checks are documented.
Area for improvement 3 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 10 February 2022	The registered person shall review the audit process for medicines management to ensure that it is effective. Ref: 5.2.5
	Response by registered person detailing the actions taken: Regular audits are taking place to ensure medication management is accurate and up to standard. Monthly medication audit has been reviewed to include a follow up action plan.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 18.9 **Stated:** First time **To be completed by:** 10 February 2022	The registered person shall ensure that for medicines prescribed on a "when required" basis for the management of distressed reactions: • clear directions indicating first line and second line medicines are recorded on the personal medication records • a full, accurate and legible record of administration is made.

	Ref: 5.2.1
	Response by registered person detailing the actions taken: New form for "when required " medication will be put in place detailig the protocol for the 1st line and 2nd line and when to be admisnistered.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 10 February 2022	The registered person shall review patients' pain management to ensure that detailed care plans are in place and pain assessments are completed. Ref: 5.2.1
	Response by registered person detailing the actions taken: Care plans and pain assessments completed.

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