

# Inspection Report

23 February 2023



## Bruce House

Type of service: Residential Care Home  
Address: 6a Duncairn Avenue, Belfast BT14 6BP  
Telephone number: 028 9504 0570

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Assurance, Challenge and Improvement in Health and Social Care

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## 1.0 Service information

<b>Organisation/Registered Provider:</b> Belfast HSC Trust  <b>Responsible Individual :</b> Dr Catherine Jack	<b>Registered Manager:</b> Mr Thomas McCorry  <b>Date Registered:</b> 9 November 2022
<b>Person in charge at the time of inspection:</b> Mr Thomas McCorry	<b>Number of registered places:</b> 30  This number includes only two service users at any time in the RC-A category of care.
<b>Categories of care:</b> Residential Care (RC) A – Past or present alcohol dependence DE – Dementia.	<b>Number of residents accommodated in the residential care home on the day of this inspection:</b> 26
<b>Brief description of the accommodation/how the service operates:</b> Bruce House is a registered residential care home which provides health and social care for up to 30 residents.	

## 2.0 Inspection summary

An unannounced inspection took place on 23 February 2023, from 10.55am to 3.40pm. 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 outcome of this inspection concluded that the two areas for improvement identified at the last medicines inspection had been addressed. No new areas for improvement were identified. The areas for improvement identified at the last care inspection have been carried forward and will 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 residents were administered their medicines as prescribed.

Based on the inspection findings and discussions held, 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.

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. The inspector spoke 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**

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

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well. Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident 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 23 July 2022		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		Validation of compliance
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 14 (2) (a) (c)  <b>Stated:</b> First time	The registered person shall ensure that all staff are made aware of their responsibility to recognise potential risks and hazards to resident and others and how to report, reduce or eliminate the hazard.	<b>Carried forward to the next inspection</b>
	<b>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.</b>	
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)		Validation of compliance
<b>Area for Improvement 1</b>  <b>Ref:</b> Standard 31  <b>Stated:</b> Second time	The registered person shall ensure that all handwritten entries on personal medication records and medication administration records are signed by two trained members of staff to ensure accuracy.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b>  This area for improvement has been assessed as met. See Section 5.2.1 & 5.2.3.	
<b>Area for Improvement 2</b>  <b>Ref:</b> Standard 31  <b>Stated:</b> First time	The registered person shall ensure that a record of all administered medicines is maintained.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b>  This area for improvement has been assessed as met. See Section 5.2.3.	

<b>Area for improvement 3</b> <b>Ref:</b> Standard 9.3 <b>Stated:</b> First time	The registered person shall ensure residents are appropriately monitored following a fall. Accurate records should be maintained to evidence actions taken following falls. Staff should comment on the status of the resident in daily evaluation records.	<b>Carried forward to the next inspection</b>
	<b>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.</b>	
<b>Area for improvement 4</b> <b>Ref:</b> Standard 8.5 <b>Stated:</b> First time	The registered person shall ensure daily care records are accurately maintained and completed contemporaneously.	<b>Carried forward to the next inspection</b>
	<b>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.</b>	

## 5.2 Inspection findings

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

Residents in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' 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.

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

Personal medication records were in place for each resident. 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 majority of personal medication records reviewed at the inspection were accurate and up to date. One discrepancy was highlighted to staff and was actioned immediately during the inspection. 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.

Copies of residents' 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.

Residents 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 resident's distress and if the prescribed medicine is effective for the resident.

The management of medicines prescribed on a "when required" basis for distressed reactions was reviewed for three residents. 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 resident's behaviour and was aware that this change may be associated with pain. The reason for and outcome of each administration was recorded for the majority of instances when these medicines were administered. The manager gave an assurance that this will be closely monitored to ensure the reason and outcome of each administration is consistently recorded.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly.

Some residents 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 resident 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 resident.

The management of thickening agents was reviewed for two residents. 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.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail in the care plan to direct staff if the resident's blood sugar was outside the recommended range.

### **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 resident'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 residents 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 resident could be easily located. The temperature of the medicine storage area was 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 residents 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 the medicines administration records was reviewed. All of the records reviewed were found to have been fully and accurately completed. One handwritten record had not been checked and signed by two staff, this was highlighted to the manager. Assurances were provided that an updated template was now in place to ensure two staff check and sign all handwritten MARs. The records were filed once completed and were readily retrievable for audit.

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.

Several residents have their medicines administered in food/drinks to assist administration. Care plans detailing how the residents like to take their medicines were in place. Written authorisation was in place when this practice occurred.

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 residents or residents returning from hospital. Written confirmation of the resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. 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 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 residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and they 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 with staff and at annual appraisal.

## 6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	1*	2*

\* The total number of areas for improvement includes three 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 Mr Thomas McCorry, Registered Manager, as part of the inspection process and can be found in the main body of the report.



<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 14 (2) (a) (c)  <b>Stated:</b> First time  <b>To be completed by:</b> Immediate action required (23 July 2022)	The registered person shall ensure that all staff are made aware of their responsibility to recognise potential risks and hazards to resident and others and how to report, reduce or eliminate the hazard.  <b>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.</b>  Ref: 5.1
<b>Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 9.3  <b>Stated:</b> First time  <b>To be completed by:</b> 23 August 2022	The registered person shall ensure residents are appropriately monitored following a fall. Accurate records should be maintained to evidence actions taken following falls. Staff should comment on the status of the resident in daily evaluation records.  <b>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.</b>  Ref: 5.1
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 8.5  <b>Stated:</b> First time  <b>To be completed by:</b> 23 August 2022	The registered person shall ensure daily care records are accurately maintained and completed contemporaneously.  <b>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.</b>  Ref: 5.1



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