Inspection Report

13 December 2021

Bloomfield Care Homes Limited

Type of service: Nursing Home
Address: 115-117 North Road, Belfast, BT5 5NF
Telephone number: 028 9065 7799

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: Bloomfield Care Homes Limited **Responsible Individual:** Mr Desmond McLaughlin	**Registered Manager:** Mrs Jincy Mathew . **Date registered:** 14 March 2016
Person in charge at the time of inspection: Mrs Jincy Mathew	**Number of registered places:** 36
Categories of care: Nursing (NH): DE – dementia	**Number of patients accommodated in the nursing home on the day of this inspection:** 36
Brief description of the accommodation/how the service operates: This is a nursing home with 36 beds that provides care for patients living with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 13 December 2021 from 10.30am to 3.20pm. It 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.

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 patients were administered their medicines as prescribed.

The outcome of this inspection concluded that the area for improvement identified at the last inspection had been addressed. No new areas for improvement were identified at this inspection.

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 reviewing a sample of medicine related records and care plans, medicines storage and the auditing systems used to ensure the safe management of medicines. Staff opinions were also obtained.

4.0 What people told us about the service

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

Staff interactions with the patients were warm, friendly and supportive. It was evident that they were familiar with the patients, their likes and dislikes.

The inspector met with nursing staff, the deputy manager, the registered manager and the responsible individual. Staff were knowledgeable about the patients' medicines. They expressed satisfaction with their role, the team working and management of the home.

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.

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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 care inspection on 8 December 2020		
Action required to ensure compliance with the Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for Improvement 1 **Ref**: Standard 23.5 **Stated:** First time	The registered person shall ensure that pressure relieving mattresses which required the setting to be completed manually are set accurately. Systems to ensure that correct setting is maintained must be implemented.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that this had been resolved immediately after the inspection and a meeting held with staff. A new system to ensure that the mattress is kept at the correct setting was put in place and this area was monitored on at least a monthly basis by management.	

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 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 or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they were 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 and injections.

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 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 nurses record this information, 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. Nurses 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, and care plans were in place. The records detailed the reason for and outcome of each administration.

The management of pain was discussed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Pain assessments were completed regularly and care plans were in place. A separate administration chart was in use to record the reason for and outcome of each administration, which is in line with best practice.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing. Care plans detailing how the patient should be supported with their fluid intake should be in place to direct staff; and 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. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Care plans were in place when patients required insulin to manage their diabetes and included the current dosage regime. A separate administration record was in use to record the blood monitoring results, the insulin dose administered and the site of administration. The use of this record is also in line with best practice.

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. Temperatures of the medicine room and medicines refrigerator were monitored and recorded to ensure that medicines were stored at the correct temperature. The medicine cupboards were tidy and organised so that medicines belonging to each patient could be easily located.

Largely satisfactory arrangements were in place for the safe disposal of medicines including controlled drugs. Occasionally one member of staff was involved in the disposal of medicines; two staff should be involved and both should sign the record. The manager advised that this would be addressed with staff and closely monitored.

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 medicine administration records (MARs) when medicines are administered to a patient. A sample of these records was reviewed; they were found to have been fully and accurately completed. The completed records were filed in a timely manner and were readily retrievable for inspection. The good standard of record keeping was acknowledged.

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 were appropriately recorded in the controlled drug record book.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Written consent and care plans were 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 medicines so that they could be easily audited and running stock balances were also maintained for a number of medicines not contained in the monitored dosage system. This is best practice.

The sample of audits completed as part of the inspection showed good outcomes, indicating patients were being administered their medicines as prescribed. Reasons for non-administration of medicines were recorded and systems were in place to notify the prescriber when a patient refused medicines.

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 patients or patients returning from hospital. Written confirmation of the patient'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 identify medicines 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.

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. Policies and procedures should be up to date and readily available for staff.

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. Medicines management policies and procedures were in place.

7.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Jincy Mathew, Registered Manager and the deputy manager, as part of the inspection process and can be found in the main body of the report.

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