Inspection Report

7 September 2022

Bohill Bungalows

Type of Service: Nursing Home
Address: 69 Cloyfin Road, Coleraine, BT52 2NY
Telephone Number: 028 7032 5180

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 (No.4) Limited **Responsible Individual:** Ms Andrea Louise Campbell	**Registered Manager:** Miss Sara Coul (Not registered)
Person in charge at the time of inspection: Miss Sara Coul	**Number of registered places:** 18
Categories of care: Nursing Home (NH) LD – learning disability LD(E) – learning disability – over 65 years PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 16
Brief description of the accommodation/how the service operates: This is a registered nursing home which provides nursing care for up to 18 persons. The home is divided into three bungalows; Dunluce, Causeway and Rathlin. Each bungalow has access to communal living and dining spaces, as well as communal gardens. A fourth bungalow is situated on the same site and this is a separately registered residential care home.	

2.0 Inspection summary

An unannounced inspection took place on 7 September 2022, from 10.45am to 3.45pm. 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.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records were maintained to a satisfactory standard. 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. One new area for improvement was identified in relation to care planning.

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 to staff and management about how they plan, deliver and monitor the management of medicines in Bohill Bungalows.

4.0 What people told us about the service

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

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

Staff expressed satisfaction with how the home was managed. They spoke positively about the teamwork and communication in the home and said that they had the appropriate training to look after patients and meet their needs.

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 28 September 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (1) (b) **Stated:** First time	The registered person shall ensure that all unwitnessed falls are managed in line with best practice guidance and that neurological observations are consistently recorded. **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.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref:** Regulation 27 (4) (b) **Stated:** First time	The registered person shall ensure that the practice of propping /wedging open doors ceases with immediate effect. Other measures must be implemented if the identified door is to remain in an open position. **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.**	**Carried forward to the next inspection**
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 35 **Stated:** First time	The registered person shall ensure that separate records are kept for the nursing home and Strand House residential home. **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 46 **Stated:** First time	The registered person shall ensure that the infection prevention control issues as outlined in this report are addressed. **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 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.

Copies of patients' prescriptions 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 and high risk medicines such as insulin.

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 nurses 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 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. Care plans directing the use of these medicines were in place; however some of the care plans reviewed lacked the required detail and did not include the name of the prescribed medicine(s). Nurses knew how to recognise a change in a patient’s behaviour and were aware that this change may be associated with pain or infection. Records included 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. Care plans and pain assessments were in place and reviewed regularly; however the care plans reviewed did not state the name of the medicine(s) prescribed for the management of pain.

The manager gave an assurance that care plans for patient’s prescribed pain relief medicines and medicines for the management of distressed reactions would be reviewed and updated to include the specific medicine prescribed and the parameters for administration. 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 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 and nutritional supplements were 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.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

The management of insulin was reviewed. Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient’s blood sugar was outside the recommended range. The administration of insulin was accurately recorded on supplementary administration records.

Epilepsy management plans were in place for patients’ emergency medication for the management of seizures. There was sufficient detail in the plans to direct nurses on how to administer these medicines.

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. However, two missed doses of an antibiotic medicine had occurred as the medicine was out of stock. This was discussed with the manager on the day of the inspection for investigation and review. An incident report detailing the outcome of the investigation and action taken to prevent a recurrence was submitted to RQIA on 8 September 2022.

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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available in each bungalow for use as needed.

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

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.

A sample of the medicines administration records was reviewed. The records reviewed were complete and accurate. The 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 were recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

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 including daily running stock balances of all boxed medicines. The manager was reminded the date of opening should be consistently recorded on all medicines so that they can be easily audited. Assurances were given that this would be discussed with nursing staff at the next supervision sessions.

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.

There had been no recent admissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the patient's medicines prior to admission and this was shared with the community pharmacist.

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 the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the medicines were being administered as prescribed, with the exception of one antibiotic medicine discussed in Section 5.2.2.

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.

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.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	2*	3*

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

The area for improvement and details of the Quality Improvement Plan were discussed with Miss Sara Coul, Manager, as part of the inspection process. The timescale for completion commences 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 (1) (b) **Stated:** First time **To be completed by:** Immediately and ongoing (28 September 2021)	The registered person shall ensure that all unwitnessed falls are managed in line with best practice guidance and that neurological observations are consistently recorded.
	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. Ref: 5.1
Area for improvement 2 **Ref:** Regulation 27 (4) (b) **Stated:** First time **To be completed by:** Immediately and ongoing (28 September 2021)	The registered person shall ensure that the practice of propping /wedging open doors ceases with immediate effect. Other measures must be implemented if the identified door is to remain in an open position.
	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. Ref: 5.1
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 December 2021	The registered person shall ensure that separate records are kept for the nursing home and Strand House residential home.
	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 2 **Ref:** Standard 46 **Stated:** First time **To be completed by:** Immediately and ongoing (28 September 2021)	The registered person shall ensure that the infection prevention control issues as outlined in this report are addressed.
	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 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 3 October 2022	The registered person shall ensure care plans for the management of pain and distressed reactions are updated to include the name of the prescribed medicine(s) and the parameters for the administration are clearly detailed. Ref: 5.2.1
	Response by registered person detailing the actions taken: All staff have been given supervision and guidance on ensuring that the additional details of prescribed medication for distressed reaction and analgesia is inputted appropriately in each individuals care plan and that there is separate care plans for both distressed reactions and analgesia.

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

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