

Inspection Report

30 April 2022



Bramblewood Care Home

Type of service: Nursing Home
Address: 201 Gransha Road, Bangor, BT19 7RB
Telephone number: 028 9145 4357

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Burnview Healthcare Ltd	Registered Manager: Ms Clair O'Connor
Responsible Individual: Mrs Briege Agnes Kelly	Date registered: 2 January 2019
Person in charge at the time of inspection: Ms Clair O'Connor	Number of registered places: 35
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	Number of patients accommodated in the nursing home on the day of this inspection: 34
Brief description of the accommodation/how the service operates: This home provides nursing care for up to 35 persons. The home is divided in three units, Cedar Square, Hawthorn Lane and Cherry Tree Walk, which provide general nursing care. Patients have access to communal lounges, the dining room, an activity room and a hairdressing salon with nail bar.	

2.0 Inspection summary

An unannounced inspection took place on 30 April 2022, from 10.30am to 3.15pm. This was completed by two pharmacist inspectors.

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.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would 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 patients were administered their medicines as prescribed.

One new area for improvement was identified in relation to care planning for the management of distressed reactions and infections.

Whilst areas for improvement were identified, it was concluded that overall the patients were being 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. Staff and patients views were also obtained.

4.0 What people told us about the service

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well. Patients were observed to be relaxing in seating areas and lounges.

The inspectors met two nurses and the manager. 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. They said that the manager and other staff were supportive and they enjoyed working in the home.

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 care inspection on 6 January 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for Improvement 1 Ref: Regulation 12 (1) (a) (b) Stated: First time	The registered person shall ensure that wound care is delivered in accordance with best practice guidelines and that wound care records are reflective of patients' needs and specialist advice. Risk assessments and evaluations should be regularly updated.	Carried forward to the next inspection
	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.	

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 state 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.

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 medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication records and records generally included the reason for and outcome of each administration. However, care plans directing the use of these medicines were not in place and there was no evidence that staff had considered that a change in a patient's behaviour may be associated with pain. An area for improvement relating to care planning was identified.

The management of antibiotics was reviewed. There was evidence that the patient's condition was monitored and timely advice was sought from the GP. The antibiotic was received, commenced without delay and administered as prescribed. However, a care plan to manage the patient's condition and direct the nursing care had not been completed. This is included in the area for improvement relating to care planning.

The management of pain was discussed. Staff 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.

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 were maintained. Accurate recording of the consistency of thickened fluids was discussed with the manager for ongoing monitoring.

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. 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 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 patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed and had been fully and accurately completed.

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 generally satisfactory arrangements in place for the management of controlled drugs. A small number of entries had been omitted by an agency staff member which had been highlighted by the manager. Advice was given to add an explanatory note and to ensure that the agency was informed of this omission. A small number of administrations at night time had not been witnessed by a second staff member. Advice was given regarding training care staff to perform this task.

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 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 to identify medicine related incidents.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. These were discussed with the manager for ongoing monitoring.

Management and staff were familiar with the type of incidents that should be reported. There have been no medicine related incidents reported to RQIA since 2016. The internal audit system was discussed and advice given on how to develop it further.

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.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1*	1

* The areas for improvement includes one that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Clair O'Connor, 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 Home Regulations (Northern Ireland) 2005	
Area for Improvement 1 Ref: Regulation 12 (1) (a) (b) Stated: First time To be completed by: With immediate effect (6 January 2022)	The registered person shall ensure that wound care is delivered in accordance with best practice guidelines and that wound care records are reflective of patients' needs and specialist advice. Risk assessments and evaluations should be regularly updated. 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 4 Stated: First time To be completed by: 30 May 2022	The registered person shall ensure care plans to direct nursing care in the management of distressed reactions and infections are completed for all relevant patients. Ref 5.2.1 Response by registered person detailing the actions taken: Care plans are in place for the relevant residents who require medications to manage distressed reactions.

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



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