The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Bohill House Nursing Home

Provider: Healthcare Ireland (No. 4) Limited

Date of Inspection: 31 October 2024

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation:	Healthcare Ireland (No. 4) Limited
Responsible Individual:	Ms Andrea Louise Campbell
Registered Manager:	Mrs Andrea McCook
Service Profile Bohill House Nursing Home is a registered nursing home which provides nursing care for up to 62 patients. There is a residential care home which is in the same building and the manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on Thursday 31 October 2024, from 10.15am to 2.15pm. This was completed by two pharmacist inspectors and focused on medicines management within the home.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led with respect to medicines management.

Review of medicines management found that medicines were stored securely. Medicine records 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 in relation to the maintenance of medicine related care plans was identified. The area for improvement identified at the last care inspection has been carried forward for review at the next care inspection. Full details, including the new area for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Whilst one new area for improvement was identified, there was evidence that patients were being administered their medicines as prescribed. RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

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, to evidence how the home is performing in relation to the regulations and standards. Discussions were held with staff and management about how they plan, deliver and monitor the management of medicines.

3.2 What people told us about the service and their quality of life

Throughout the inspection the RQIA inspector will seek to speak with patients, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home.

Through actively listening to a broad range of patients, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

The inspector spoke with a range of staff to seek their views of working in the home.

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 team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the deputy 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.

3.3 Inspection findings

3.3.1 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 a GP, a 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 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/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All patients should have care records 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 etc.

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 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 distressed reactions, was reviewed. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. Directions for use were clearly recorded on the personal medication records. Records of administration included the reason for and outcome of each administration. Care plans directing the use of these medicines were in place; however, some lacked the required detail and did not include the name of the prescribed medicine(s).

Care plans were in place for patients prescribed insulin for the management of diabetes and for patients prescribed emergency medication for the management of seizures.

However, the care plans reviewed did not contain the necessary level of detail required to direct care and did not include the name of the prescribed medication(s) to manage the condition.

The deputy manager gave an assurance that care plans for patient's prescribed medicines for distressed reactions, insulin and epilepsy would be reviewed and updated to include the specific medicine prescribed and the parameters for administration. An area for improvement was identified.

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 records 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 records 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. Speech and language assessment reports and care records were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

3.3.2 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.

Records reviewed 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 medicine 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. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

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

3.3.3 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 were found to have been fully and accurately completed. 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 should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

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. This is good practice.

The audits completed at the inspection identified that the medicines were being administered as prescribed. A very small number of minor discrepancies were highlighted to the deputy manager for ongoing monitoring.

3.3.4 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 at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 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.

3.3.6 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. Medicines management policies and procedures were in place.

4.0 Quality Improvement Plan/Areas for Improvement

One new area for improvement has been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	2*

* the total number of areas for improvement includes one which is carried forward for review at the next inspection.

The new area for improvement and details of the Quality Improvement Plan were discussed with the nurse in charge 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 Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 43 **Stated:** First time **To be completed by:** 29 March 2024	The registered person shall ensure that the flooring in the identified area is repaired or replaced.
	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.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 12 December 2024	The registered person shall ensure care plans for the management of distressed reactions, epilepsy and insulin are updated to include the name of the prescribed medicine(s) and the parameters for the administration are clearly detailed. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Care Plans have been reviewed to reflect more detail regarding the medication management of distressed reactions, epilepsy & diabetes. A date for completion has been given of 31/12/24. These will be reviewed monthly and as and when medication changes occur.

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

The Regulation and Quality Improvement Authority

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