The Regulation and Quality Improvement Authority

Inspection Report

18 October 2022

Maryland Healthcare Care Centre of Distinction

Type of Service: Nursing Home
Address: 95 Knockbracken Road, Castlereagh, Belfast, Antrim, BT6 9SH
Tel no: 028 9044 8797

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

1.0 Service information

Organisation: Maryland Healthcare Limited **Responsible Individual:** Mrs Susan McCurry	**Registered Manager:** Mrs Jacquelyn Grace Woods **Date registered:** 18 September 2017
Person in charge at the time of inspection: Mrs Jacquelyn Grace Woods	**Number of registered places:** 85 A maximum of 20 patients in category NH-DE to be accommodated in the Rowan Unit. A maximum of 20 patients in category NH-DE to be accommodated in the Larch Unit. A maximum of 10 patients in category NH-DE to be accommodated in the Willow Unit.
Categories of care: Nursing Home (NH) DE – Dementia PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years I – Old age not falling within any other category TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 79
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 85 patients. The home is divided into four units all of which are on the ground floor. These units are named: Willow, Larch, Juniper and Rowan. The patients have access to various communal spaces including lounges and gardens.	

2.0 Inspection summary

An unannounced inspection took place on 18 October 2022, from 10.00 am to 3.10 pm. This was completed by two pharmacist inspectors 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.

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 patients were being administered their medicines as prescribed. Medicines were stored safely and securely and arrangements were in place to ensure that staff were trained and competent in medicines management. However, two new areas for improvement were identified in relation to the maintenance of electronic medicine records and the management of warfarin. Areas for improvement are detailed in the Quality Improvement Plan.

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 inspectors spoke to staff and management about how they plan, deliver and monitor the management of medicines within the home.

4.0 What people told us about the service

The inspectors 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 expressed satisfaction with how the home was managed. They said that the team communicated well and 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 25 November 2021		
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:** Second time	The registered person shall ensure record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **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)(c) **Stated:** First time	The registered person shall ensure fire doors are not propped open. **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 3 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure that chemicals are not accessible to patients in any area of the home in keeping with COSHH legislation. **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 4 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection. This relates specifically to the following: • raised toilet seats are effectively cleaned • hand gel dispensers are effectively cleaned • communal bathrooms are kept free from clutter. **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 4 **Stated:** Second time	The registered person shall ensure that supplementary repositioning records are completed in a contemporaneous and comprehensive manner at all times; nursing records should also evidence meaningful evaluation of this care by nursing staff. **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 39 **Stated:** First time	The registered person shall ensure that the staff receive training in regard to Control of Substances Hazardous to Health regulations (COSHH). **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 3 **Ref:** Standard 37.5 **Stated:** First time	The registered person shall ensure that staff are trained to create, use, manage and dispose of records in line with good practice and legislative requirements. This is specifically relates to: • the use of correction fluid • errors in documentation are corrected in line with best practice and professional	**Carried forward to the next inspection**

	guidance.	
	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.	

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.

Paper based personal medication records were in place for patients residing in the Willow, Larch and Rowan units of the home. The 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.

Electronic based personal medication records were in place for patients residing in the Juniper unit. Review of a sample of these records identified inaccuracies in the recorded doses of a controlled drug pain patch, warfarin and a bisphosphonate medicine. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. The records were not readily accessible on the electronic system and nurses were required to print paper copies for the inspector's review. An area for improvement was identified in relation to the maintenance of electronic medicine records.

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 for four patients. 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 patient's behaviour and were aware that this change may be associated with pain. Review of the administration records identified these medicines were used infrequently. Nurses were aware to record the reason and outcome of administration of these medicines should they be required.

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. One care plan needed to be updated and it was agreed that this would be actioned following the inspection.

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 on paper based records for patients prescribed thickening agents in the Willow, Larch and Rowan units of the home. However, the recommended consistency level was not recorded on electronic administration records for patients prescribed thickening agents in the Juniper unit. This was highlighted to the manager for remedial action.

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.

Warfarin is a high risk medicine and systems must be in place to ensure that blood monitoring is carried out on the specified date and dosage directions are received in writing. This ensures that nurses refer to the current dosage directions and warfarin is administered correctly. Review of the management of warfarin identified safe systems were not in place. The warfarin dose recorded on the electronic personal medication record was inaccurate and did not reflect the latest prescribed regime. Gaps were observed in the electronic warfarin administration records and audits completed at the inspection identified the wrong dose had been administered on one occasion. An area for improvement was identified.

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.

In order to maintain their effectiveness, medicines which require cold storage must be stored between 2^{o}C – 8^{o}C. The maximum, minimum and current temperature of the medicines refrigerator in each unit was monitored each day. A review of the daily records in the Juniper unit showed that the minimum temperature was regularly below 2 ^{o}C; corrective action had not been taken. The thermometer was reset by the inspector during the inspection and the minimum temperature recorded after a period of time was 2 ^{o}C; it was evident that staff were not resetting the thermometer daily. This was discussed with the manager who provided assurances this would be discussed with staff and addressed moving forward.

There was evidence that the single-use medicine cups used to administer medicines were being washed and re-used. The manager gave an assurance that this practice would stop.

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.

Within the home, a record of the administration of medicines in the Willow, Larch and Rowan units is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The records had been completed in a satisfactory manner. Records were filed when completed and were readily available for audit/review.

In the Juniper unit, a record of the administration of medicines is completed on electronic medicine administration records. Review of a sample of these records identified a number of discrepancies. Audits completed by the inspectors in relation to the administration of warfarin identified two missing entries in the electronic records. A bisphosphonate medicine prescribed to be administered once monthly had been recorded as being administered six times in the previous three months. Some stock balances of medicines recorded on the electronic system were inaccurate and not reflective of the actual stock. Fully complete and accurate records of the administration of medicines is necessary to evidence patients are administered their medicines as prescribed. As stated in Section 5.2.1, an area for improvement in relation to electronic medicine records was identified.

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 books. 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 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.

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 majority of medicines were being administered as prescribed. A small number of discrepancies were highlighted to the manager for ongoing monitoring.

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 they are supported. Policies and procedures should be up to date and readily available for staff reference.

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. The need for further staff training in the use of the electronic medicine record system was discussed with the manager during feedback.

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.

	Regulations	Standards
Total number of Areas for Improvement	6*	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Jacquelyn Grace Woods, 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:** Second time **To be completed by:** With immediate effect (25 November 2021)	The registered person shall ensure record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **Action required to ensure compliance with this regulations was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
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Area for improvement 3 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** With immediate effect (25 November 2021)	The registered person shall ensure that chemicals are not accessible to patients in any area of the home in keeping with COSHH legislation. **Action required to ensure compliance with this regulations was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 4 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect (25 November 2021)	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection. This relates specifically to the following: • raised toilet seats are effectively cleaned • hand gel dispensers are effectively cleaned • communal bathrooms are kept free from clutter.

	Action required to ensure compliance with this regulations was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 5 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure electronic medicine records are fully and accurately maintained. This is in specific reference to the Juniper Unit and includes: - Personal medication records - Medicine administration records Ref: 5.2.1 & 5.2.3.
	Response by registered person detailing the actions taken: A full review was undertaken of the eletronic system and it has been removed , Juniper now have hand written medication records which are easier to audit and are available at all times
Area for improvement 6 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure safe systems for the management of warfarin are in place. Ref: 5.2.1 & 5.2.3
	Response by registered person detailing the actions taken: Juniper has reverted back to hand written medication records , which includes record of warfarin sheets .
Action required to ensure compliance with the Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** With immediate effect (25 November 2021)	The registered person shall ensure that supplementary repositioning records are completed in a contemporaneous and comprehensive manner at all times; nursing records should also evidence meaningful evaluation of this care by nursing staff.
	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 39	The registered person shall ensure that the staff receive training in regard to Control of Substances Hazardous to Health regulations (COSHH).

Stated: First time **To be completed by:** 25 January 2022	**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 37.5 **Stated:** First time **To be completed by:** With immediate effect (25 November 2021)	The registered person shall ensure that staff are trained to create, use, manage and dispose of records in line with good practice and legislative requirements. This is specifically relates to: • the use of correction fluid • errors in documentation are corrected in line with best practice and professional guidance.
	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

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