The Regulation and Quality Improvement Authority

Inspection Report

25 July 2024

Nightingale Care Home

Type of service: Residential Care Home
Address: 34 Old Eglish Road, Dungannon, BT71 7PA
Telephone number: 028 8775 2666

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 2 Ltd **Responsible Individual:** Ms Amanda Mitchell	**Registered Manager:** Miss Iulia Nicolae **Date registered:** 17 May 2024
Person in charge at the time of inspection: Ms Anu John, Senior Care Assistant (before 12.00) Mrs Karen Agnew, Regional Manager (12.00 onwards)	**Number of registered places:** 10
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment	**Number of residents accommodated in the residential care home on the day of this inspection:** 10
Brief description of the accommodation/how the service operates: Nightingale Care Home is a residential care home which is registered to provide health and social care for up to 10 residents. The home is a single storey building. All bedrooms are single occupancy. Residents have access to a communal lounge, a dining room and a garden. The residential care home shares the same building as the nursing home and the manager is responsible for both services.	

2.0 Inspection summary

An unannounced inspection took place on 25 July 2024 from 10.45am to 12.50pm. The inspection 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 were carried forward for review at the next inspection.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines. Medicine records were well maintained and medicines were stored securely. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines. There was evidence that residents were administered their medicines as prescribed. No new areas for improvement were identified.

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 in relation to the management of medicines.

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 the home was 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. To complete the inspection, the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with one agency care assistant, one senior care assistant and the regional manager.

Staff were warm and friendly and it was evident from discussions that they knew the residents well.

The staff members spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise. The agency member of staff advised that they had received a thorough induction and orientation.

Feedback methods included a staff poster and paper questionnaires which were provided to the senior care assistant for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report no responses 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 21 November 2023		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure staff are aware of residents' SLT recommendations and that these are adhered to at mealtimes.	**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.	
Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 19 **Stated:** First time	The registered person shall ensure that recruitment records are available in the home and are compliant with Access NI's Code of Practice.	**Carried forward to the next inspection**
	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?

Residents in residential care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' 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.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. 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. One anomaly was brought to the attention of the regional manager for immediate review. In line with safe practice, a second senior care assistant had checked and signed the personal medication records when they were written and updated to confirm that they were accurate.

The management of pain was discussed. The senior care assistant advised that staff were familiar with how each resident expressed their pain and that pain relief was administered when required. Protocols for the management of pain were available for each resident.

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 resident'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.

All medicines were available for administration on the day of the inspection. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner. With the exception of one medicine which had been out of stock for three days, the records inspected showed that medicines were available for administration when residents required them. The regional manager was requested to investigate this finding. An incident report was submitted to RQIA on 26 July 2024 detailing the outcome of the investigation and actions taken to prevent a recurrence.

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 resident could be easily located. Staff were commended for their efforts.

Satisfactory systems were in place to ensure that medicines were stored at the correct temperature.

Appropriate arrangements were in place for the 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 residents to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. The sample of these records reviewed had been completed in a satisfactory manner.

Management and staff audited medicine administration on a regular basis within the home. In addition, running stock balances were maintained for all medicines. The audits completed at the inspection indicated that medicines were administered as prescribed.

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 residents new to the home or returning from hospital. Written confirmation of the residents' medicine regimes was obtained at or prior to admission and details shared with their general practitioners and community pharmacy. The medicine records reviewed at the inspection had been accurately completed and there was evidence that medicines were administered as prescribed.

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.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported. The regional manager was reminded that the non-administration of medicines due to supply issues is a medication related incident which should be referred to the prescriber for advice and reported to the appropriate authorities, including RQIA. See 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 residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and they are supported. Policies and procedures should be up to date and readily available for staff.

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. Records of induction, annual update training and competency assessments were available for inspection.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	1*	1*

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

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mrs Karen Agnew, Regional Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 13 (1) 9a) (b) **Stated:** First time **To be completed by:** With immediate effect (21 November 2023)	The registered person shall ensure staff are aware of residents' SLT recommendations and that these are adhered to at mealtimes. **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 the Residential Care Homes Minimum Standards, December 2022	
Area for Improvement 1 **Ref:** Standard 19 **Stated:** First time **To be completed by:** With immediate effect (21 November 2023)	The registered person shall ensure that recruitment records are available in the home and are compliant with Access NI's Code of Practice. **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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