Inspection Report
24 November 2020

Abbey View

Type of Home: Nursing Home
Address: 48 Newtownards Road, Bangor, BT20 4BP
Tel No: 028 9146 9644
Inspector: Helen Daly

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home which is registered to provide care for up to 25 patients.

2.0 Service details

Organisation/Registered Provider: Maria Mallaband Ltd **Responsible Individual:** Mrs Victoria Craddock	**Registered Manager and date registered:** Mrs Luz Agnes Juinar, registration pending
Person in charge at the time of inspection: Mrs Luz Agnes Juinar	**Number of registered places:** 25
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	**Total number of patients in the nursing home on the day of this inspection:** 22

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 24 November 2020 from 10.30 to 14.00. The inspection focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified at or since the last care and medicines management inspections.

To prepare for the inspection we reviewed information held by RQIA about the home. This included the last inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration
- medicine receipt and disposal
- controlled drugs
- care plans related to medicines management
- governance and audit in relation to medicines management
- staff training and competency
- medicine storage temperatures
- RQIA registration certificate

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	1*

The total number of areas for improvement includes one which has been carried forward for review at the next inspection.

No new areas for improvement were identified at this inspection.

Enforcement action did not result from the findings of this inspection.

5.0 What has this home done to meet any areas for improvement identified at the last care inspection on 17 September 2020?

Areas for improvement from the last care inspection		
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure that infection prevention and control issues regarding notices displayed throughout the home are managed to minimise the risk and spread of infection.	**Met**
	Action taken as confirmed during the inspection: We observed that posters were laminated and could be wiped clean in order to adhere to infection prevention and control (IPC) best practice.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 44 **Stated:** Third and final time	The registered person shall ensure that: • The corridor upstairs should be repainted. • The ceiling in the laundry should be made good and repainted.	**Carried forward for review at the next inspection**
	Action taken as confirmed during the inspection: Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this will be carried forward to the next inspection.	
Area for improvement 2 **Ref**: Standard 44.8 **Stated:** Second time	The registered person shall ensure that the premises, engineering plants and care equipment are kept safe and suitable and maintained in line with the relevant statutory requirements, approved codes of practice and the manufacturers' and installers' instructions. This relates specifically to the damaged equipment identified during the inspection.	**Met**
	Action taken as confirmed during the inspection:	

	We observed the damaged chairs had been replaced. The furniture in the lounges was observed to be free from damage. We saw the iron roller machine had been repaired.	
Area for improvement 3 **Ref:** Standard 28 **Stated:** First time	The registered person shall closely monitor the administration of Ebixa solution.	**Met**
	Action taken as confirmed during the inspection: Daily running stock balances were maintained for Ebixa. We audited four supplies of Ebixa and found that they had been administered as prescribed.	
Area for improvement 4 **Ref**: Standard 46 **Stated:** First time	The registered person shall ensure that areas identified on inspection are decluttered and that equipment is appropriately stored to minimise the risk of infection for staff and patients.	**Met**
	Action taken as confirmed during the inspection: The bathrooms and lounges had been decluttered. Damaged equipment had been repaired/replaced and was stored appropriately.	
Area for improvement 5 **Ref**: Standard 46.2 **Stated:** First time	The registered person shall ensure that all pull cords throughout the home are fitted with washable covers in order to adhere to infection prevention and control best practice.	**Met**
	Action taken as confirmed during the inspection: We observed that pull cords throughout the home had been fitted with washable covers in order to adhere to infection prevention and control best practice.	
Area for improvement 6 **Ref**: Standard 46.2 **Stated:** First time	The registered person shall ensure that a robust hand washing audit tool is developed to comply with infection prevention and control policies, procedures and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: The manager had developed and implemented an audit tool. Review of the hand washing audit tool (September 2020 and October 2020) evidenced that audits had been carried out with all staff at least monthly.	

6.0 What people told us about this home?

We greeted several patients who were observed to be relaxing in their bedrooms and in the lounge during the inspection.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well.

We met with two care assistants, two nurses and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed throughout the home.

Staff expressed satisfaction with how the home was managed. They 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. Four questionnaires were returned. All respondents indicated that they were satisfied or very satisfied with all aspects of the care in the home.

7.0 Inspection Findings

7.1 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 will 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 local GPs 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 e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they were written and updated to check 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.

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, modified diets, etc.

Patients may 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, they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for two patients. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. Records of administration were clearly recorded, and the reason for and outcome of administration were recorded.

We reviewed the management of pain for two patients. Care plans and personal medication records provided clear details. Staff advised that they were familiar with how each patient expressed their pain and that additional pain relief was administered when required. Pain was assessed at each medicine round. This is good practice.

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.

We reviewed the management of thickening agents for two patients. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail in the care plans to direct staff if the patient's blood sugar was too low/too high. We noted that the date of opening had not been recorded on insulin pens. This is necessary to facilitate audit and disposal at expiry. This was discussed with the manager and nurses and addressed during the inspection.

7.2 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.

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.

Medicines were observed to be stored at the manufacturers' recommended temperatures and controlled drugs were stored in controlled drugs cabinets.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to a waste management company. The manager advised that, as required, controlled drugs in Schedules 2, 3 and 4, Part (1) were denatured prior to disposal. It was agreed that the records of disposal would clearly state that the controlled drugs had been denatured from the date of this inspection onwards.

7.3 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 is completed on pre-printed medicine administration records. The sample of these records reviewed was found to have been fully and accurately completed. The records were filed once completed and they were readily retrievable for review/audit.

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 a controlled drug record book. Balances were checked at each handover of responsibility.

Management and staff audited medicine administration on a regular basis within the home. Running stock balances were maintained for the majority of medicines. The audits completed during this inspection showed that medicines had been given as prescribed.

7.4 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.

We reviewed the management of medicines for one recently admitted patient. A hospital discharge letter had been received and a copy had been forwarded to the patient's GP. The patient's personal medication record had been verified and checked by two nurses. Their medicines had been accurately received into the home and administered in accordance with the most recent directions.

7.5 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.

7.6 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 staff 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.

Records of staff training and competency in relation to medicines management were available for inspection.

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

The outcome of this inspection concluded that one area for improvement regarding the décor of the home was carried forward for review at the next inspection. The remaining areas for improvement identified at the last inspection had been addressed.

No new areas for improvement were identified at this inspection. We can conclude patients were being administered their medicines as prescribed.

We would like to thank the patients and staff for their assistance throughout the inspection.

9.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Agnes Juinar, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

9.1 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 the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

9.2 Actions to be taken by the home

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 44

Stated: Third and final time

To be completed by:
29 January 2021</td><td>The registered person shall ensure that:

• The corridor upstairs should be repainted.
• The ceiling in the laundry should be made good and repainted.</td></tr>
<tr><td>Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this will be carried forward to the next inspection.

Ref: 5.0</td></tr>
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Please ensure this document is completed in full and returned via the Web Portal

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