The Regulation and Quality Improvement Authority

Inspection Report

23 June 2022

Arches

Type of service: Nursing Home
Address: 144 Upper Newtownards Road, Belfast, BT4 3EQ
Telephone number: 028 9065 8274

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: Four Seasons Health Care **Responsible Individual:** Mrs Natasha Southall	**Registered Manager:** Ms Suzanne Johnston **Date registered:** 4 April 2022
Person in charge at the time of inspection: Ms Suzanne Johnston	**Number of registered places:** 33 This number includes no more than one patient in categories NH-PH/PH(E).
Categories of care: Nursing (NH): PH – physical disability other than sensory impairment LD – learning disability LD(E) – learning disability – over 65 years PH(E) - physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 22
Brief description of the accommodation/how the service operates: Arches is a nursing home which is registered to provide care for up to 33 patients.	

2.0 Inspection summary

An unannounced inspection took place on 23 June 2022 from 10.30am to 2.00pm. 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.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last inspection would be followed up at the next care inspection.

Review of medicines management found that patients were being administered their medicines as prescribed. Arrangements were in place to ensure nurses were trained and competent in medicines management. The majority of medicine records were well maintained and there were arrangements for auditing medicines.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include the storage of medicines, records of medicines received into and transferred out of the home, and record keeping in relation to enteral feeding.

Although areas for improvement were identified, it was concluded that the patients were being administered their medicines as prescribed.

RQIA would like to thank the staff and patients 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 the nursing sister, the deputy manager and the manager.

Staff were warm and friendly and it was evident from discussions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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.

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 feedback 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 14 December 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure chemicals are stored in keeping with the Control Of Substances Hazardous to Health regulation. This is stated in reference to the access to the chemicals in the sluice and the hairdresser's room and appropriate storage of patients' prescribed creams.	**Carried forward to the next inspection**
	Action taken as confirmed during the inspection: Patients did not have access to the chemicals in the sluice and the hairdresser's room; both rooms were locked during the inspection. The storage of prescribed creams in bedrooms was not reviewed. **Action required to ensure compliance with this regulation was not fully reviewed as part of this inspection and this is carried forward to the next inspection.**	
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 46 **Stated:** Second time	The registered person shall ensure the shower chairs and raised toilet seats are effectively cleaned after use and attention to detail is given when cleaning the hand gel dispensers.	**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.	

Area for improvement 2 **Ref:** Standard 4 **Stated:** Second time	The registered person shall ensure for those patients who require assistance with repositioning: • the care plan accurately states the frequency of the • repositioning required • the type of pressure relieving mattress in use and setting is recorded on all relevant documentation • a contemporaneous record is maintained of the patients • repositioning provided as per the care plan **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 38 **Stated:** First time	The registered person shall ensure that during recruitment checks any gaps in employment records and reasons for leaving previous employment are explored and explanations are recorded. **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 4 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that monthly care plan reviews and daily evaluations of care are meaningful; patient centred and include the oversight of supplementary care. **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**

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 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 at the inspection were accurate and up to date. In line with safe practice, a second nurse had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. Nurses were reminded that obsolete personal medication records should be cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient. It was agreed that this would be actioned following the inspection and followed up through the home's audit process.

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.

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 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 nurses 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. Nurses advised that these medicines were prescribed for a small number of patients and that they were required infrequently. Directions for use were clearly recorded on the personal medication records. Nurses 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. Care plans directing the use of these medicines were available; one care plan needed to be updated and this was discussed and agreed. There had been no recent administration of these medicines. Nurses advised that the reason for and outcome of

administration was recorded and that any administration would be discussed with the prescriber during the weekly clinics.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and pain relief was administered when required. Each patient had a pain management care plan and regular pain assessments were carried out by the nursing staff.

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

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was reviewed. Nurses advised that they had received training and felt confident to manage medicines and nutrition via the enteral route. Care plans were in place. Records of prescribing and administration of the prescribed supplements and fluids were maintained. However, the daily regimen (which should provide clear details of the prescribed nutritional supplement and recommended daily fluid intake) was not clearly written and a record of the total daily fluid intake was not maintained. This is necessary to ensure that nurses are following the current regimen and the recommended fluid intake is achieved. 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. Nurses advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

Records of medicines received into the home for patients receiving respite care and medicines received outside the monthly cycle, for example, antibiotics and newly prescribed medicines were not accurately maintained. In addition, records of medicines transferred to the patient following respite care were not been maintained. This is necessary to provide a clear audit trail and to show that the medicines have been administered as prescribed. An area for improvement was identified.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were 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. The following improvements were necessary in the storage of medicines: the treatment rooms should be decluttered and the trolleys should be deep cleaned in order to meet infection prevention and control standards; spacer devices should be cleaned/ replaced regularly and the date of reconstitution should be recorded on liquid antibiotics in order to facilitate audit and disposal at expiry. An area for improvement was identified.

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 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.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The records of receipt, administration and disposal of controlled drugs were maintained to the required standard in a controlled drug record book.

Management and staff audited medicine administration on a regular basis within the home. In addition, running stock balances were maintained for the majority of 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.

There had been no recent admissions to the home. However, the admission process for patients new to the home or returning to the home after receiving hospital care was discussed. The manager and nurses advised that robust arrangements were in place to ensure that they were provided with a current list of the patient's medicines and this was shared with the community pharmacist.

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 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 learning shared with staff in order to prevent a recurrence.

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

There were records in place to confirm that nurses had received a structured induction which included medicines management. Competency was assessed following induction and annually thereafter. Update training had been provided in accordance with the home's policy.

Medicines management policies and procedures were in place.

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	4*	4*

* The total number of areas for improvement includes five that have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Suzanne Johnston, 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 14 (2) (a) (c) **Stated:** First time **To be completed by:** Immediately and ongoing (14 December 2021)	The registered person shall ensure chemicals are stored in keeping with the Control Of Substances Hazardous to Health regulation. This is stated in reference to the access to the chemicals in the sluice and the hairdresser's room and appropriate storage of patients' prescribed creams. **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
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediately and ongoing (23 June 2022)	The registered person shall ensure that when nutrition and medicines are administered via the enteral route an up-to-date daily regimen is available and total fluid intake is recorded daily. Ref: 5.2.1 **Response by registered person detailing the actions taken:** A record of the administration of nutritional supplements and medicines via the enteral route are recorded daily on a regime sheet. This is a running sheet for 14 days and will be attached to Marrs at the end of 28 day cycle. Supervisions have been carried out on the management of enteral feeding. This will be monitored during medication audits.
Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** Immediately and ongoing (23 June 2022)	The registered person shall ensure that records of medicines received into the home and transferred out of the home are accurately maintained. Ref: 5.2.2 **Response by registered person detailing the actions taken**: Medications given for home leave or for respite are entered onto marrs when they are received and a hand written record is written on the back of Marrs when individual leaves home and medicines are transferred back out. Evidence of this will be monitored during medication audits.
Area for improvement 4 **Ref**: Regulation 13 (4)	The registered person shall review the storage arrangements for medicines as detailed in the report. Ref: 5.2.2

Stated: First time **To be completed by:** Immediately and ongoing (23 June 2022)	**Response by registered person detailing the actions taken**: A robust cleaning regime has been reviewed and will be overseen by senior staff nurses to include the cleaning of trolleys, individual boxes and equipment to include spacers. The clinical rooms have been decluttered and extra storage will be purchased to ensure adequate storage space. All medication should have the date of opening clearly marked on label, this will be monitored during the weekly and monthly audit process.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 46 **Stated:** Second time **To be completed by:** Immediately and ongoing (14 December 2021)	The registered person shall ensure the shower chairs and raised toilet seats are effectively cleaned after use and attention to detail is given when cleaning the hand gel dispensers.
	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 4 **Stated:** Second time **To be completed by:** 1 March 2022	The registered person shall ensure for those patients who require assistance with repositioning: • The care plan accurately states the frequency of the repositioning required • the type of pressure relieving mattress in use and setting is recorded on all relevant documentation • a contemporaneous record is maintained of the patients repositioning provided as per the care plan.
	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 38 **Stated:** First time **To be completed by:** Immediately and ongoing (14 December 2021)	The registered person shall ensure that during recruitment checks any gaps in employment records and reasons for leaving previous employment are explored and explanations are recorded.
	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 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Immediately and ongoing (14 December 2021)	The registered person shall ensure that monthly care plan reviews and daily evaluations of care are meaningful; patient centred and include the oversight of supplementary care.
	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

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care