The Regulation and Quality Improvement Authority

Inspection Report

25 April 2023

The Beeches Professional & Therapeutic Services

Type of service: Nursing Home
Address: 9-11 Lurgan Road, Aghalee, BT67 0DD
Telephone number: 028 9265 2233

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: The Beeches Professional & Therapeutic Services Ltd **Responsible Individual:** Mr James Brian Wilson	**Registered Manager:** Mrs Janette McGann (Acting)
Person in charge at the time of inspection: Mrs Janette McGann	**Number of registered places:** 41
Categories of care: Nursing (NH): LD – learning disability LD(E) – learning disability – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 34
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 41 patients who have a learning disability. Patients' bedrooms are accommodated over two floors and patients have access to communal day spaces, dining room and garden area.	

2.0 Inspection summary

An unannounced inspection took place on 25 April 2023, from 10.30am to 3.00pm. This 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.

One area for improvement identified at the last care inspection has been addressed and the other areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection.

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 management of; medicines for new admissions, thickening agents and distressed reactions and recording the date of opening of all medicines to facilitate audit.

Following the inspection, the findings were discussed with the Senior Pharmacist Inspector. RQIA decided that a period of time would be given to implement the necessary improvements.

A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained.

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 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 nursing staff and the manager. 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. Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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 care inspection on 16 June 2022		
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:** First time	The registered person shall ensure that patients are appropriately monitored following a fall where a head injury has occurred or the potential of a head injury is possible. **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 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that wound care is managed and recorded in line with best practice 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 3 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure that chemicals in the home are appropriately stored when not in use and not left accessible to patients. **Action taken as confirmed during the inspection**: The inspector did not observe any chemicals left unsupervised or accessible to patients during the inspection.	**Met**

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for Improvement 1 **Ref:** Standard 23 **Stated:** Second time	The registered person shall review the frequency in which patients' pressure management risk assessments are completed to ensure the safe and effective monitoring of patients' skin.	**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?

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.

The personal medication 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.

Copies of patients' prescriptions 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 for 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. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. The manager gave an

assurance that one care plan would be updated to reflect the most recent prescribed medication following the inspection. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. However, the reason for and outcome of each administration were not consistently recorded. An area for improvement was identified

The management of warfarin was reviewed. Warfarin is a high risk medicine and safe systems must be in place to ensure that patients are administered the correct dose and arrangements are in place for regular blood monitoring. Review of the warfarin administration records and audits completed at the inspection identified satisfactory arrangements were in place for the management of warfarin. Staff were reminded that transcribing must always be checked and verified as accurate by two nurses and to ensure that stock of both strengths is monitored and ordered on time to ensure a continuous supply.

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. Pain assessments were in place and reviewed regularly. One patient identified during the inspection had no pain care plan and the manager gave an assurance that a care plan would be written immediately 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 was reviewed. A speech and language assessment report and care plan was in place. One identified care plan and personal medication record had the incorrect consistency level recorded. Records of prescribing and administration did not always include the recommended consistency level. An area for improvement was identified.

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. In use insulin pen devices were not individually labelled with the date of opening recorded to facilitate disposal at expiry. The manager gave an assurance that this would be implemented immediately. An area for improvement regarding the recording of the date of opening for all medicines has been identified see section 5.2.3.

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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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.

A sample of the medicines administration records was reviewed. The records were found to have been fully and accurately completed. The records were filed once completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. There were no controlled drugs in stock at the time of the inspection. However, there is a controlled drugs cabinet and record book available if required.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. However, the date of opening was not recorded on all medicines. Recording the date of opening of all medicines is good practice. This facilitates audit and ensures medicines are disposed of at expiry. An area for improvement was identified.

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 not in place to manage medicines for new patients or patients returning from hospital. Written confirmation of two patients' medicine regimes could not be located during the inspection and therefore could not be determined if the medicine records had been accurately completed and if medicines had been administered as prescribed. An area for improvement was identified.

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 date of opening was not recorded on all boxed medicines so the inspector was unable to determine if these medicines were being administered as prescribed (see section 5.2.3).

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 they staff are competent in managing medicines and that they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	2*	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Janette McGann, Manager and Ms Chelsea McKeown, Registered Nurse, 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 Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect (16 June 2022)	The registered person shall ensure that patients are appropriately monitored following a fall where a head injury has occurred or the potential of a head injury is possible. **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 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect (16 June 2022)	The registered person shall ensure that wound care is managed and recorded in line with best practice 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.** Ref: 5.1
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 23 **Stated:** Second time **To be completed by:** 31 July 2022	The registered person shall review the frequency in which patients' pressure management risk assessments are completed to ensure the safe and effective monitoring of patients' skin. **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 28 **Stated:** First time **To be completed by:** Immediate and ongoing (25 April 2023)	The registered person shall review the management of distressed reactions to ensure that the reason for and outcome of administration of “when required” medicines are consistently recorded. Ref: 5.2.1
	Response by registered person detailing the actions taken: Relevant staff informed of necessity to record anxiolytic medications in kardex and in appropriate care plan stating why the medication was needed and the effect of same. Audits carried out this month with positive outcomes.
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** Immediate and ongoing (25 April 2023)	The registered person shall review the management of thickening agents to ensure that the recommended consistency level is recorded on records of prescribing and administration and that care plans are accurate and up to date. Ref: 5.2.1
	Response by registered person detailing the actions taken: Thickening agents are now recorded in careplan and relevant staff informed of need to update this information when recommendations change. Consistency is now written on MARs to correspond with SLT recommendations.
Area for improvement 4 **Ref:** Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing (25 April 2023)	The registered person shall ensure that the date of opening is recorded for all medicines to facilitate audit and disposal at expiry. Ref: 5.2.1, 5.2.3, 5.2.5
	Response by registered person detailing the actions taken: All nursing staff have been informed to write date, time and sign medication taken from cupboards when they restock trolleys. Audits carried out reflect this is being done.

Area for improvement 5 **Ref:** Standard 28 **Stated:** First time	The registered person shall ensure that written confirmation of all new patients' medicines is obtained at or prior to admission to the home. Ref: 5.2.4
To be completed by: Immediate and ongoing (25 April 2023)	**Response by registered person detailing the actions taken:** Nursing staff informed of need to get confirmation from hospital or GP of current medications. This information needs to be retained in resident's main careplan. In the case of the most recent admission this process has been followed.

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

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