The Regulation and Quality Improvement Authority

Inspection Report

1 November 2021

Carnalea

Type of service: Nursing Home
Address: 20 Crawfordsburn Road, Bangor, BT19 1BE
Telephone number: 028 9145 1121

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:** Mrs Josette Fernandez **Date registered:** 8 February 2016
Person in charge at the time of inspection: Mrs Josette Fernandez	**Number of registered places:** 73
Categories of care: Nursing (NH): DE – dementia 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	**Number of patients accommodated in the nursing home on the day of this inspection:** 54
Brief description of the accommodation/how the service operates: This home is registered to provide nursing care for up to 73 patients in three separate units.	

2.0 Inspection summary

An unannounced inspection took place on 1 November 2021 between 10.15am and 3.30pm. The inspection was carried out by a pharmacist inspector and focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care inspection.

Arrangements were in place to ensure that staff were trained and competent in medicines management. Medicine records were well maintained and there was an auditing system. The majority of medicines were administered as prescribed. Areas for improvement were identified in relation to care plans for covert administration and records for the administration of thickening agents.

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. 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. We also spoke to 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

We met with five nurses 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.

Staff 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 24 June 2021		
Action required to ensure compliance with 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 make arrangements to minimise the risk of infection. This is in relation to: • equipment inappropriately stored in bathrooms	**Met**

	• torn chairs, chipped sink surrounds, rusted radiators • a damaged side table, a rusted shower chair and broken bathroom tiles.	
	Action taken as confirmed during the inspection: Review of a number of bathrooms indicated that equipment was no longer inappropriately stored in bathrooms. The torn chairs, damaged side table and rusted shower chair had been replaced. The chipped sink surrounds, damaged tiles and rusted radiators had been repaired. The manager advised that ongoing repairs are undertaken in the home.	
Area for improvement 2 **Ref:** Regulation 14(2)(a)(c) **Stated:** First time	The registered person shall ensure all areas of the home which patients have access to are free from hazards including cleaning chemicals, access to the treatment room, and fluid thickening powders.	**Met**
	Action taken as confirmed during the inspection: The doors to cleaning stores were locked. The cleaning trolleys were observed to be under the direct control of the domestic staff. All three treatment rooms were locked. Thickening agents were stored in the treatment rooms and kitchen. Discussion with staff indicated that they were aware of the risks.	
Area for improvement 3 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that all notifiable events are reported to RQIA appropriately and in a timely manner.	**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 Care Standards for Nursing Homes, April 2015		Validation of compliance summary
Area for improvement 1 **Ref:** Standard 43 **Stated:** Second time	The registered person shall ensure that all the identified doors in toilet and shower areas are free from damage and can all be locked.	**Met**
	Action taken as confirmed during the inspection: The inspector was shown the identified doors in toilet and shower areas. They were free from damage and could be locked.	

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 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 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 and 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 verified and signed the personal medication records when they are written and updated to provide a check that they were accurate.

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 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 distressed reactions was reviewed for four 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. Care plans directing the use of these medicines were available. Directions for use were clearly recorded on the personal medication records and accurate records of administration were maintained. The reason for and outcome of administration were recorded on most occasions. It was agreed that this would be monitored as part of the audit process.

The management of pain was reviewed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Two patients' records were reviewed; 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 patients. The management of thickening agents was reviewed for four patients. Up to date speech and language reports, care plans and records of prescribing were maintained. However, records of administration by care assistants were found to be incomplete for three patients and had not been maintained for one patient. Records for the administration of thickening agents must be accurately maintained. An area for improvement was identified.

Some patients have their medicines administered covertly in food/drinks to assist administration. This had been agreed with the patients' family and written authorisation form their GP was available. The care plans reviewed at the inspection did not provide sufficient detail to ensure that the medicines were administered safely. 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. The storage of emollient preparations in the dementia unit was discussed with the manager. It was agreed that a risk assessment would be completed and alternative storage arranged if deemed necessary.

Medicine refrigerators and controlled drugs cabinets were being used appropriately and suitable 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 receipt, administration and disposal of controlled drugs were recorded in controlled drug record books. Records were maintained to the required standard.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The audits completed at the inspection indicated that the majority of medicines were administered as prescribed. However, audit discrepancies were identified in a number of eye preparations. The manager agreed to discuss this finding with staff for improvement and to include in the home's audit processes.

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.

The management of medicines for two patients who had been recently admitted to the home was reviewed. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. Personal medication records had been accurately written. Medicines had been received into the home and administered in accordance with the most recent directions.

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.

The medicine related incidents which had been reported to RQIA since the last inspection were discussed. Management and staff were familiar with the type of incidents that should be reported and there was evidence that 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 that they are supported.

There was evidence that staff 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.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to the management of medicines.

Based on the inspection findings and discussions held, RQIA was assured that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager with respect to the management of medicines. Although two areas for improvement was identified, we can conclude that overall, patients were administered their medicines as prescribed.

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

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, April 2015

	Regulations	Standards
Total number of Areas for Improvement	2*	1

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Josette Fernandez, 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 30 **Stated:** First time **To be completed by:** Immediately from the date of inspection (24 June 2021)	The registered person shall ensure that all notifiable events are reported to RQIA appropriately and in a timely manner. **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:** From the date of the inspection (1 November 2021)	The registered person shall ensure that records for the administration of thickening agents are accurately maintained. Ref: 5.2.1 **Response by registered person detailing the actions taken**: Thickening agents are recorded by Care Staff on the Residents' Daily Food Intake or the Fluid Balance chart and is counterchecked by the Nurse and signed in the MARR sheet.
Action required to ensure compliance with the Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** From the date of the inspection (1 November 2021)	The registered person shall ensure that care plans for the covert administration of medicines contain sufficient detail to ensure the medicines are administered safely. Ref: 5.2.1 **Response by registered person detailing the actions taken: Care plans on Covert medication are now reviewed and specific details are added.**

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