

Inspection Report

13 January 2022



Comber Care Home

Type of Service: Nursing Home
Address: 17 Castle Street,
Comber, BT23 5DY
Tel no: 028 9187 8200

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 Michelle MacMillan
Person in charge at the time of inspection: Mrs Michelle MacMillan	Number of registered places: 72
Categories of care: Nursing Home (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.	Number of patients accommodated in the nursing home on the day of this inspection: 45
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 72 patients.	

2.0 Inspection summary

An unannounced inspection took place on 13 January 2022, from 9.40am to 2.25pm by a pharmacist inspector.

This inspection focused on medicines management within the home and also assessed progress with the area for improvement identified at the last inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were broadly well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed.

The outcome of this inspection concluded that the area for improvement identified at the last inspection had been addressed. No new areas for improvement were identified at this inspection.

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.

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, a review of 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. Staff views were also obtained.

4.0 What people told us about the service

To reduce footfall throughout the home, the inspector did not meet any patients.

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

The inspector also met with nursing staff and the registered manager. 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. They also 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. 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 inspection on 20 July 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) Stated: Second time	The registered person shall ensure all parts of the home to which patients have access are free from hazards to their safety.	Met
	Action taken as confirmed during the inspection: The home was observed to be free from safety hazards. The cleaning stores were 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 medical 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 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 broadly accurate and up to date. One medicine entry needed to be updated with the current dosage instructions; this change was made during the inspection. 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 check that they were accurate. A couple of obsolete personal medication records had not been removed from the medicines kardexes.

This was drawn to the attention of the manager and nursing staff for their attention. The need for obsolete records to be promptly archived was emphasised. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient.

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 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 the management of distressed reactions was reviewed for two patients. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. These medicines were infrequently used.

The management of pain was reviewed for four patients. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly.

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 for four 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.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. The management of medicines and nutrition via the enteral route was reviewed for one patient. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

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. Medicine refrigerators and controlled drugs cabinets 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs, when medicines are administered to a patient. A sample of these records was reviewed. The records were found to have been completed in a satisfactory manner. The completed records were filed once completed.

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 appropriately recorded in the controlled drug record books. Robust arrangements were in place for the management of controlled drugs.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. With the exception of several insulin pens, the date of opening was recorded on medicines so that they could be easily audited. This is good practice. The need for staff to routinely record the dates of opening on insulin pens was discussed with the manager and nursing staff. The manager gave an assurance that this matter would be closely monitored; given this assurance an area for improvement was not 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.

The management of medicines was reviewed for two patients who had been admitted to this home. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. The patients' personal medication records had been accurately written and signed by two nurses. Medicines had been accurately 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. Management and staff were familiar with the type of incidents that should be reported.

The audits completed at the inspection indicated that the medicines were being administered as prescribed.

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. Policies and procedures should be up to date and readily available for staff use.

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. A written record was completed for induction and competency assessments.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

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



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