The Regulation and Quality Improvement Authority

Inspection Report

22 September 2021

Rush Hall

Type of service: Nursing Home
Address: 51 Broighter Road, Limavady, BT49 9DY
Telephone number: 028 7776 9326

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: Ann's Care Homes Limited **Responsible Individual:** Ms Charmaine Hamilton	**Registered Manager:** Mrs Carol Craig **Date registered:** 15 May 2018
Person in charge at the time of inspection: Mrs Carol Craig	**Number of registered places:** 66 This number includes a maximum of 32 patients in NH-DE category of care.
Categories of care: Nursing (NH): I – old age not falling within any other category DE – dementia	**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 is a nursing home which is registered to provide care for up to 66 patients.	

2.0 Inspection summary

An unannounced inspection took place on 22 September 2021, between 10.10am and 3.30pm. The inspection was conducted 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. Following discussion with the aligned care inspector, it was agreed that six of the 11 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. There were arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management.

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 the four nurses on duty 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, one patient/representative questionnaire had been received. No comments were provided, but the respondent indicated that they were very satisfied with the care provided.

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 dated 18 May 2021		
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 27 (2) (b) (d) (g) **Stated:** First time	The registered persons must ensure that all areas of the home are kept in good state of repair, is reasonably decorated and has adequate seating. **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 14 (2) (a) **Stated:** First time	The registered persons must ensure that all areas of the home to which patients have access are free from hazards to their safety. With specific reference to ensuring that: • chemicals are securely stored in keeping with COSHH legislation. **Action taken as confirmed during the inspection**: Cleaning trolleys and chemicals were attended when in use and stored securely when not in use.	**Met**
Area for improvement 3 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered persons must ensure that all areas of the home to which patients have access are free from hazards to their safety. With specific reference to ensuring that: • food trolleys are supervised. **Action taken as confirmed during the inspection**: Food trolleys were supervised during observations throughout the lunchtime period.	**Met**

Area for improvement 4 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the infection prevention and control issues identified during the inspection are addressed. **Action taken as confirmed during the inspection**: Observation of the environment and staff practices evidenced that this area for improvement has been met.	**Met**
Area for improvement 5 **Ref:** Regulation 29 **Stated:** First time	The registered person shall ensure that the monthly quality monitoring report is robust, provides sufficient information on the conduct of the home and includes the person responsible for completing any actions generated from the visit. **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**
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 46 **Stated:** Second time	The registered person shall ensure, in accordance with regional infection prevention and control guidelines that: • clean and unclean linen are stored separately. **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 2 **Ref:** Standard 46 **Stated:** Second time	The registered person shall consider increasing the availability of alcohol hand sanitiser and PPE supplies along the corridor areas throughout the home to reduce the distance staff have to travel to reach supplies. **Action taken as confirmed during the inspection**: Sufficient PPE and hand sanitising gel were available, additional dispensers had been installed in corridors.	**Met**

Area for improvement 3 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that prescribed supplements are stored securely. **Action taken as confirmed during the inspection**: Prescribed supplements were stored securely in treatment rooms.	**Met**
Area for improvement 4 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that where a patient requires pressure area care a care plan is implemented detailing the recommended frequency of repositioning which is recorded within the chart and reflective of 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 5 **Ref:** Standard 37 **Stated:** First time	The registered person shall ensure that any record retained in the home which details patient information is stored safely in accordance with the General Data Protection Regulation and best practice standards. **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 6 **Ref:** Standard 35 **Stated:** First time	The registered person shall ensure that a robust system of audits is implemented and maintained to promote and make proper provision for the nursing, health and welfare of patients. With specific reference to: • environment • IPC • care records. **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**

This is the first medicines management inspection since the change of ownership.

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 and hospital appointments.

The majority of personal medication records reviewed 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 provide a double check that they were accurate. For one critical medicine the personal medication record was not up to date. Previous entries on the personal medication record had been amended, rather than discontinued and a new entry made. This could result in the medicine being administered incorrectly or the wrong information being provided to another healthcare professional. An area for improvement was identified.

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 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 the management of 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. Directions for use were clearly recorded on the personal medication records. Care plans directing the use of these medicines were available.

Records of administration were clearly recorded. The reason for and outcome of administration were recorded.

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. Three 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 patient.

The management of thickening agents was reviewed for three patients. A speech and language assessment report and care plan was in place. Records of prescribing which included the recommended consistency level were maintained.

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 being used appropriately.

Appropriate arrangements were in place for the 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 a controlled drug record book. 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. The date of opening was recorded on medicines so that they could be easily audited. This is good practice.

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. The medicines prescribed had been confirmed with the GP practice and/or hospital discharge letters had been received and a copy had been forwarded to the patient's GP. Personal medication records had been accurately written. 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.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. 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.

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.

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

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. Whilst one area for improvement was identified, we can conclude that overall, patients were being 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*	5*

* the total number of areas for improvement includes two under regulations and four under standards which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Carol Craig, 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 27 (2) (b) (d) (g) **Stated:** First time **To be completed by:** With immediate effect (18 May 2021)	The registered person must ensure that all areas of the home are kept in good state of repair, is reasonably decorated and has adequate seating. **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 29 **Stated:** First time **To be completed by:** With immediate effect (18 May 2021)	The registered person shall ensure that the monthly quality monitoring report is robust, provides sufficient information on the conduct of the home and includes the person responsible for completing any actions generated from the visit. **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 Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the current prescribed dose is recorded on medicine records and that obsolete doses are discontinued to ensure a clear audit trail. Ref: 5.2.1 **Response by registered person detailing the actions taken:**
Area for improvement 2 **Ref:** Standard 46 **Stated:** Second time **To be completed by:** With immediate effect (18 May 2021)	The registered person shall ensure, in accordance with regional infection prevention and control guidelines that: • clean and unclean linen are stored separately. **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 23 **Stated:** First time **To be completed by:** With immediate effect (18 May 2021)	The registered person shall ensure that where a patient requires pressure area care a care plan is implemented detailing the recommended frequency of repositioning which is recorded within the chart and reflective of the care plan.
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	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 5 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 18 June 2021	The registered person shall ensure that a robust system of audits is implemented and maintained to promote and make proper provision for the nursing, health and welfare of patients. With specific reference to: • environment • IPC • care records.
	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

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