Inspection Report

2 July 2021

Rosemount Care Centre

Type of service: Nursing Home
Address: 2 Moy Road, Portadown, BT62 1QL
Telephone number: 028 3833 1311

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: Zest Care Homes Limited **Responsible Individual:** Mr Philip Scott	**Registered Manager:** Ms Patricia Purvis **Date registered:** 8 November 2019
Person in charge at the time of inspection: Ms Patricia Purvis	**Number of registered places:** 41 This number includes a maximum of 19 patients in category NH-I accommodated in the Jasmine Unit and a maximum of 22 patients in category NH-DE accommodated in the Sunflower Unit.
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:** 40
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for up to 41 patients. This home shares the same building as Rosemount Care Centre Residential Care Home.	

2.0 Inspection summary

An unannounced inspection took place on 2 July 2021, between 10.45am and 3.10pm. The inspection was carried out by a pharmacist inspector.

This inspection focused on medicines management within the home.

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

To complete the inspection 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 was reviewed.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

4.0 What people told us about the service

We met with two nurses, the deputy manager and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well. Patients were observed to be relaxing in lounges/bedrooms throughout the home.

Nurses expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after patients and meet their needs. They spoke highly of the support given by management.

In order to reduce footfall throughout the home, the inspector did not meet with any patients. 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 responses had been received.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last care and medicines management inspections?

No areas for improvement were identified at the last medicines management inspection on 25 April 2017.

Areas for improvement from the last care inspection on 11 March 2021		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that when registered nurses are prescribing patient care the care plans accurately reflect the assessed need, specifically in relation to: • responding to behaviours • potential restrictive practice.	**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 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 checked and signed the majority of the personal medication records when they are written and updated to provide a double check that they were accurate. Nurses were reminded that dosage directions for insulin should not be abbreviated.

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, self-administration 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 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. Nurses said that they 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 and the reason for and outcome of administration were recorded. For one patient the care plan did not provide details of which medicine should be used first line. This was discussed with the nurse on duty and the manager who provided assurances that the care plan would be updated.

The management of pain was discussed. Care plans were in place and there was evidence that medication was administered as prescribed. Staff advised that they were familiar with how each patient expressed their pain.

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 and nutritional supplements was reviewed for three patients. Records of prescribing and administration which included the recommended consistency level were maintained. For two of the patients, speech and language assessment (SALT) reports and care plans were in place. Staff advised that the care plan and SALT report for the third patient had been archived in error and that this would be addressed following the inspection.

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 the majority of medicines were available for administration when patients required them (however, see Section 5.2.4). Nurses advised that they had a good relationship with the community pharmacist and with the GP surgeries.

However, they advised that they had experienced difficulty obtaining prescriptions during the pandemic and that orders had to be placed almost a week before the medicines were required and followed up daily to ensure that there were no out of stocks.

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. Nurses were reminded that quetiapine suspension must be discarded 28 days after opening. This was addressed during the inspection.

The maximum, minimum and current refrigerator temperatures were monitored and recorded each day in both treatment rooms. For one refrigerator temperatures within the accepted range ($2^{o}C$ – $8^{o}C$) for the cold storage of medicines were observed. For the second refrigerator temperatures were frequently outside this range; this can affect the stability/ effectiveness of medicines. Nurses had not taken corrective action or informed the management team. When the thermometer was reset at the inspection satisfactory readings were observed. Medicines must be stored at the correct temperature. Nurses should receive training on resetting the refrigerator thermometer and must take corrective action when necessary. An area for improvement was identified.

Satisfactory systems 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). A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed (however, see Section 5.2.4). The records were filed once completed and were readily retrievable for audit/review.

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. Mostly satisfactory arrangements were in place for the management of controlled drugs; however, nurses were reminded that they should record that controlled drugs have been denatured prior to disposal.

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 all medicines so that they could be easily audited. This is good practice. It was agreed that the audit process would be further developed to include the management of medicines on admission for all new/returning patients. (See Section 5.2.4)

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 recent admissions was reviewed. For one patient a hospital discharge letter had been received and a copy had been forwarded to the patient's GP. The patient's personal medication record correlated with the hospital discharge letter. Medicines had been accurately received into the home and administered as prescribed.
For the second patient, written confirmation of the patient's medicines had not been requested from their GP. Their personal medication record had not been verified by a second nurse and the quantity of each medicine received into the home had not been recorded. For one medicine four doses had been omitted as it was out of stock and for a second medicine the wrong dose had been administered. The GP was contacted following the inspection for advice and an incident report form detailing the action taken to prevent a recurrence was submitted to RQIA.

The management of medicines on admission should be reviewed to ensure: dosage regimens are received in writing; two nurses verify the personal medication records and medication administration records; the month and year of administration are recorded on hand-written medication administration records; quantities of medicines received into the home are recorded to facilitate a clear audit trail and medicines are ordered in a timely manner to prevent out of stocks. In addition, the management of medicines on admission should be included in the audit process. 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.

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

The manager advised that 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 or more frequently if a need was identified. A written record was completed for induction and competency assessments.

Refresher training on the management of medicines was provided annually for nurses. The manager advised that following the outcome of this inspection nurses would receive supervision on the management of medicines on admission and how to accurately monitor refrigerator temperatures.

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.

Whilst areas for improvement were identified in relation to the cold storage of medicines and the management of medicines on admission, RQIA is assured that, with the exception of a small number of medicines, the 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 Ms Patricia Purvis, 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 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person must ensure that medicines requiring cold storage are stored at the correct temperature. Nurses must take corrective action if temperatures outside the recommended range are observed. Ref: 5.2.2
	Response by registered person detailing the actions taken: Staff training on fridge temperatures completed with nursing staff and staff informed of corrective actions they need to take if not within the normal range.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person must review and revise the management of medicines on admission as detailed in the report. Ref: 5.2.4
	Response by registered person detailing the actions taken: The management of medicines on admissoin has been revised and will be completed accurately as per standards.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 9 April 2021	The registered person shall ensure that when registered nurses are prescribing patient care the care plans accurately reflect the assessed need, specifically in relation to: • responding to behaviours • potential restrictive practice.
	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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