The Regulation and Quality Improvement Authority

Inspection Report

19 October 2021

Daleview House

Type of Service: Nursing Home
Address: Shepherds Way, Dungiven Road, Londonderry, BT47 5GW
Telephone number: 028 7134 8015

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: Apex Housing Association **Responsible Individual:** Miss Sheena McCallion	**Registered Manager:** Mrs Marcella McCorkell **Date registered:** 31 December 2008
Person in charge at the time of inspection: Mrs Marcella McCorkell	**Number of registered places:** 30
Categories of care: Nursing Home (NH) I – Old age not falling within any other category	**Number of patients accommodated in the nursing home on the day of this inspection:** 23
Brief description of the accommodation/how the service operates: This is a nursing home registered to provide nursing care for up to 30 patients.	

2.0 Inspection summary

An unannounced inspection took place on 19 October 2021, from 10.15am to 2.20pm. The inspection was conducted by a pharmacist inspector and focused on medicines management within the home.

The inspection also assessed progress with some areas for improvement identified at the last care inspection. Following discussion with the aligned care inspector, it was agreed that the remaining areas for improvement would be followed up at the next care inspection.

A 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. Systems were in place to ensure that staff were trained and competent in medicines management. No new areas for improvement were identified.

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, reported 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

Patients were observed to be relaxed and content in the home. The inspector met with three 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.

The nurses 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, four questionnaires had been returned. All responses indicated that the respondent was satisfied/very satisfied with the care provided/received. No staff responses were received.

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 1 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 (1) (a) (b) **Stated:** Second time	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. This is in specific reference to care plans and risk assessments: • contain clear information regarding medical conditions where treatment is being provided • where a patient has a history of weight loss the MUST is accurately reflected within the	**Carried forward to the next inspection**

	care records. **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.**	
Area for improvement 2 **Ref:** Regulation 27 (4)(c) **Stated:** First time	The registered person must ensure that arrangements are made to ensure that means of escape from the home are readily available and maintained free from obstruction at all times, with particular reference to sand bags that were observed to be in place at identified fire exit doors during the inspection. **Action taken as confirmed during the inspection**: Fire doors were observed to be free from obstruction.	**Met**
Area for improvement 3 **Ref:** Regulation 27 (4)(b) **Stated:** First time	The registered person must ensure that adequate precaution is taken against the risk of fire with specific reference to ensuring that fire doors are not propped open. **Action taken as confirmed during the inspection**: No fire doors were observed to be propped open.	**Met**
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for improvement 1 **Ref:** Standard 41 **Stated:** First time	The registered person shall ensure the staff duty rota clearly identifies: • the person in charge in the absence of the manager • the first and surname of each staff employee, their role and hours worked • any abbreviations have a code to signify what they represent. **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 35 **Stated:** First time	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to care record audits on newly admitted patients to ensure that care plans and risk assessment are completed within the required timeframe.	**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 the GP, the pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by a 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 were written and updated to provide a check that they were accurate.

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 safe 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 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 distressed reactions was reviewed for four patients. The nurses on duty 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 personal medication records and care plans directing the use of these medicines were in place. Records of administration were maintained. The reason for and outcome of administration were recorded on the majority of occasions. This should be recorded on all occasions and it was agreed this would be addressed.

The management of pain was discussed. Nurses 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.

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 two patients. A speech and language assessment report (SALT) and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.
For one patient, the handover sheet used by staff did not match the prescribed consistency recorded on the personal medication record, care plan and SALT report. This could lead to an error in administration. The manager agreed to address this following the inspection. It was observed that a referral for a SALT review had been made and the patient was receiving the correct prescribed consistency.

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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

It was noted that the controlled drug key had been left in the lock, inside of another locked cupboard. This was discussed with the manager, who advised that this was not the expected practice and that all relevant staff would be reminded following the inspection.

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.

A sample of medicine administration records was reviewed. The records had been completed in a satisfactory manner. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. 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 recorded appropriately in a controlled drug record book.

Management and staff audited the management and administration of medicines on a regular basis. The date of opening was recorded on medicines so that they could be easily audited. Where shortfalls had been identified action plans were developed and implemented. It was agreed that the number of audits of medicine records would be increased to ensure that all records are reviewed on a regular basis.

The audits completed at the inspection indicated that overall, medicines were being administered as prescribed. Some minor discrepancies were discussed for ongoing close monitoring.

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 recently admitted patients or patients returning to the home following discharge from hospital was reviewed. There was evidence that robust arrangements were in place to ensure that written confirmation of the patients' current medicine regime was obtained and the GP and community pharmacy were contacted as necessary. 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. 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.

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.

Records of staff training in relation to medicines management were available for inspection. Policies and procedures were up to date and readily available for staff use.

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 regarding the management of medicines.

We can conclude that overall that the patients were being administered their medicines as prescribed. No new areas for improvement were identified.

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

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	1*	2*

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

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

Quality Improvement Plan

Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** Second time **To be completed by:** 1 July 2021	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. This is in specific reference to care plans and risk assessments: • contain clear information regarding medical conditions where treatment is being provided • where a patient has a history of weight loss the MUST is accurately reflected within the care records.
	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 41 **Stated:** First time **To be completed by:** With immediate effect (1 June 2021)	The registered person shall ensure the staff duty rota clearly identifies: • the person in charge in the absence of the manager • the first and surname of each staff employee, their role and hours worked • any abbreviations have a code to signify what they represent.
	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 35 **Stated:** First time **To be completed by:** 1 July 2021	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to care record audits on newly admitted patients to ensure that care plans and risk assessment are completed within the required timeframe.
	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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