

Inspection Report

4 April 2022



Meadowbank

Type of service: Nursing Home
Address: 11a Trench Road, Londonderry, BT47 2DT
Telephone number: 028 7134 7281

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation: Ann's Care Homes Limited Responsible Individual: Mrs Charmaine Hamilton	Registered Manager: Mrs Emma Quigley Date registered: 19 July 2021
Person in charge at the time of inspection: Mrs Emma Quigley	Number of registered places: 35
Categories of care: Nursing Home (NH) LD – learning disability LD(E) – learning disability – over 65 years	Number of patients accommodated in the nursing home on the day of this inspection: 26
Brief description of the accommodation/how the service operates: This is a registered nursing home which provides nursing care for up to 35 patients living with a learning disability.	

2.0 Inspection summary

An unannounced inspection took place on 4 April 2022 from 11.00am to 2.45pm. This was completed by a pharmacist inspector and focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

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

Review of medicines management identified there were arrangements in place to ensure that staff were trained and competent in medicines management. Medicines were stored safely and securely and medicine related care plans were maintained. Two areas for improvement, in relation to accurate completion of personal medication records and recording the date of opening on all medicines, were identified. Whilst areas for improvement were identified, it was concluded that overall, patients were being administered their medicines as prescribed.

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 in respect of medicines management.

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, 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

The inspector met with nursing staff, 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 interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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 13 January 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 12 (1)	The registered person shall ensure the following in regards to the repositioning of patients:	Carried forward

<p>Stated: First time</p>	<ul style="list-style-type: none"> • that patients are repositioned in keeping with their prescribed care • that repositioning records are accurately and comprehensively maintained at all times. <p>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.</p>	<p>to the next inspection</p>
<p>Area for improvement 2</p> <p>Ref: Regulation 14 (2) (a) (c)</p> <p>Stated: First time</p>	<p>The registered person shall ensure that chemicals are not accessible to patients in any area of the home in keeping with COSHH legislation.</p> <p>Thickening agents must be stored appropriately when not in use.</p> <p>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.</p>	<p>Carried forward to the next inspection</p>
<p>Area for improvement 3</p> <p>Ref: Regulation 13 (7)</p> <p>Stated: First time</p>	<p>The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection.</p> <p>This relates specifically to the following:</p> <ul style="list-style-type: none"> • the use of vinyl gloves • notices are laminated • damaged bed rail protectors are replaced. <p>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.</p>	<p>Carried forward to the next inspection</p>
<p>Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)</p>		<p>Validation of compliance</p>
<p>Area for improvement 1</p> <p>Ref: Standard 37</p> <p>Stated: First time</p>	<p>The registered person shall ensure that clear, documented systems are in place for the management of records in accordance with legislative requirements and best practice guidance.</p> <p>This refers specifically to the storage of patient care records in the home.</p>	<p>Carried forward to the next inspection</p>

	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.	
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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 may 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 majority of personal medication records reviewed at the inspection were accurate and up to date. However, a review of medicines administered via the enteral route identified that the personal medication record had not been completed accurately. It was not clear that medicines were administered via the enteral route and not orally. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. A small number of other minor discrepancies in the personal medication records were highlighted to the manager for review. 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.

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 nurses 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 nurses 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. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain.

The reason for and outcome of each administration were recorded. 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 and pain assessments 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 three patients. A speech and language assessment report and care plan was in place for each patient. 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 feeding tube. The management of medicines via the enteral route was examined. There was evidence that advice had been sought and received regarding how each medicine should be administered. Records of the administration of medicines 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. As stated above, the personal medication record for a patient prescribed medicines via the enteral route had not been completed accurately to denote that medicines were administered via the enteral route and not orally.

Epilepsy management plans were in place for patient's prescribed buccal midazolam or rectal diazepam for the management of seizures. There was sufficient detail in the plans to direct nurses on how to administer these medicines.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines and records were maintained.

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 medicines administration records was reviewed. The records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for 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 the controlled drug record book. There were satisfactory arrangements 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 audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The date of opening was not consistently recorded on all medicines meaning that the administration of medicines could not be accurately audited. Eye drop preparations with a limited shelf-life were not marked with the date of opening and therefore it could not be determined if these medicines had passed their expiry date. An area for improvement was 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.

There had been no recent admissions to the home. However, the admission process for patients new to the home or returning to the home after receiving hospital care was discussed. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the patient's medicines and this was shared with the community pharmacist.

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. A robust audit system will help 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 the learning shared with staff in order to prevent a recurrence.

As stated in Section 5.2.3, the date of opening was not consistently recorded on all medicines, including limited shelf-life eye drop preparations. This is necessary to facilitate audit which in turn will help staff to identify medicine related incidents.

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 they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

6.0 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, 2015.

	Regulations	Standards
Total number of Areas for Improvement	3*	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Emma Quigley, 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 12 (1) Stated: First time To be completed by: With immediate effect (13 January 2022)	<p>The registered person shall ensure the following in regards to the repositioning of patients:</p> <ul style="list-style-type: none"> • that patients are repositioned in keeping with their prescribed care • that repositioning records are accurately and comprehensively maintained at all times.
	<p>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.</p> <p>Ref: 5.1</p>
Area for improvement 2 Ref: Regulation 14 (2) (a) (c) Stated: First time To be completed by: With immediate effect (13 January 2022)	<p>The registered person shall ensure that chemicals are not accessible to patients in any area of the home in keeping with COSHH legislation.</p> <p>Thickening agents must be stored appropriately when not in use.</p>
	<p>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.</p> <p>Ref: 5.1</p>
Area for improvement 3 Ref: Regulation 13 (7) Stated: First time To be completed by: With immediate effect (13 January 2022)	<p>The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection.</p> <p>This relates specifically to the following:</p> <ul style="list-style-type: none"> • the use of vinyl gloves • notices are laminated • damaged bed rail protectors are replaced.
	<p>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.</p> <p>Ref: 5.1</p>

Action required to ensure compliance with the Care Standards for Nursing Homes, April 2015	
Area for improvement 1 Ref: Standard 37 Stated: First time To be completed by: 13 February 2022	<p>The registered person shall ensure that clear, documented systems are in place for the management of records in accordance with legislative requirements and best practice guidance.</p> <p>This refers specifically to the storage of patient care records in the home.</p>
	<p>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.</p> <p>Ref: 5.1</p>
Area for improvement 2 Ref: Standard 29 Stated: First time To be completed by: Ongoing from the date of inspection (4 April 2022)	<p>The registered person shall ensure that fully complete and accurate personal medication records are maintained.</p> <p>Ref: 5.2.1</p>
	<p>Response by registered person detailing the actions taken: The personal medication record for the identified resident was rewritten on day of inspection. A further review is taking place of all personal medication records to ensure that they are accurate and up to date.</p>
Area for improvement 3 Ref: Standard 28 Stated: First time To be completed by: Ongoing from the date of inspection (4 April 2022)	<p>The registered person shall ensure that the date of opening is recorded on all medicines to facilitate audit.</p> <p>Ref: 5.2.3</p>
	<p>Response by registered person detailing the actions taken: Nurses meeting held post inspection 07/04/22 to discuss actions going forward. Nurses has been advised that date and time of opening is to be recorded on all medications and this is checked on a new daily audit.</p>

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