Inspection Report

16 July 2024

Meadowbank

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

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Ann's Care Home **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 (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:** 30
Brief description of the accommodation/how the service operates: Meadowbank is a registered nursing home which provides nursing care for up to 35 patients with a learning disability. The home is a single storey building with individual bedrooms. Patients have access to communal lounges, a dining room and bathrooms. There is an outdoor area with seating and mature gardens for patient use.	

2.0 Inspection summary

An unannounced inspection took place on 16 July 2024, from 10.00am to 1.45pm. 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.

This inspection also assessed progress with the areas for improvement identified at the last medicines management inspection. The areas for improvement identified at the last care inspection have been carried forward for review at the next care inspection.

Review of medicines management found that medicines were stored safely and securely. 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.

One area for improvement identified at the last medicines management inspection in relation to the maintenance of personal medication records has been stated for a second time. The area for improvement in relation to recording the date of opening on all medicines to facilitate audit had been addressed. Details of the restated area for improvement can be found in the quality improvement plan (QIP).

Whilst one area for improvement was stated for a second time, it was concluded that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed.

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. Discussions were held with staff and management about how they plan, deliver and monitor the management of medicines within the home.

4.0 What people told us about the service

The inspector met with care staff, nursing staff and the manager. 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		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure the cleanliness and infection prevention and control issues identified during the inspection are addressed.	**Carried forward to the next inspection**
	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 14 (2)(a) **Stated:** First time	The registered person shall ensure all areas in the nursing home to which patients have access to are free from hazards to their safety.	**Carried forward to the next inspection**
	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.	
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 29 **Stated:** First time	The registered person shall ensure that fully complete and accurate personal medication records are maintained.	**Not met**
	Action taken as confirmed during the inspection: Review of a sample of personal medication records identified a number of errors. This area for improvement was assessed as not met. See Section 5.2.1	

Area for improvement 2 **Ref:** Standard 28 **Stated:** First time	The registered person shall ensure that the date of opening is recorded on all medicines to facilitate audit.	**Met**
	Action taken as confirmed during the inspection: The date of opening was recorded on all medicines to facilitate audit. This area for improvement was assessed as met.	
Area for improvement 3 **Ref:** Standard 23 **Stated:** Second time	The registered person shall ensure that patients are repositioned in keeping with their prescribed care and that repositioning records are accurately and comprehensively maintained at all times.	**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.	
Area for improvement 4 **Ref:** Standard 4.7 **Stated:** First time	The registered person shall ensure care records for patients who required their food to be modified are up to date and reviewed to ensure they continue to meet the needs of patients.	**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 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.

It was identified that some of these records were not up to date with the most recent prescription. Discrepancies were identified between the directions on the personal medication records and the dosage signed as administered on the medicine administration records. Assurances were provided that the medicines had been administered in accordance with the most recent directions. However, if the personal medication records are not accurate and up to date, this could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. The area for improvement in relation to the maintenance of personal medication records has been stated for a second time.

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. 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. Records included the reason for and outcome of each administration.

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. 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. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained. However, a small number of discrepancies between the consistency recommended in the speech and language assessment report and the consistency stated on the personal medication records were identified. This was highlighted to the manager and assurances were provided that the correctly prescribed consistency of fluids were being administered. As stated above, an area for improvement in relation to the maintenance of personal medication records was stated for a second time.

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 and nutrition via the enteral route was examined. 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.

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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was 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.

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 the medicines administration records was reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. The audits completed at the inspection indicated that the medicines had been administered as prescribed. The records were filed once completed and 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 should be 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 date of opening was recorded on all medicines so that they could be easily audited. This is good practice. The manager was advised to include the review of personal medication records as part of the home's routine medicines audit process moving forward.

The audits completed at the inspection indicated that the large majority of medicines were administered as prescribed. A small number of minor discrepancies were highlighted to the manager for ongoing review and 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.

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 reviewed. 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.

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. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been stated for a second time where action is required to ensure compliance with the Care Standards for Nursing Homes, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	2*	3*

* The total number of areas for improvement includes one that has been stated for a second time and four which are carried forward for review at the next inspection.

The restated area for improvement and details of the Quality Improvement Plan were discussed with Mrs Emma Quigley, Registered Manager, as part of the inspection process. The timescale for completion commences 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 (7) **Stated:** First time **To be completed by:** With immediate effect (9 April 2024)	The registered person shall ensure the cleanliness and infection prevention and control issues identified during the inspection are addressed. **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 14 (2)(a) **Stated:** First time **To be completed by:** With immediate effect (9 April 2024)	The registered person shall ensure all areas in the nursing home to which patients have access to are free from hazards to their safety. **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, December 2022	
Area for Improvement 1 **Ref:** Standard 29 **Stated:** Second time **To be completed by:** Ongoing from the date of inspection (16 July 2024)	The registered person shall ensure that fully complete and accurate personal medication records are maintained. Ref: 5.1 & 5.2.1 **Response by registered person detailing the actions taken:** A full review of all personal medication records has been completed to ensure that they reflect the prescription directions and the IDDSI levels prescribed for individual residents. Staff have been advised to enter an end date to the electronic personal medication record for all short term therapies.This will

	alert staff to discontinue treatment and care plans in a timely basis. A new audit has been devised to ensure that IDDSI food and fluid levels reflect care plans, personal medication records and the medicine administration records. The Home Manager/Deputy Manager will monitor compliance during the monthly medication audit.
Area for improvement 2 **Ref:** Standard 23 **Stated:** Second time **To be completed by:** With immediate effect (9 April 2024)	The registered person shall ensure that patients are repositioned in keeping with their prescribed care and that repositioning records are accurately and comprehensively maintained at all times.
	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 4.7 **Stated:** First time **To be completed by:** With immediate effect (9 April 2024)	The registered person shall ensure care records for patients who required their food to be modified are up to date and reviewed to ensure they continue to meet the needs of patients.
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