The Regulation and Quality Improvement Authority

Inspection Report

24 January 2023

Ringdufferin Nursing Home

Type of service: Nursing Home
Address: 36 Ringdufferin Road, Killyleagh, BT30 9PH
Telephone number: 028 4482 1333

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: M Care Ltd **Responsible Person:** Mrs Caroline Malone, registration pending	**Registered Manager:** Ms Jacqueline Bowen **Date registered:** 15 October 2020
Person in charge at the time of inspection: Ms Jacqueline Bowen	**Number of registered places:** 64 This number includes: • a maximum of 31 patients accommodated in the Dunmore Suite (categories NH-I, NH-PH, NH-PH(E) & NH-TI) • a maximum of 32 patients in category NH-DE accommodated in the Strangford Suite. • one named resident receiving residential care in category RC-I accommodated in the Dunmore Suite
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 47
Brief description of the accommodation/how the service operates: Ringdufferin is a nursing home which is registered to provide care for up to 64 patients. The home is divided into two units, the Dunmore Suite and the Strangford Suite. Patients have access to communal lounges, dining rooms and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 24 January 2023, from 10.00am to 1.50pm. The inspection was completed by two pharmacist inspectors 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 inspection.

Review of medicines management found that patients were being administered their medicines as prescribed. Medicine records were well maintained and medicines were stored securely. Nurses had received training and been deemed competent to manage and administer medicines. There were robust governance systems. No new areas for improvement were identified at the inspection.

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 will led by the management team in relation to medicines management.

The inspectors would like to thank staff and management 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 the home was 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. The inspectors spoke with 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

The inspectors met with one team leader, three nurses, the manager and the responsible person.

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, no responses 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 21 & 22 November 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) (a) (b) **Stated:** First time	The responsible person shall ensure that all nursing staff are aware of, and adhere to, the recommended frequency of the completion of neurological observations in order that these are completed consistently and in line with best practice guidelines in this area.	**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, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 18 **Stated:** First time	The responsible person shall ensure that risk assessments completed regarding the use of bed rails provide a clear rationale for their use which is reflective of the needs of the individual patient. Care plans for restrictive practices should include details of recommended equipment and any other additional safety measures that are required.	**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 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 or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with safe practice, a second nurse had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. Nurses were reminded that the personal medication records should be used as part of the administration of medicine process.

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 distressed reactions was reviewed. Nurses 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, infection or constipation. Directions for use were clearly recorded on the personal medication records. Care plans directing the use of these medicines were available. Records of administration and the reason for and outcome of administration were recorded.

The management of pain was reviewed. 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. Speech and language assessment reports and care plans were in place. Records of prescribing and administration, which included the recommended consistency level, were maintained.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside the recommended range.

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. Medicines were stored at the manufacturers' recommended temperatures.

Nurses were reminded that inhaler spacer devices must be cleaned /replaced regularly and that medicines awaiting disposal should be stored securely.

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. The sample of these records reviewed 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 records of receipt, administration and disposal of controlled drugs were maintained to the required standard in controlled drug record books.

Management and staff audited medicine administration on a regular basis within the home. In addition, running stock balances were maintained for medicines which were not supplied in the monitored dosage system. The audits completed at the inspection indicated that medicines were administered as prescribed. Nurses were commended for their ongoing efforts.

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 admission process for patients new to the home or patients returning from hospital was reviewed. Written confirmation of the patients' medicine regimes was obtained at or prior to admission and details shared with the community pharmacy. Records of receipt, prescribing and administration were accurately maintained. The audits showed that the medicines were administered as prescribed.

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 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.

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.

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 nurses had been trained and deemed competent to manage and administer medicines. Ongoing review was monitored through supervision and at annual appraisal. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

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

* The two areas for improvement identified at the last inspection 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 Ms Jacqueline Bowen, Registered Manager, and Mrs Caroline Malone, Responsible Person, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan

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	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
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Area for Improvement 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** With immediate effect (22 November 2022)	The responsible person shall ensure that risk assessments completed regarding the use of bed rails provide a clear rationale for their use which is reflective of the needs of the individual patient. Care plans for restrictive practices should include details of recommended equipment and any other additional safety measures that are required.
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