The Regulation and Quality Improvement Authority

Inspection Report

4 May 2022

Parkview House

Type of service: Nursing Home
Address: Parkview Road, Castlederg, BT81 7XH
Telephone number: 028 8167 9192

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 Marion Davina McAllister **Date registered:** 1 April 2005
Person in charge at the time of inspection: Mrs Marion Davina McAllister	**Number of registered places:** 27 Maximum of two persons in category NH-LD (E) and one person in category NH-PH.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. LD (E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 18
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 27 patients. The home is a single storey building and all bedrooms are single occupancy. Patients have access to communal lounges, a dining room and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 4 May 2022, from 9.45am to 2.00pm. This was completed by two pharmacist inspectors.

The inspection 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 found that robust arrangements were in place for the safe management of medicines.

Medicine records and medicine related care plans were mostly well maintained. 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 new area for improvement was identified in relation to thickener records.

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.

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 and patients views were also obtained.

4.0 What people told us about the service

To reduce footfall throughout the home, the inspectors did not meet any patients.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

The inspectors met with nursing staff and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The nurses spoken with generally expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and that management were 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 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 9 November 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 16 (2) (b) **Stated:** Second time	The registered person shall ensure that a review of all patient care records is completed to include specific details within care plans regarding: • the patients normal bowel type and frequency	**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 27 (4) (b) **Stated:** First time	The registered person shall take adequate precautions against the risk of fire to ensure the safety and wellbeing of patients in the home. Specific reference to ensuring: • that fire doors are not obstructed or propped open.	**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 3 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that all staff employed to work in the home are aware of and adhere to the IPC guidelines and best practice requirements. With specific reference to ensuring: • appropriate storage of items and patient equipment • patient equipment is effectively cleaned following use • emergency pull cords are covered to facilitate effective cleaning • staff are bare below the elbow • gloves and apron are removed after direct contact with a patient and in accordance with IPC guidelines • the correct procedure for the disposal of bodily fluids is adhered to.	**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 4 **Ref:** Regulation 29 **Stated:** First time	The registered person shall ensure that the monthly quality monitoring visits are unannounced and reports of the visits are available and accessible to the person in charge within the home.	**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 39.1 **Stated:** First time	The registered person shall ensure that staff who are newly appointed, complete a structured orientation and induction within two days of employment commencing, with a full induction carried out within three months and a record of induction is retained within the employees file.	**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:** Standard 39.4 **Stated:** Second time	The registered person shall ensure that the training needs of individual staff for their roles and responsibilities are identified and arrangements are in place to meet them.	**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 3 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that any changes in the assessed needs of a patient are reflected within their care records and that relevant risk assessments including a body map are completed on admission and 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.	
Area for improvement 4 **Ref:** Standard 12.4 **Stated:** First time	The registered person shall ensure that a MUST assessment is completed on a monthly basis or more frequently depending on the assessed needs of the patient.	**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 medical 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 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 personal medication records when they were written and updated to state 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 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 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. Directions for use were clearly recorded on the personal medication records. Care plans directing the use of these medicines were in place; however, the prescribed medicine and dosage directions were not specified. This was discussed with the manager and nurses who gave an assurance that the care plans would be amended accordingly. 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 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 for four patients. 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, for two patients the recorded thickener consistency did not correlate across all records (for both patients the personal medication records had not been updated with the current thickener consistency and for one of the patients the care plan had also not been updated). An area for improvement was identified.

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. The nurse advised that they had received training and felt confident to manage medicines and nutrition via the enteral route

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.

With one exception, the records inspected showed that medicines were available for administration when patients required them.

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. Medicine refrigerators and controlled drugs cabinets 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. The records were found to have been fully and accurately 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 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.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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 nurses can learn from the incident. A robust audit system will help nurses to identify medicine related incidents.

The manager and nurses 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 the nurses in order to prevent a recurrence.

The audits completed at the inspection indicated that the medicines were being administered as prescribed.

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 they 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. A written record was completed for induction and competency assessments.

6.0 Quality Improvement Plan/Areas for Improvement

One new area for improvement has been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	5*	4*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Davina McAllister, 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 16 (2) (b) **Stated:** Second time **To be completed by:** 9 December 2021	The registered person shall ensure that a review of all patient care records is completed to include specific details within care plans regarding: • the patients normal bowel type and frequency **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 27 (4) (b) **Stated:** First time **To be completed by:** With immediate effect (9 November 2021)	The registered person shall take adequate precautions against the risk of fire to ensure the safety and wellbeing of patients in the home. Specific reference to ensuring: • that fire doors are not obstructed or propped open. **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 4 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** With immediate effect (9 November 2021)	The registered person shall ensure that the monthly quality monitoring visits are unannounced and reports of the visits are available and accessible to the person in charge within the home.
	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 5 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** With immediate effect (4 May 2022)	The registered person shall ensure that thickener consistencies are accurately recorded on all relevant records. Ref: 5.2.1
	Response by registered person detailing the actions taken: All Care Plans/Medication kardexes and Folder for special diets have been updated following Inspection and all information cross referenced to Epic Care
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 39.1 **Stated:** First time **To be completed by:** With immediate effect (7 January 2021)	The registered person shall ensure that staff who are newly appointed, complete a structured orientation and induction within two days of employment commencing, with a full induction carried out within three months and a record of induction is retained within the employees file.
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