The Regulation and Quality Improvement Authority

Inspection Report

2 June 2021

Silverdale

Type of Service: Nursing Home
Address: 29a Castlegore Road, Castlederg, BT81 7RU
Tel No: 028 8167 9574

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: SRB Care Limited **Responsible Individual:** Mrs Sarah Roberta Brownlee	**Registered Manager:** Mrs Geraldine Browne **Date registered:** 10 June 2009
Person in charge at the time of inspection: Mrs Geraldine Browne	**Number of registered places:** 41 A maximum of 14 patients in category NH-DE, one bedroom in NH-I category only to be used by ambulant persons. The home is also approved to provide care on a day basis for four persons.
Categories of care: Nursing (NH): I – Old age not falling within any other category DE – Dementia PH – Physical disability other than sensory impairment	**Number of patients accommodated in the nursing home on the day of this inspection:** 39
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for up to 41 patients.	

2.0 Inspection summary

An unannounced inspection took place on 2 June 2021, from 9.30am to 1.15pm. The inspection was conducted by a pharmacist inspector.

This inspection focused on medicines management within the home.

The inspection also assessed progress with three of the seven areas for improvement identified at the last care inspection. The other areas for improvement were carried forward for review by the care inspector at the next inspection.

The inspection concluded that the home was delivering safe, effective and compassionate care and was well led with respect to the management of medicines.

Review of medicines management found that patients were being administered their medicines as prescribed. There were robust arrangements for auditing medicines and medicine records had been fully and accurately completed.

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 we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration
- medicine receipt and disposal
- controlled drug
- care plans related to medicines management
- governance and audit
- staff training and competency
- medicine storage temperatures
- RQIA registration certificate

4.0 What people told us about the service

We met with the three registered nurses and the manager. Staff were warm and friendly and it was evident from their interactions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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 registered 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 last inspection?

Areas for improvement from the last inspection on 3 March 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 14 (2)(a) **Stated:** First time	The registered persons must ensure that all areas of the home to which patients have access are free from hazards to their safety. With specific reference to: • denture cleaning tablets • maintenance tools • the potential risks associated with safety pins are included within the patients risk assessment • all grades of staff are aware of their responsibility to report and action any actual or potential hazards.	**Met**
	Action taken as confirmed during the inspection: Denture tablets were stored in a lockable cupboard in the patient's room. No maintenance tools were observed in the home. The manager advised that a risk assessment had been performed for each patient regarding the use of safety pins; this had led to the decision being taken to replace safety pins with crocodile clips. Staff spoken to were aware of their responsibility to report and action any actual or potential hazards.	

Area for Improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that infection prevention and control practices are reviewed. Specific reference to: • review the availability of PPE and hand sanitising gel in identified areas of the home • staff wear appropriate PPE when transporting soiled linen from patients' bedrooms • items within linen stores are stored above the ground • net pants are labelled and for individual use • hoist and slings are not stored where there is a toilet • patient equipment is effectively cleaned following use.	**Met**
	Action taken as confirmed during the inspection: Six additional spray sanitisers had been installed in the building. Staff transporting soiled linen from patients' bedrooms wore aprons. Items in the linen stores were stored above the ground. Net pants were labelled for individual use. There were no hoists or slings being stored in toilets. The manager confirmed that there is a cleaning schedule for housekeeping activities.	
Area for Improvement 3 **Ref:** Regulation 27 (4)(b) **Stated:** First time	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that fire doors are not obstructed.	**Met**
	Action taken as confirmed during the inspection: No fire doors were obstructed during the inspection.	

Area for Improvement 4 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that RQIA are notified of any event in the home in accordance with Regulation 30. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**	**Carried forward to the next inspection**
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 37 **Stated:** First time	The registered person shall ensure that any record retained in the home which details patient information is stored safely in accordance with the General Data Protection Regulation and best practice standards. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**	**Carried forward to the next inspection**
Area for Improvement 2 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that there are clear and documented processes for the prevention, detection and treatment of pressure damage. With specific reference to ensuring: • that where a wound has been assessed as requiring treatment, a care plan is implemented to include the directions for the frequency of dressing renewal and dressing type • where a patient has been assessed as requiring repositioning the frequency should be recorded within the care plan and reflected within the repositioning chart. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**	**Carried forward to the next inspection**

Area for Improvement 3 **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: • IPC • Environment	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	

5.2 Inspection outcome

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 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 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 e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate.

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. Staff 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 the personal medication records and care plans directing the use of these medicines were available in the medicines file. Records of administration were clearly recorded. The reason for and outcome of administration were recorded in the daily progress notes.

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.

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 and nutritional supplements for two patients 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.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. We reviewed the management of medicines and nutrition via the enteral route. 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. Staff on duty 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.

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.

Discontinued medicines were returned to the community pharmacy for disposal and records 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 medicine 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 were recorded in a controlled drug record book. Appropriate arrangements were 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 audits completed during this inspection showed that medicines had been given as prescribed.

Several patients have their medicines administered in food/drinks to assist administration. Care plans detailing how the patients like to take their medicines were in place.

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.

We reviewed the management of medicines for two patients who had been admitted to this home. In each instance, the patient's prescribed medication had been confirmed with the GP practice. The personal medication records had been accurately written and the medicines had been accurately received into the home. Medicines had been administered in accordance with the prescribed 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. 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 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.

Records of staff training in relation to medicines management were available for inspection.

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.

Based on the inspection findings and discussions held we 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 manager. We can conclude that the patients were being administered their medicines as prescribed by their GP.

The inspection also assessed progress with three of the seven areas for improvement identified at the last care inspection. These three areas for improvement were assessed as having been met. The remaining four areas for improvement were not reviewed and are carried forward to the next care inspection. 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*	3*

* the total number of areas for improvement includes four that have been 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 Geraldine Browne, 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 30 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that RQIA are notified of any event in the home in accordance with Regulation 30.
	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 37 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that any record retained in the home which details patient information is stored safely in accordance with the General Data Protection Regulation and best practice standards.
	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 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that there are clear and documented processes for the prevention, detection and treatment of pressure damage. With specific reference to ensuring: • that where a wound has been assessed as requiring treatment, a care plan is implemented to include the directions for the frequency of dressing renewal and dressing type • where a patient has been assessed as requiring repositioning the frequency should be recorded within the care plan and reflected within the repositioning chart.
	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 35 **Stated:** First time **To be completed by:** 3 April 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: • IPC • Environment
	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**

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews